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Mission

The Mission of Louisiana State University Health Sciences Center - Shreveport’s University Hospital is to serve the Ark-La-Tex community by providing:

- quality patient care services,
- a teaching environment for training future medical and allied health care professionals,
- and support for medical and scientific research.

Quality Patient Care is the first priority of the organization. Empowered employees will maximize Quality Patient Care by balancing Patient Expectations, Patient Needs, and Available Resources.

DEFINITIONS

Patient Expectations are those aspects of care most appropriately identified by the patient. The patient and secondly their families take the leadership role in defining Patient Expectations. These include consideration for a patient’s rights, comfort, culture, dignity, privacy, security, and individuality. Collectively, how these patient’s interests are allowed to affect patient treatment shows our respect and care for the individual.

Patient Needs are those clinical aspects of care best identified by healthcare professionals. Attending physicians take a leadership role in defining needs. Other physicians, nurses, technicians, allied health professionals, and others involved in helping those who deliver care all have expertise to contribute towards identifying and meeting the needs of the patient. The patient has the right to expect that these needs will be coordinated in an atmosphere that supports quality, interdisciplinary respect, and professionalism.

Available Resources are the facilities, equipment, supplies and people that are brought to bear to improve the health of the patient. Resources are limited in quantity. The use of resources must respect the long term viability and priority goals of the organization. The end use of all resources should support our mission.

The challenge to the physicians and the employees of the hospital is to balance Patient Expectations, Patient Needs, and Available Resources to achieve Patient Satisfaction and Quality Care. This can best be accomplished within a culture of mutual trust, mutual respect, and appropriate empowerment of patients, physicians, and hospital employees.
Institutional Commitment

LSU Health Shreveport is a major division of the Louisiana State University Health Sciences Center, which in turn is a major segment of the Louisiana State University System under the direction and control of the Louisiana State University Board of Supervisors. As such, there is a direct constitutionally mandated commitment to education in general. The Board of Supervisors has delegated educational responsibility to this campus for the medical and postgraduate medical education under the direct supervision of the Dean and Chancellor.

LSU Health Shreveport, formerly the Louisiana State University Health Sciences Center-Shreveport, Shreveport Charity Hospital, Confederate Memorial Medical Center, and Louisiana State University Medical Center, was founded with a mission to provide physicians to the Northern area of Louisiana but this has been subsequently expanded to meet the needs of the other areas of the state, region and country. There is substantial financial commitment to post graduate medical education as the institutional budget just for Resident salaries and benefits exceeds $15 million. Base faculty salaries in the clinical departments are given just for the teaching requirements. The institution has invested over $750,000 in video-conferencing equipment to link our affiliated hospitals and sister medical school (LSU School of Medicine in New Orleans) so that educational opportunities for all Residents may be enhanced.

There has been and continues to be an aggressive Capital Outlay Expenditure Program before the Legislature. These programs do have a large patient service component in them, but they will be extensively used in Resident education.

The hospital provides a fully funded budget dedicated to the Office of Medical Education to provide coordination of all related Graduate Medical Education Programs. This office is integrated and works closely with the Graduate Medical Education Committee of the Health Sciences Center.

Faculty at this facility are recruited for their teaching ability as well as their service skills. Hospital Administrators are required to consider teaching needs in their administrative decisions, and these decisions are reviewed.

Finally, there are firm commitments to post graduate medical education from the Chancellor, Dean, DIO and Administrators. The Administrators, faculty, clinicians and staff are proud of our teaching programs, and will take whatever actions are necessary to preserve their integrity.

Accreditation Council for Graduate Medical Education

Accreditation Council for Graduate Medical Education (ACGME) serves as the reference source for the Residency Training Programs that are sponsored by LSU Health Sciences Center in Shreveport. The ACGME, under the direction of the Association of American Medical Colleges (AAMC), is governed by representatives from the other medical professional groups dedicated to quality education and patient care.

The Graduate Medical Education Committee (GMEC) is responsible for ensuring that the residency training programs require its Residents to obtain competencies in the 6 areas below to the level
expected of a new practitioner. Toward this end, programs must define the specific knowledge, skills, and attitudes required and provide educational experiences as needed in order for their Residents to demonstrate:

a. ACGME Six Competencies:

1) Patient Care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.
2) 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.
3) Practice-Based Learning and Improvement that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care.
4) Interpersonal and Communication Skills that result in effective information exchange and teaming with patients, their families, and other health professionals.
5) Professionalism as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.
6) Systems-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.

Definitions

Designated Institutional Official (DIO) is the individual in a sponsoring institution who has the authority and responsibility for all of the ACGME-accredited GME programs.

Chief Resident is a resident, usually of a senior level, who serves as the representative for the Resident’s training program. The Chief Resident may be selected by his program Resident peers or by his Program Director and/or Clinical Service Faculty.

Clinical Chairs are those physicians who serve as the Chairpersons of the Clinical Departments of the Medical School and Hospital. In some departments, the Clinical Chair also serves as the Residency Training Program Director.

Dean is appointed by the Chancellor of the Health Sciences Center and confirmed by the Louisiana State Board of Supervisors. The Dean serves as the executive chief of the Health Sciences Center.

Resident is the physician and or dentist who participates in a post-graduate training program at Louisiana State University Health Sciences Center in Shreveport in year levels one through eight.

Resident Council Member is a resident who has been selected by his/her peers to serve as the primary representative for the residents.
Program Directors are those physicians who are the designated departmental representative responsible for the oversight of the residency training programs at Louisiana State University Health Sciences Center in Shreveport.

Office of Graduate Medical Education

The Office of Graduate Medical Education is strategically located on the first floor of the Medical School (Room 1-201). The Office serves as the central contact point for all Residents in the Training Programs. That point of contact begins at the time of their selection to a residency or fellowship training program and continues throughout their training period until completion of that educational requirement of their professional career. The Resident’s permanent record remains in the Graduate Medical Education Office. The office hours are 8:00 a.m. to 5:00 p.m., Monday through Friday, the telephone numbers are 675-5054 or 675-5053, and the fax number is 675-5069.

Graduate Medical Education Committee

Purpose of GMEC

The overall role of the Institutional GMEC at LSU Health Sciences Center-Shreveport is one of ensuring that individual departmental programs meet the Institutional Requirements of the Accreditation Council for Graduate Medical Education (ACGME) and the program requirements of the various Residency Review Committees (RRCs). Residents/fellows with complaints/suggestions about their program are encouraged to bring these matters to the attention of their Program Director and the Departmental Chair. If they feel they have been unable to effect change within their respective program/departments by this method, Residents/fellows are encouraged to bring these matters to the attention of their GMEC representative or the Designated Institutional Official (DIO).

The role of the Institutional GMEC in the adverse action/disciplinary policy is one of ensuring that due process mechanisms are in place and functioning. The GMEC Committee does not hear adverse action/disciplinary matters against individual Residents/fellows but rather ensures that prompt, appropriate, fair and free access is available through an appeals mechanism.

The Graduate Medical Education Committee (GMEC) is responsible for monitoring and supervising all aspects of residency education. The composition of the Graduate Medical Education Committee include the DIO, all Program Directors, Resident/Fellow representatives and a quality improvement or patient safety officer or designee.

The GMEC meets monthly. Minutes are maintained in the Graduate Medical Education office and are available for reference and inspection by appropriate accreditation personnel.

Roles and Responsibilities

GMEC responsibilities must include oversight of:

- ACGME-accreditation status of the Sponsoring Institution and its ACGME-accredited programs
The quality of the GME learning and working environment within the Sponsoring Institution, its ACGME-accredited programs, and its participating sites

The quality of educational experiences in each ACGME-accredited program that lead to measurable achievement of educational outcomes as identified in the ACGME Common and specialty/subspecialty-specific Program Requirements

The ACGME-accredited program(s)’ annual evaluation and improvement activities

All processes related to reductions and/or closures of individual ACGME-accredited programs, major participating sites, and the Sponsoring Institution

The GMEC must review and approve:

- Institutional GME policies and procedures
- Annual recommendations to the Sponsoring Institution’s administration regarding resident/fellow stipends and benefits
- Applications for ACGME accreditation of new programs
- Requests for permanent changes in Resident/Fellow complement
- Major changes in ACGME-accredited programs’ structure or duration of education
- Additions and deletions of each of its ACGME-accredited programs’ participating sites
- Appointments of new program directors
- Progress reports requested by a Review Committee
- Responses to Clinical Learning Environment Review (CLER) reports
- Requests for exceptions to duty hours requirements
- Voluntary withdrawals of ACGME program accreditation
- Requests for appeal of an adverse action by a Review Committee
- Appeal presentations to an ACGME Appeals Panel

The GMEC must demonstrate effective oversight of the Sponsoring Institution’s accreditations through an Annual Institutional Review (AIR).

The GMEC must demonstrate effective oversight of underperforming program(s) through a Special Review process.

**Faculty and Departmental Roles**

Faculty in the Departments of the sponsored programs are best qualified to judge the performance and capabilities of Residents/Fellows in their program. The Departments under the administrative guidance of the Departmental Chair and specific supervision of the program director have the responsibility for the educational program for their residency or fellowship program. They are responsible for the evaluation of those individuals enrolled in such programs according to the established guidelines of the respective Residency Review Committees. Each Department establishes its mechanisms for the ongoing evaluations of its Residents/fellows. Written evaluations should be given and discussed with the Residents so that they may be made aware of their strengths, weaknesses, and recommendations for improvement. The Departments evaluate their Residents/fellows on a regular basis, but in no case less than **twice yearly**. At this time, the departmental representative conducting the evaluation should attempt to elicit recommendations from the Resident/fellow to improve the quality of the Resident’s/fellow’s training experience. These evaluations are residency/fellowship program specific but should include (but are not necessarily limited to) an evaluation of:
1. Competency
2. Knowledge
3. Work habits
4. Personal interaction with patients, patient’s families, peers, subordinates, and superiors.

If a Resident’s/fellow’s performance is substandard, **disciplinary action is determined and administered by the individual department**. Disciplinary action may take the form of:

1. Oral counseling
2. Written counseling
3. Suspension
4. Extension of residency training
5. Dismissal

**Next Accreditation System (NAS)**

The Next Accreditation System is an outcomes-based accreditation process through which the doctors of tomorrow will be measured for their competency in performing the essential tasks necessary for clinical practice. The NAS is based on a continuous accreditation model with no cycle lengths.

1. Clinical Learning Environment Review
   The ACGME established the Clinical Learning Environment Review (CLER) program as a key component of the NAS, with the aim to promote safety and quality of care. CLER consists of three related activities:
   - The **CLER site visit program** is used solely for providing feedback, learning, and helping to establish baselines for sponsoring institutions, the Evaluation Committee, and the IRC. The first cycle of visit findings will result in dissemination of salutary practices by the Evaluation Committee.
   - The **CLER Evaluation Committee** includes a broad cross-section of individuals with expertise related to the aim of the CLER program. The Committee provides input to the design and implementation of CLER site visit activities and conducts evaluation review of sponsoring institutions that are visited during each cycle.
   - The ACGME recognizes the great interest by sponsoring institutions to support **faculty development** in those areas on which the CLER program will focus (e.g., patient safety, health care quality, transitions of care, etc.). Therefore, as part of the CLER program, the ACGME will develop a program to support faculty development.

CLER focuses on six areas important to the safety and quality of care in teaching hospitals and the care residents will provide in a lifetime of practice after completion of education:
- engagement of residents in patient safety
- engagement of residents in quality improvement
- enhancing practice for care transitions
- promoting appropriate resident supervision
- duty hour oversight and fatigue management
- enhancing professionalism in the learning environment and in reporting to the ACGME.
Institutional Review Subcommittee

The Graduate Medical Education Committee (GMEC) is responsible for the oversight of the Sponsoring Institution and their approved ACGME-accredited programs. The Sponsoring Institution is responsible for oversight and documentation of resident/fellow engagement in improvement processes within patient care and the learning and working environment. In order to pursue proper oversight, the Institutional Review Subcommittee, designated by the GMEC, is responsible for reviewing each program and assuring compliance with the Institutional and Program Requirements of the ACGME.

1. Policy

   Members will be appointed to the Institutional Review Subcommittee (IRS) to review all programs on an annual basis. The program being reviewed shall complete an Annual Program Evaluation (APE) form along with supporting documents and submit to the Institutional Review Subcommittee. The Institutional Review Subcommittee will review the documents and score the program based on the answers and required documents submitted. If after review, a program has scored below the minimum score or has a 30% variation (<20), the program will be required to go through the Special Review Process. After a program has been reviewed by the IRS, the program’s results will be presented to the GMEC.

2. Procedure

   • The Institutional Review Subcommittee consists of members which are Program Directors of various programs, a staff member from the graduate medical education office and chief residents of Internal Medicine.
   • The program being reviewed completes the APE form and submits to the GME Office no later than the first Tuesday of the program’s submission month.
   • In addition to the APE form, the program must submit the following documents:
     - Printed summary of the program’s ACGME WEBADS Annual Update
     - The policy, member roster, and most recent minutes for your Clinical Competency Committee
     - Copies of your program’s action plan for this year from your Program Annual Curriculum Evaluation
     - Progress report on the action plan Program Annual Curriculum Evaluation from last year
     - Departmental Program Evaluation policy and members list
     - The most recent ACGME Resident Survey and ACGME Faculty Survey
     - An update to your Institutional Annual Program Evaluation submitted last year with updated & completed Action Plan submitted to the GMEC in 2017
   • The IRS meets on the 2nd Tuesday of the month and evaluates the program’s answers and the quality and safety of the environment for learning and patient care. The IRS reviews the program based on the APE form and additional documents submitted.
   • In reviewing the program, the IRS assesses the program’s resident/fellow engagement in the following six areas:
     1. Patient Safety
     2. Quality Improvement
     3. Transitions of Care
     4. Supervision
     5. Duty Hours
     6. Professionalism (Scholarly Activity)
   • The IRS also assesses the program’s compliance in monitoring and tracking in the following areas:
     - Resident Wellness
     - Practice Based Habits
     - In-service Training Exams
     - Board Pass and Take Rate
     - TB and CED Compliance
     - ACGME Resident and Faculty Survey results
     - Previous year’s APE Action Plan results
     - Submitted APE complete and timely
   • The IRS will then score the program based on the documents submitted. A total of 36 points may be earned. A score below 70% will result in the program going through the Special Review Process.
The score of the programs being reviewed shall be reported monthly at the GMEC meeting (4th Tuesday) of the review month. The Program Directors and/or Associate Program Directors of the reviewed program are required to be present at the GMEC meeting in the program’s assigned review month.

Support Services and Systems
The Graduate Medical Education Committee (GMEC) shall provide support to the Hospital in meeting all requirements to provide the support services necessary to ensure the delivery of quality patient care. It is the priority of the Committee that all support services needed to provide patient care be available 24 hours a day, seven days a week.

The Institution must provide support services and develop health care delivery systems to minimize residents’/fellows’ work that is extraneous to their ACGME-accredited programs’ educational goals and objectives and to ensure that residents’/fellows’ educational experience is not compromised by excessive reliance on residents’/fellows to fulfill non-physician service obligations.

The Institution provides an effective Clinical Laboratory, Health Information Management System (Medical Records) and Radiological Information retrieval system to support the Resident’s educational program needs as well as addressing quality and timely patient care. The institution provides all support services required to be accredited by the Joint Commission on Healthcare Organizations.

The Institution provides appropriate security and personal safety measures in all locations of the Hospital 24 hours a day, seven days a week. These include but are not limited to the parking facilities, on-call quarters, Hospital and Institutional grounds and related clinical buildings. Also, those residents/fellows on duty will be provided adequate and appropriate food services and sleeping quarters.

Questions concerning the support services are included in the Resident interview during the Internal Review Process. Any areas of concern identified are reported to the GMEC, Department Chairman, Residency Program Director and others as necessary to assure appropriate actions are taken to provide the necessary support service.

Human Resources

1. Benefits
   a. Malpractice Insurance
      The State of Louisiana provides professional liability coverage pursuant to LSA-R.S. 40:129939 et.seq. to Residents when acting within the course and scope of their training or staff which they are assigned as part of their prescribed training, regardless of where the services are performed. However, Residents assigned to a health care facility outside the state of Louisiana may be required to provide additional professional liability coverage with indemnity limits set by the Resident Program Director. Malpractice Insurance is provided through the State of Louisiana self-insurance plan at no cost to the Resident and covers in-house duties only. External moonlighting is not covered. Any questions regarding any malpractice claims or legal inquiry should be reported to the Office of Legal Affairs (675-5406).
b. Disability Insurance

Residents receive, without charge, a basic group disability insurance benefit. Additional individual, own-specialty coverage may be purchased by the Resident at a discounted premium. Any questions concerning the Disability Program and its benefits should be directed to the Medical Education Office. The Medical Education Office then will refer the Resident to the current representative of the benefit.

Unum Provident Representative:
Robert Redstone
318-213-2500

c. Health Care Insurance

It is required that proof of Health Care Insurance be presented at the beginning of each contract year. It is mandatory that all house officers obtain health insurance while in training. The institution does not offer free health care to house officers. The institution offers a variety of Health care insurance coverage benefit options for its employees. House Officers may purchase health care insurance as part of the benefits package.

The U.S. Code of Federal Regulations (22 CFR § 62.14) mandates that all J-1 exchange visitors and accompanying J-2 dependents secure comprehensive health insurance effective on the program start date indicated on Form DS-2019 and maintain coverage, without interruption, for the full duration of stay in the United States in J-1 status. Any J-1 exchange visitor who willfully refuses to comply with insurance requirements will be considered to be in violation of his/her status and subject to termination from the J-1 program.

d. Deferred Compensation

Residents have the option of participating in the State Deferred Compensation Program instead of contributing to FICA/Social Security.

A representative from the State Office assists the Resident with their enrollment and assists when the Resident is no longer in a training program and must determine how the accumulated dollars will be managed or withdrawn.

If the Resident does not wish to participate, the normal withholdings will be processed by the Payroll Office and submitted to FICA/Social Security.

Questions regarding Health Care Insurance or Deferred Compensation should be directed to the Benefits Section of Human Resources located on the first floor of the Administration building.

2. Leave

a. Family and Medical Leave Act

All employees who have been employed for twelve (12) months and who have worked for at least 1,250 hours during the 12 months preceding the start of a leave, are eligible for up to 12 weeks of unpaid leave for certain qualifying events. Qualifying events include:

- For a serious health condition that makes the employee unable to perform the employee’s job.
- the birth of a son or daughter and to care for the child.
- the placement of a son or daughter by adoption or foster care.
- to care for a spouse, son, daughter or parent if the family member has a serious health condition.

The University shall require thirty (30) days advance notice of the request, whenever reasonable. Certification as to the authenticity of the precipitating event will be required.

Employees must substitute any applicable accrued paid leave for the 12 weeks of unpaid leave.
The University’s portion of employee health coverage will be maintained while the employee is on leave without pay and as long as the employee’s portion is paid. LSU will not contribute to other benefit plans during periods of unpaid leave.

Requests for leave along with pertinent certification documents should be forwarded by the employee’s supervisor and Department Director to the Employee Relations Section of the Human Resource Management Department. The Human Resource Management Department will determine the employee’s eligibility under the Family and Medical Leave Act.

Employees returning to work from Family and Medical Leave will be restored to the same jobs held before going on leave, or to equivalent positions with the same pay, benefits, and other terms and conditions of employment.

**Family and Medical Leave (FMLA) Act Expanded for Military Families**

The Support for Injured Service Members Act, which grants additional leave under the FMLA to “eligible” employees who have family members in the military. The legislation creates two (2) new categories of FMLA leave:

1) Active Duty Family Leave – Employees with a spouse, parent, or child who is on or has been called to active duty in the Armed Forces may take up to 12 weeks of FMLA leave when they experience a “qualifying exigency”.

2) Injured Service member Leave – Employees who are the spouse, parent, child, or next of kin of a service member who incurred a serious health or illness on active duty in the Armed Forces may take up to 26 weeks of leave in a 12-month period (including regular FMLA leave).

Employees may take “injured service member leave” intermittently but must use it up within 12 months. More information on the new leave requirements will be forthcoming once guidelines have been issued by the Department of Labor.

You may contact Pam Owens in Human Resource Management at 675-5614 with your questions or concerns or visit [http://myhsc.lsuhscshreveport.edu/hr/fmla.php](http://myhsc.lsuhscshreveport.edu/hr/fmla.php).

**b. Funeral**

In accordance with the University Policy on Funeral Leave, funeral leave may be given to Residents without loss of pay or required use of annual leave or sick leave to attend the funeral or burial rites of an immediate family member when such rites occur on a scheduled work day.


**c. Maternity/Paternity**

The Resident is required to notify the Human Resources, the Medical Education Office and their Program Director as soon as pregnancy has been confirmed. Sick leave and if necessary, annual leave will be used for the maternity absence. Any leave beyond that will necessitate Leave without Pay Status and result in the extension of the training period.

Paternity leave is authorized only if the Resident has adequate annual leave available.

**d. Leave of Absence**

The Graduate Medical Education Committee (GMEC) supports the policy for Leave of Absence as referenced by the Presidential Memorandum PM 20, “Leave Policies for Academic and Unclassified Employees and Classified Personnel”. Once all sick and annual leave has been exhausted the house officer may request Leave without pay in writing. In order to be eligible for Family Medical Leave Act
(FMLA) a house officer must have worked for at least one year and for 1,250 hours over the previous twelve months.

House Officers who find themselves in a position to require the need to “request a leave of absence” must do so in writing. The request shall be submitted to the Program Director and/or Clinical Chief. The “Leave of Absence” is approved by the Program Director and submitted to the Medical Education Office for record keeping.

The leave of absence shall not exceed the house officer’s current contract. When leave is taken, the House Officer must submit an official certificate from the physician stating the anticipated date of return as well as identify the length of time the period of training will need to be interrupted. A medical release from your physician must be provided to the programs, the Medical Education departments before being able to return to training.

House officers granted a “leave of absence” shall be in a non-paid or “leave without pay” status. During this period, the Resident will be responsible for both portions of the health insurance premium payment if the “leave without pay status” exceeds a two-week period. The Resident shall be directed to review the payment options with the Department of Human Resources, Benefits Division.

Agreements for postgraduate training are valid for a specified period of time no greater than 12 months. Renewal of the agreement is at the discretion of the Program Director or Department Chairman and will be dependent upon available funding and/or my performance rating. Agreements may be terminated at any time for just cause that includes unsatisfactory job performance and conduct unbecoming a physician.

**Resident Application and Eligibility**

**National Resident Matching Program**

Residency Program Directors are encouraged to utilize the National Resident Matching Program (NRMP) in the selection process of their incoming Residents.

The institutional administrator registers LSUHSC-S each year for participation in the NRMP. Each participating program director must register for participation in the NRMP via the NRMP website by agreeing to abide by the match agreement.

Changes in quotas and other program data must be submitted to the Office of Medical Education for submission to NRMP.

The Graduate Medical Education Office provides support to the Residency Programs in the data entry of the ranking listings. The Program Directors confirm the official NRMP results and the individual is then processed as a new Resident.

**VISA Eligibility and Requirements**

The Office of Legal Affairs serves as the liaison for all immigration issues involving Residents. The institution accepts applicants on a J-1 visa status to participate in training programs. The Educational Commission for Foreign Medical Graduates (ECFMG) should be contacted for application materials (www.ecfmg.org). It is the responsibility of the applicant to initiate the visa process.

The U.S. code of Federal Regulations governing the alien physician category of the J-1 Exchange Visitor Program strictly forbids the performance of activities outside the primary objective of clinical training covered by the resident contract and is considered unauthorized employment. An exchange visitor
who is found by ECFMG to engage in unauthorized employment is considered to be in violation of program status and may be terminated. In addition, the consequences of allowing unauthorized employment could result in a loss of federal grants and contracts for LSUHSC. The Resident is responsible for the continuity of his/her sponsorship or employment authorization to continue as a Resident at this institution.

Due to Federal Guidelines, individuals with the J-1 VISA are not allowed to moonlight.

**Employment**

**Terms of Employment**

Employment in residency or fellowship training is by contract. The contractual relationship governs issues that are specific to the residency/fellowship program and supplements those rules and regulations of the State of Louisiana and the LSU System. These items are covered more fully in other portions of the Resident Manual. Residents/fellows are expected to read this manual, as they are held accountable for its content. Although the residency/fellowship training programs may vary in length, contracts are issued for a period of one-year. Renewal of the contract for each subsequent year is completely discretionary at the option of either the resident/fellow or the Department.

Programs must provide a Resident with a written notice of intent when that resident’s agreement will not be renewed, when that Resident will not be promoted to the next level of training, or when that resident/fellow will be dismissed. Any Resident receiving notice of intent to not renew his/her contract may request a hearing as outlined in the Due Process and Appeals Policies located in the Resident Manual.

Louisiana law DOES NOT require that the Health Sciences Center allow appeals for a contract non-renewal. However, since the non-renewal of a training contract may have an effect upon a resident’s/fellow’s career the Health Sciences Center does provide a process by which the resident/fellow may appeal the decision of the Department not to renew the contract. The appeal for a contract non-renewal will be handled procedurally in the same manner as an adverse action matter. Residents/fellows are advised to read the section under ADVERSE ACTION/DISCIPLINARY POLICY carefully as certain time constraints and other regulations apply. Failure to meet timely the requirements may WAIVE the right of appeal.

**ADVERSE ACTIONS/DISCIPLINARY POLICY**

Disciplinary action is defined as those actions taken to correct, to encourage the correction of, or punish substandard performance or lack of professional conduct. Disciplinary actions beyond written counseling are considered to be serious offenses.

An adverse action is defined as something that adversely affects a resident's/fellow’s career and includes not only disciplinary action but also such matters as a non-renewal of a training contract. As stated above a non-renewal of a contract is not appealable under Louisiana law. However, in keeping with the requirements of the ACGME, appeals for contract non-renewals are allowed since they represent a potential (but not necessarily certain) adverse effect upon the resident’s chosen pathway.

**NOTE: AS A MATTER OF LOUISIANA LAW, ANY STATE EMPLOYEE WHO IS CONVICTED OF A FELONY MUST BE DISCHARGED FROM STATE SERVICE WITHIN 48 HOURS AFTER THE CONVICTION IS FINAL. THIS LAW APPLIES TO RESIDENTS/FELLOWS, AS WELL AS ANY OTHER STATE EMPLOYEE. ANY**
RESIDENT OR FELLOW WHO HAS BEEN EXCLUDED FROM PARTICIPATION IN FEDERAL PROGRAMS MUST BE REMOVED FROM EMPLOYMENT IMMEDIATELY UPON DISCOVERY OF THEIR EXCLUSION.

Salary Guidelines for House Officers

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House Officer Pay Scales are subject to final approval by the State of Louisiana legislature. House Officers are paid every other Friday. There are 26 paydays in our fiscal year. House Officers salaries are based on the University’s policies and procedures for determining the level of compensation. Factors used to determine salaries include:

a. Graduates of medical schools in the United States and Canada accredited by the Liaison Committee on Medical Education (LCME)
b. Graduates of colleges of osteopathic medicine in the United States accredited by the American Osteopathic Association (AOA)
c. Graduates of medical schools outside the United States and Canada who meet one of the following qualifications:
   1. Have received a currently valid certificate from the Educational Commission for Foreign Medical Graduates or
   2. Have a full and unrestricted license to practice in a U.S. licensing jurisdiction.
d. All applicants must satisfy any requirements for prerequisite residency/fellowship training, as established by the relevant Residency Review Committee and/or certifying board for the specialty.
e. House officers changing specialties, may receive advance credit but not additional compensation.
f. Additional years of training, special background and experience beyond a traditional residency or fellowship, is not a prerequisite for training, thus additional compensation will not be granted.
Resident Responsibilities and Policies

Orientation

1. Pre-Employment Processing

The Louisiana State University Health Sciences Center-Shreveport consists of the School of Medicine and campuses of two other professional schools, the School of Graduate Studies and the School of Allied Health Professions. All are part of the statewide Louisiana State University Health Sciences Center. The Graduate Medical Education Committee supports the Health Sciences Center’s pre-employment requirements, which include a drug screen and full background review, including a review of any questions, which may be raised concerning the application. The signature of the applicant on the application gives the Institution approval to verify any information pertaining to the application involving inquiries.

The Department of Human Resources coordinates the pre-employment process and reports any significant “findings” to the appropriate individual for action and/or follow-up.

Individuals who fail to comply with the pre-employment requirements may not be eligible for employment at LSUHSC-S. The Department of Human Resources shall notify the appropriate individual(s) as soon as feasible.

In the event that a Resident’s status changes and he/she does not meet the requirements established by the Institution, the Resident will be advised of his/her non-compliance and appropriate action will be taken. The action taken may include “leave without pay status” until compliance with the institutional requirements are met, or the action may extend to Resident resignation, and/or termination.

2. Incoming House Officer Orientation

The Office of Graduate Medical Education hosts a mandatory Annual Orientation for incoming House Officers on the last day in June. The House Officer Orientation includes a number of required orientation topics. Also required of Incoming House Officers is the Graduate Medical Education online orientation. Incoming House Officers must complete this online orientation before they can begin work.

3. Departmental Orientation

Each department has its own orientation program to familiarize their House Officers with the practices and policies of each individual program.

4. New Employee Orientation

LSU Health Sciences Center conducts online new employee orientations throughout the year. House Officers unable to attend the House Officer Orientation in June will be required to complete new employee orientation when they begin training.

Campus Education Day

Campus Education Day (CED) is a review of annual mandatory training requirements mandated by Joint Commission, State Executive Order, OSHA, and LSUHSC Shreveport Administrative Directive that all LSU Health Shreveport employees are required to complete.

CED On-Line Training provides a quick and easy alternative to training, available 24 hours a day, 7 days a week, and as close as your desktop computer. Employees have access to the Project CARE lab to complete CED On-Line, also. Call ext 5-6381 to schedule an appointment.

House Officers will meet their initial CED requirement during their New Employee orientation. House
Officers are required to complete their CED training prior to July 1st every year. House Officers that fail to meet compliance by July 1st will be subject to suspension without pay until their training is current.

Identification Badge/ Access Card
All Residents will be issued an identification badge/access card. The card allows access to those areas that require controlled access/entrance after hours or may be considered restricted areas during regular work hours. The access card also authorizes entrance to House Officer assigned parking. The access card identifies access to controlled areas. The access card also serves as the meal card to be used in the cafeteria and deli areas. Please do not allow others to use your card.

Identification badges are required and can be obtained in the Parking Office in the Administration Building. Badges will be issued as part of the Orientation program only after all required paperwork and training has been completed. The card is the property of LSU Health Sciences Center. Loss of the card will result in a $20 replacement fee to be paid by the House Officer. The cards are returned to LSU Health Sciences Center when the sign out process occurs.

Licenses and Certifications
1. Louisiana State Medical License

Intern (PGY I) Registration
U.S. Medical School graduates who are first yearResidents may serve the PGY I (Internship) year with an INTERN REGISTRATION issued by the Louisiana State Board of Medical Examiners. If you took the NATIONAL BOARDS or USMLE you will be granted Intern Registration on that basis, and a copy of the test results must be furnished to the Medical Education Office (National Boards/USMLE).

Graduate Education Temporary Permit
International graduates who are not eligible for full license will be processed for Licensure of the Graduate Educational Temporary Permit outlined by the Louisiana State Board of Medical Examiners (LSBME). Graduates may request the license application form from the LSBME at their website: www.lsbme.louisiana.gov. Fingerprint cards and fees must be submitted with the application (contact University Police for assistance).

- Upon receipt of your medical license, NOTIFY the Office of Medical Education immediately.

Residents (PGY II and beyond)
Residents (PGY II and beyond) are eligible, but not required, to apply for full Louisiana license with the Louisiana State Board of Medical Examiners, with the following exceptions:
- Any Attending Fellow acting as an Attending in their primary area must obtain a full license
- Any Resident engaging in external moonlighting
These exceptions must obtain a full Louisiana license with the LSBME.

Residents (PGY II and beyond) not requiring a full Louisiana license may apply for a temporary permit issued by the LSBME while participating in a residency program beyond postgraduate year one.

All Residents are responsible for maintaining appropriate licensure during their training program. Failure to do so will result in Leave without Pay until licensure is obtained or termination from their training program.
USMLE
Residents are responsible for making application in accordance with time frames established by the LSBME and the Federation of Licenses FOR THE USMLE. Any questions regarding the USMLE should be referred to the Federation website: www.fsmb.org or the State Board.

2. Drug Enforcement Administration (DEA) License Policy

Institution issued DEA numbers
- House Officers are issued an institutional specific DEA by University Health while in training. The UH issued DEA is to be used when treating patients seen through University Health only (inpatient, clinic, ER, etc.).
- House Officers rotating to other facilities should use the responsible attending’s DEA# on all prescriptions unless they have applied and received their own personal DEA# (linked to LSU).
- Facility specific DEA numbers may not be used at other sites or for non-patients such as fellow residents, family members and friends. If that facility does not have an institutional DEA number, prescriptions should be written under their supervising physician (see above).

Personal DEA numbers
- Personal/Individual DEA numbers may be obtained when the provider has a full license granted by the Louisiana State Board of Medical Examiners (LSBME) or Louisiana State Board of Dental Examiners (LSBDE).

LSBME
- After completing one year of training and passing USMLE Step 3, U.S. graduates may apply for and may be granted full LA State Medical licensure by the LSBME. House Officers that have a full LA Medical license may apply for their own DEA after obtaining a personal CDS license.
- House Officers seeking their own DEA while in training may apply and be exempt from the application fee.

LSBDE
- Oral & Maxillofacial Surgery residents holding a restricted or full dental license should follow the requirements of the LSBDE regarding CDS and DEA licensure.

Any House Officer eligible and seeking to moonlight must obtain a full license and their own DEA number. Any House Officer with a personal DEA number must provide the GME office a copy of their DEA license.

Programs may have their own departmental specific policies/requirements regarding LA Medical, CDS, and DEA licensure for their House Officers in training.

3. Louisiana Controlled Dangerous Substance (CDS) License & Physician Monitoring Program (PMP)
The Louisiana Board of Pharmacy requires that all Residents and Fellows are to apply and receive their own CDS License. The application fee is $45.00 and must be renewed annually. Residents are also required to register for the Physician Monitoring Program (PMP). Medical interns and residents seeking PMP access privileges must first acquire a Louisiana CDS license. Once the CDS license has been issued, the intern must then apply for PMP access privileges.

4. Medicaid ID Number
Medicaid ID numbers are issued to each House Officer by the DHH through the Medical Education Office. House Officers without a US Social Security will not have a Medicaid number until a card is issued. The number must be recorded on each Medicaid patient prescription, and will be pre-printed on the House Officer Prescription pad. The Medicaid number will remain active until the House Officer completes training.

5. Advanced Cardiac Life Support (ACLS) and other Certifications

House Officers are eligible to participate in the ACLS Program associated with the New Resident Orientation program according to their respective departments’ requirements. However, if the House Officer can provide evidence of having taken the class at a different facility, he or she may be excused from the course. In addition to ACLS, the institution offers BLS, NRP and PALS for the House Officers.

Immunization Requirements

At the time of employment, all House Officers and LSU Health Sciences Center employees are required to meet with the Occupational Health Clinic representative. Proof of immunizations, titers, TB status, and other pertinent health records should be reviewed with the OHC Nurse or Medical Director at that time.

House Officers must comply with all institutional on-going immunization requirements. Failure to comply may result in loss of privileges, suspension from the program and/or other disciplinary action.

Any questions regarding the immunization or other Occupational Health issues may be directed to the OHC Medical Director, the Program Director or other administrative officials.

Prescription Pads

All House Officers are required to use preprinted prescription pads or use the designated printers in the clinics when writing prescriptions. House Officers are required to use their own preprinted prescription pads. Initial issue of preprinted prescription pads is four pads of 100. Requests for additional prescription pads should be made in the Graduate Medical Education office or call 675-5053.

House Officers are responsible for safeguarding their prescription pads at all times, to prevent unauthorized use of them. Each House Officer must pick up his or her prescription pads in person only in the Medical Education Office.

Uniforms

1. White Coats

The Medical Education Office will order three (3) new lab coats for interns in their initial PGY-I year. Medical Education will order coats for PGY-II or first-year fellows with name, degree and department monogrammed on the coats.

2. Scrub Suits

Scrubs will be ordered for interns in their initial PGY-I year and for new first-year fellows. Scrub Suits are worn ONLY in the Operating Room Suite. Green Suits are restricted to Obstetrics, Labor and Delivery. Blue Suits, initial issue is two. These suits may be worn in the LSU Health Sciences Center and University Health campus other than the restricted areas as outlined.
University Police has been directed to instruct personnel leaving the institution with “Hospital Owned” scrub suits of the current scrub suit policy (hospital owned scrub suits are not to leave the designated areas). Continued abuse of the scrub suit policy may result in disciplinary action.

3. Dress Code
House Officers are encouraged to dress appropriately as a medical professional. Individuals are reminded that personal hygiene is also an aspect of a physician’s professionalism. Individual departments may establish more specific guidelines for dress.

Communications
1. Cell Phones
The use of cellular phones is prohibited in the following areas of the hospital.

- MICU
- SICU
- PICU
- NICU
- OR
- Recovery Room
- Labor & Delivery
- Burn Unit
- Telemetry (7K)
- Heart Cath Lab
- Special Procedures
  The use of cellular phones is limited to those times when an employee or volunteer are on break from their work assignments.
  Cellular phones are not to be used by employees while in their work areas, including elevators, nursing stations, any patient care or diagnostic area. Phones are to be turned off when the employee is not on break.
  Cellular phones may be used in staff lounges/break areas, the cafeteria or designated smoking areas.

Exception: Hospital drivers may utilize cellular phones in order to expedite response to requests; phones are to be used for hospital business only.

2. E-mail
The Office of Medical Education coordinates the assignment of email addresses with the Office of Computer Services for the House Officers. The e-mail system is one of the primary notification systems used when communicating important and timely notices to the House Officers. It is the responsibility of the House Officers to check email messages regularly.

3. Pagers
The LSU Health Sciences Center and University Health considers it essential to have certain employees readily accessible by telephone in order to affirm its mission. To facilitate this accessibility need, there is a pocket pager system in place.
The pocket pagers are the property of University Health and, therefore, the person to whom the pager is assigned has the responsibility for its safe keeping. If the pager is lost, or shows abuse other than normal wear and tear the House officer to whom the pager has been assigned should contact the Switchboard to seek a replacement pager.

How to Page
Dial 57007 to access paging system. Listen for instructions.
Voice pager: At sound of beep:
- Dial beeper number (Example 0081)
- Give message twice (Ex-call 5000, call 5000)
- Digital Beepers:
  Voice-it will state “please dial in your number”. Press your number. Press # sign followed by * sign. This procedure will let the next person/call access the system immediately.

**STAT OR EMERGENCY ON DIGITAL PAGER:**
Any number followed by 222
(Ex- “222” - Call STAT 7181 by pressing “*” 222 - Call 7181 STAT)

Pager Policy:
- All pagers/beepers shall be answered within ten minutes of a message being received. If a pager/beeper is not answered within this prescribed time frame, the individual initiating the page/beep will follow the chain of command until contact has been made with an appropriate staff member. A variance report shall be completed by the individual initiating the page/beep when response is not within the ten-minute time frame.

- The Hospital Switchboard is responsible for the procurement and distribution of local pagers/beepers.

- Telecommunications is responsible for the procurement and distribution of long range pagers/beepers. To obtain long range pagers/beepers—requesting department submits a memo indicating the type of pager/beeper requested and name of employee who will utilize it to LSU Telecommunications Office G-112.

- The University Health Switchboard is responsible for facilitating the repair of local pagers/beepers.

- LSU Telecommunications is responsible for facilitating the repair of long range pagers/beepers.

- To access the University Health local pager/beeper system, dial 675-7007 and follow the recorded prompts. A current pager/beeper list is maintained by the University Health Switchboard.

- Departments reassigning a previously issued pager/beeper to another person shall notify the University Hospital Switchboard immediately of the reassignment by memo or email. The memo or email shall contain the pager/beeper number, the persons’ name and office/contact telephone number. If the person will at any time be required to be on-call, a home or cellular contact number is required.

4. **Overhead Page**
Paging is by an audible voice system through the hospital switchboard. It is limited to the Hospital. When needed, you will be paged by name. When you hear your name, go to the nearest hospital telephone and dial “0”. “House phones” are located in the dining room and snack bar and provide automatic connection with the hospital switchboard.
5. Personal Call Policy
The Personnel Department is routinely asked to forward incoming telephone calls to employees who do not have immediate access to an office or departmental phone. The demands on the Personnel Department to locate employees have grown substantially and have diverted staff resources from more important activities.

The purpose of this policy is to insure that all employees are aware of the position which the university has taken with regard to personal telephone calls during work hours and to insure the appropriate utilization of the Medical Center’s telephone system.

Policy:
• Non-emergency telephone calls to or from employees while the employee is on duty are not permitted. Non-emergency calls should be handled during non-work periods. Employees should provide a departmental phone number to relatives or persons who may need to contact them in the event of an emergency.
• General calls referred from the switchboard to the Personnel Department will be screened to determine the nature of the call. Non-emergency calls will not be referred. Callers will be advised that the Personnel Department will refer only emergency calls.
• Provided the caller informs the Personnel Department that the call is of an emergency nature and is willing to describe the emergency, a message will be relayed to the employee via the department head or supervisor.
• The caller will be asked for the telephone number the employee is to call, should a return call be necessary, and/or the appropriate department will be advised of the extent of emergency.
• Telephone devices shall be restricted to local calling capability only. Exceptions to this restriction shall be made only upon request from the budget head and approved by the Medical Center Administrative Head responsible for the department.
• Medical Center telephones with long distance calling capability shall be used for University business only. Failure to adhere to this policy may result in disciplinary action, up to and including termination of employment. Restitution to the University for personal long distance Calls made shall be required.

Patient Care Guidelines
Purpose
To ensure that ACGME-accredited training programs adhere to established criteria and guidelines set forth to foster optimal patient care in the hospital setting.

Policy
1) Patients may be admitted to LSUHSC by faculty members of the medical staff with admitting privileges and by Residents admitting patients to the designated attending physician for their assigned service. The patient’s physician shall establish the patient’s condition and provisional diagnosis on admission. All patients admitted to LSUHSC shall be considered teaching patients and optimum care provided.
2) The institution will delegate the responsibility to each ACGME-accredited training program to develop and implement guidelines that will result in a sound educational benefit to the Residents and ensure that optimal Residents provide patient care at all times. The established guidelines must meet
compliance with the responsible ACGME Residency Review Committee (RRC) and program requirements.

3) ACGME-accredited training programs are responsible for developing and implementing written criteria and guidelines to govern the following Resident duties:
   a. Order writing by Residents and attending on all teaching services within their respective clinical department;
   b. Number of admissions allowed for each Resident per each 24-hour period;
   c. Number of admissions allowed for each Resident per 48-hour period;
   d. Number of patients allowed under the care of each Resident at any given time on inpatient medical services (non-acute care).

**Service Behavior Expectations**

*Attitude/Appearance*
- Promptly welcome each patient/visitor in a friendly manner, smiling warmly and introducing yourself. Don’t allow anyone to feel ignored.
- Neither patients nor their family members are an interruption of our work; they are our reason for being here.
- Every employee’s attire will always be professional, tasteful, tidy and discreet.

*Communication/Etiquette*
- Employees will introduce themselves promptly when speaking to patients, family or visitors. Script: Good morning, afternoon, evening. I am (first and last name) and I am from (department name) and I am here to (describe duties).
- All employees will be courteous when dealing with patients or visitors using terms such as ‘please’ and ‘thank you’ as well as showing proper respect.
- All employees will listen to any concern or complaint identified by any patient, family member, friend, or visitor showing proper concern and appropriate follow up.
- Employees will communicate with each other in a polite and respectful manner.

*Telephone Etiquette*
- Employees will know how to operate the telephone system in their areas. When transferring a call, first provide the caller with the correct number in case the call is lost.
- Calls must be answered as soon as possible.
- Answer all calls by identifying your department and yourself, asking ‘How may I help you?’ or the equivalent. Speak clearly.
- Obtain the caller’s permission before putting them on hold. Thank the caller for holding when returning to the line.
- If a call is for another employee in your area, place the caller on hold and politely locate the person don’t just holler down the hall.

*Elevator Etiquette*
- Use the elevator as an opportunity to make a favorable impression. Smile at and/or speak to fellow passengers.
- Do not discuss patients, their care or hospital business on elevators.
- When a patient is on a bed or stretcher and needs to be transported by elevator, don’t allow that patient to be surrounded by other visitors or employees. Politely ask the others to wait for another elevator. Also, use only appropriate freight elevators.
- When transporting patients in wheelchairs, always face them toward the elevator door.
- Once on an elevator, make room for others and hold the door open for them.
**Call Lights**

- All direct patient care providers are responsible for understanding and answering any patient call light.
- Any direct patient care provider noticing an unanswered call light is to enter the room and ask the patient, “What can your nurse bring you?” Do not leave the floor until you are sure the message has been conveyed to the proper direct patient care provider.
- The nurse’s station should never be left unattended. An employee should be in the nurse’s station to answer the call light and telephone at all times, if at all possible.

**Patient & Family Concerns/Privacy**

- Use easily understood and appropriate language when providing information to the patient regarding health, special diets, tests, procedures, and medications. Avoid technical or professional jargon when communicating with patients, family members, and friends.
- Take time to educate families about the procedure that the patient is to undergo. Politely inform family members that all procedures do not begin as soon as a patient enters the appropriate area.
- Provide a comfortable atmosphere for waiting family/friends.
- The patient’s family is just as important as the patient.
- Update family members periodically while a patient is undergoing a procedure.
- Reduce the unnecessary noise on patient units to provide a restful atmosphere.
- Be sure that patients know when diagnostic tests results are available and how they can obtain the results (i.e., next clinic appointment, etc.)

**Confidentiality**

- Information about patients and their care must never be discussed in public areas such as the cafeteria, elevators, lobbies, and waiting rooms. Likewise, hospital business should not be discussed in public areas.
- Interview patients in privacy. Close doors if available; close curtains when indicated.
- All employees shall respect the privacy of their co-workers by eliminating gossip.

**Privacy**

- Always knock before entering a patient’s room.
- Provide the proper size gowns for patients.
- Close curtains or doors during examinations, procedures or when otherwise needed.
- Provide sheets or blankets when a patient is being transported.
- Provide a robe or second gown when a patient is ambulating or in a wheelchair.

**Commitment to Co-Workers**

- Keep your work area and surrounding environment clean and safe.
- Do not say, "it’s not my job.” If you are unable to meet a request, be responsible for finding someone who can.
- Check on patients before shift change to minimize patient requests during shift change report.
- Rudeness is never appropriate. We must treat each other with courtesy and respect at all times.
- Treat every co-worker as a professional. Recognize that we each have an area of expertise.
- Welcome new or floating employees. Be supportive by offering help and setting an example of the cooperation expected in the workplace.
- Do no chastise or embarrass fellow employees.

**Safety**

- Report all accidents and incidents promptly.
- Identify all safety hazards and correct or if not able to correct, report it.
- Protect your back when lifting, pushing, pulling, or carrying. Get help if necessary.
- Use protective clothing and equipment when appropriate.
Any employee who notices litter should immediately pick it up and properly dispose of it. All spills must immediately be cleaned up. This will help prevent any person from slipping and falling due to debris or spillage.

**Services and Programs**

**Meal Program**
The LSUHSC Meal Card for House Staff participating in the Meal Program is valid throughout one’s Residency/Fellowship training at LSUHSC. One of three food plan options may be selected; the plan will be in effect for one contract year. Plans cannot be changed until the time of contract renewal. Deductions will be taken from the House Officer’s check each pay period and the corresponding amount credited to the meal plan per month. House Officers may also choose to opt out and not receive the discounted meal plan. Please refer to House Officer Food & Nutrition Services Meal Plan Policy for more detailed information.

1. **Cafeteria**
The cafeteria is located on the ground floor of the main hospital across the hall from the credit union. For breakfast the cafeteria provides an extensive variety of hot & cold breakfast items to choose. For lunch & dinner the cafeteria provides a variety of entrees & vegetables from the main serving lines.

<table>
<thead>
<tr>
<th>Cafeteria Hours of Operation</th>
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<tbody>
<tr>
<td>Everyday</td>
</tr>
<tr>
<td>6:15am – 10:30am</td>
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<tr>
<td>Monday – Friday</td>
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<tr>
<td>11:00am – 9:00pm</td>
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<tr>
<td>Sunday</td>
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<tr>
<td>11:30am – 4:00am</td>
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<tr>
<td>Weekends &amp; Holidays</td>
</tr>
<tr>
<td>11:00am – 7:30pm</td>
</tr>
</tbody>
</table>

2. **Atrium Deli**
The Medical School Deli is located on the ground floor of the Medical School. It features a PJ’s Coffee offering a variety of fresh brewed coffees, cappuccinos, lattes, & other espresso drinks and a WOW Café which serving wings, salads, burgers, sandwiches, and more.

<table>
<thead>
<tr>
<th>Atrium Deli Hours of Operation</th>
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<tr>
<td>Monday-Friday</td>
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<tr>
<td>7:00am-4:00pm</td>
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</table>

3. **ACC Deli**
The ACC Deli is located on the 1st Floor of the ACC Building. The Deli in the ACC Bldg. will serve breakfast sandwiches, made-to-order subs, pizza and salads. Hot brewed coffee and fountain drinks will also be available.

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<tr>
<th>ACC Deli Hours of Operation</th>
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<tr>
<td>Monday-Friday</td>
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<tr>
<td>7:30am – 10:15am</td>
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<tr>
<td>10:45am – 3:00pm</td>
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Medical Library
Louisiana State University Health Sciences Center in Shreveport has an excellent medical library located in the school adjacent to the hospital. The Library is staffed with qualified medical library professionals who are available to assist Residents with any query they may have. In addition, there are many online resources available to the Residents and/or their clinical departments. The library also houses two computer labs, scanners and copy machines.

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<th>Library Hours</th>
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<td>Monday – Friday</td>
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<tr>
<td>Saturday</td>
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<td>Sunday</td>
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For more information and services about the Medical Library please visit [http://lib.sh.lsuhs.edu/](http://lib.sh.lsuhs.edu/)

On-Call Quarters
Services requiring overnight coverage have designated call rooms in a secured area accessible by card access only on the ninth (9th) floor of the hospital. Clean linens are provided on a daily basis. Each room has a telephone for call-back. Do not use any room not assigned to your service. All call rooms are accessible by key and/or combination only. Residents must request a key or door code through his/her respective departments. The call room should only be utilized by on-call Residents.

The Resident Lounge is also located on 9th Floor. The lounge has seating, microwave, TV, telephone and refrigerator.

Medical Records, Radiology Films and other patient documents should not be left in the on-call rooms. Periodic room inspections are conducted and items may be removed and returned to their appropriate location. Hospital owned scrub suits should be returned to the appropriate designated area. Residents have a responsibility of removing their personal items as deemed appropriate to allow proper cleaning of the on-call room.

Any problems with the on-call rooms should be reported to the Office of Medical Education for follow-up. On weekends, if a problem occurs, the House Manager should be contacted. If a room requires additional cleaning during the week, please make proper use of the “Second Cleaning Required” signage available in each room. If a room requires additional cleaning on the weekends, please notify the Environmental Services Office. Any problems with the on-call rooms should be reported to the Office of Graduate Medical Education for follow-up. On weekends, if a problem occurs, the House Manager.

Counseling Services
Group Support, Employee Assistance Program and the Physician’s Health Foundation of Louisiana are available to provide counseling support and direction for House Officers seeking assistance.

Physicians take care of others continuously. However, physicians also need assistance at times, and we want you to know that it is ok to ask for help. It is the primary role of the Physicians’ Health Foundation of Louisiana (PHFL) Physicians Health Program (PHP) to offer assistance to physicians who may be suffering from difficulties such as substance use issues, depression, anxiety, etc., in addition to a host of physical ailments and disruptive behavioral patterns. The PHFL PHP supports physicians who are in our program and advocates for them with hospitals, health plan networks, malpractice insurance
The Resident may contact the PHFL, a subsidiary of LSBME directly (1-888-743-5747) to seek assistance or a referral/request may be made by a concerned individual regarding the physician. The PHFL proceeds very carefully in their review of the individual’s case. All inquiries are handled with extreme confidentiality. In the event the physician in question is in immediate danger or may endanger his patients, a suspension could occur until adequate data has been collected.

If the physician is found to have impairment and agrees to work with the PHFL to address the problem, he or she will not be penalized by the Louisiana State Board of Medical Examiners. Confidentiality is always stressed.

In the event that a Residency Training Director believes that a psychiatric evaluation is necessary for training to continue, the Residency Training Director will request an evaluation by Dr. Mark A. Cogburn, DrNP, PhD or another psychiatry faculty member in writing. This request will also list specific information as to why the evaluation is warranted. Dr. Cogburn will request the Resident to sign a release of information in order to notify the Residency Training Director of the diagnosis, treatment recommendations, and if the recommendations are followed. If the Resident does not agree with the above, he has access to the due process procedure as outlined in the Resident Manual. Any Resident who is in need of psychiatric care may contact Dr. Cogburn or a psychiatry faculty member Dr. Cogburn is available for confidential evaluation and referral if necessary. The Resident may also request short term counseling from the Employee Assistance Program.

1. Employee Assistance Program

   It is estimated that in a typical employee population, six to ten percent of the work force suffers from alcoholism or an alcohol related problem; two to three percent have difficulty with drugs, and six to seven percent experience emotional problems. Statistics specifically related to hospital employees reflect estimates similar to the general employee population. Studies indicate that approximately 15% of physicians are alcohol or drug dependent. Data regarding nurses indicate problems with chemical dependency as well as with depression, stress, and burn-out. Also, because 75% to 80% of a typical hospital’s employees are women, family problems such as divorce and domestic violence as well as concerns about alcoholism or drug dependence of a family member may be more prominent than in other employee populations. During periods of economic recession and unemployment when many women workers become the family’s sole economic provider, financial and legal difficulties appear more frequently.

   Because of the nature of their work, many health care professionals are subject to considerable job stress. The life and death responsibilities of hospital work and the need to be always caring and concerned can create substantial stress and strain on an employee’s emotional life. Also, the disruption in an employee’s routine caused by rotating shifts, weekend work, and on-call duties can magnify personal problems. Stressful work situations can often exacerbate existing problems. The impact of personal problems on health care workers can have more serious and lasting consequences than in some other occupations. An impaired health care worker can cause direct harm to patient through carelessness, mismanagement of medication, or failure to communicate the patient’s requirements.

   Although personal problems occur among hospital employees with at least the same frequency as in other work forces, the belief that health care workers should be immune from personal problems impedes the identification of these problems. An EAP in a hospital can provide “help for the helper”.
The Employee Assistance Program (EAP) is a sponsored service which is designed to encourage employees to take the initiative for their own health and wellness. With the assistance of professional consultation, employees can solve a wide range of personal problems that could adversely affect their personal lives or professional careers.

a. Frequently Asked Questions:

*Can I be guaranteed that participation in the Employee Assistance Program will not hurt my job promotional opportunities?*

It is in your best interest to seek early counseling through the EAP program. Even if management has talked to you about a possible problem, you may voluntarily seek treatment and counseling by stepping forward and accepting the help that is available.

If management is sufficiently concerned about job performance, a formal referral to EAP may be made. If the employee elects not to follow referral for evaluation and possible treatment, the referral person will be notified. Should job performance continue to decline, disciplinary actions may be taken by LSUHSC-S management?

*How confidential is the program?*

The Employee Assistance Program goes to great lengths to respect your right to privacy. Like all medical files, EAP records and discussions regarding the nature of personal problems will be handled in strict confidence. EAP records will be maintained separately from personnel files by the Director of the EAP. EAP insures that employees at all levels have the opportunity to obtain the best professional help in an atmosphere of understanding and privacy.

*My problems are private. What right does LSUHSC-S have to interfere with my personal life?*

You’re right! Your problems are personal, until they begin to have a detrimental effect on your work performance. Then personal problems affect more than just you, they affect your co-workers and the productivity of your team.

*How do I get started in the program?*

There are two ways to get started in the program. (1) If you feel you have a problem, you can simply call the EAP Office at 675-7397 and ask to speak to Dr. Betty Joiner. (2) Or, if your performance has declined, your supervisor may recommend on a formal or informal basis that you call the EAP consultant to discuss your problem.

*Can I participate if job performance has not been affected?*

Absolutely! LSUHSC-S hopes that awareness of the EAP and understanding of its principles will encourage employees to seek help on their own before problems impact job performance.

*Who will pay for the cost of the counseling, or for other recommended assistance?*

The EAP guidance and referral services are free. Diagnosis and treatment cost outside Employee Health Services will, to the extent they are covered by regular group health insurance, be paid for by your insurance.

*How long does it take to get help?*

It’s LSUHSC-S’s goal to have all employees receive the help they need as soon as they contact the EAP director. Once the medical/emotional problem is evaluated, you will be counseled and offered referral to an appropriate treatment source.
Payroll Services
The Shreveport Payroll Center’s mission is to administer and facilitate payroll services in a timely, accurate and professional manner, and to provide quality service to our employees, vendors and governmental agencies.

The Payroll Professionals will assist any employee with questions, concerns and problems regarding paycheck issues. Please call or go by the Payroll Department where “Quality Service” matters.

3rd Floor Administration Building Rm. 311.
Ph: 318-675-5251
Office hours 8:00am to 4:30pm Monday – Friday
Residents are paid biweekly. Supplemental pay will be included on the last payday of the month. If you have any questions regarding your check, please contact the Office of Medical Education immediately or the Payroll Office.

Employees must complete a Direct Deposit Authorization Form as part of the hiring process. The completed form must be submitted prior to the employee’s date of hire. Failure to submit this form in a timely manner may delay the start of employment. The direct deposit may take one to two pay periods to take effect and the employee will receive a physical check during this period of time. (See AD 6.13)

All Payroll Forms can be found on the Payroll website at: http://myhsc.lsuhsclshreveport.edu/Payroll/payrollhome.aspx

Parking
House Staff are currently assigned to “P” and “M” lots at no charge, but must register to park with the Parking office located on the 1st floor of the Administration Building, Room 123. Emergency (call-back) parking should not be in designated fire lanes. If you require an escort after hours, please notify University Police. Adherence to the University Parking Rules and Regulations is expected. Violations may result in fines and/or towing of your vehicle.

Multicultural Affairs Office
The Office of Multicultural Affairs was established to enhance diversity within LSUHSC by assisting in the recruitment of underrepresented minorities and disadvantaged students for the Schools of Medicine, Graduate Studies, and Allied Health Professions. The office works in collaboration with other administrative and social support services within the institution to assure successful retention of students by providing academic and career counseling and diversity training.
To obtain additional information, brochures, or applications for any of our programs, please contact:

PH: 318.675.5049
E-mail: mrob38@lsuhsc.edu
Marisa Roberson, Director
Office of Diversity Affairs and Equal Employment Opportunity
LSU Health – Shreveport values a diverse community and does not discriminate in our employment practices on the basis of race, color, religion, sex, national origin, political affiliation, sexual orientation, gender identity, marital status, disability, veterans status, genetic information, age (over 40), or other non-merit factors to ensure compliance with all applicable federal, state, and local laws.

The Office of Diversity Affairs and Equal Employment Opportunity is responsible for advancing and monitoring the Equal Employment Opportunity Commission (EEOC) laws that cover Title VII, Equal Pay Act (EPA), Americans with Disabilities Act (ADA), Age Discrimination in Employment Act, ADEA (age over 40), and Genetic Information Nondiscrimination Act (GINA) as well as the diversity and inclusion policies, procedures and initiatives of the LSU system.

The office develops programs and procedures to promote a culturally diverse and inclusive work and educational environment where faculty, staff, and patients are treated fairly and recognized for their individuality. The university’s commitment to diversity is reinforced through training and education.

Debbie A. Chandler, MD Asst. Dean of Diversity Affairs
dchan3@LSUHSC.edu
Phone: 675-4810

Resident/Fellow Council
Residents/Fellows from all training programs can communicate and exchange information with each other relevant to their ACGME-accredited programs and their learning and working environment by participating in the Resident Association at Louisiana State University Health Sciences Center – Shreveport. Dues are $10 every year and will substantiate the Resident Association’s working budget.

Purpose and Objectives:
This association is a non-profit organization whose purpose and objectives shall be to:
1. Provide a coordinated communication mechanism between the institution and residents.
2. Provide support for members experiencing difficulties with residency and a venue for expression of grievances.
3. Promote an effective and satisfactory working and training environment for residents.
4. Provide a forum for the professional development of members via educational programs, networking opportunities and leadership experience.
5. Provide a venue to support the residents in the exchange of ideas, and dissemination of information relevant to the profession and social development of its members.
6. Assume roles in policy making decision by serving on various hospital committees to provide resident representation.
8. Facilitate resident involvement with organized medicine.
9. Reject the use of strike by a Resident Association member for the purpose of negotiation.
POLICIES AND PROCEDURES

*Please note all policies are subject to revision and updates. Please ensure you are reviewing the most recent version when referring to any policy.

GMEC POLICIES

Resident Eligibility Requirements for Residency Training (GME 1.1)
The program director is responsible for ensuring all applicants under consideration for residency training in the program meet the eligibility requirements of the Hospital and the Accreditation Council for Graduate Medical Education (ACGME) detailed below. The enrollment of non-eligible Residents may be cause for withdrawal of accreditation of the program by the ACGME. Only applicants who meet the following qualifications are eligible for appointment to accredited residency programs sponsored by the Hospital:

1. Medical Education: Only applicants who meet one of the following criteria may be accepted for residency training in accredited programs sponsored by the Hospital:
   - Graduates of medical schools in the United States and Canada accredited by the Liaison Committee on Medical Education (LCME).
   - Graduates of colleges of osteopathic medicine in the United States and Canada accredited by the American Osteopathic Association (AOA).
   - Graduates of medical schools outside the United States and Canada (international medical graduate, FMG) must possess a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG).
   - Graduates of medical schools outside the United States, who have completed a Fifth Pathway program provided by an LCME-accredited medical school.

2. Entry of Foreign-Born Medical Graduates to the United States: The entry of foreign-born graduates of non-U.S. medical schools to the United States is governed by the U.S. Immigration and Nationality Act, as amended, which is administered by the US Citizenship and Immigration Services (USCIS). It is a violation of federal law to provide employment to a non-U.S. citizen who does not hold an appropriate visa or other appropriate work authorization documents from the USCIS.
   - Residency program directors considering foreign-born applicants should carefully review the applicant’s visa status to ensure the applicant holds a visa valid for graduate medical education [exchange visitor (J-1), or immigrant visa]. International medical graduates must also hold a currently valid Standard Certificate of the Educational Commission for Foreign Medical Graduates (ECFMG).
The Office of Legal Affairs must be notified of all non-US citizens accepted for residency training. Legal Affairs will ensure the Resident holds an appropriate visa and assist in processing the paperwork required for visas for residency training at LSUHSC-S.

3. Prerequisite Residency Training: All applicants must satisfy any requirements for prerequisite residency training, as established by the relevant Residency Review Committee and/or certifying board for the specialty. If a program director wishes to recruit an applicant who does not meet the criteria established for prerequisite training, written approval to appoint the applicant as a Resident must be obtained from the Residency Review Committee and/or certifying board.

4. Resident Transfer: If a Resident transfers from a residency program at another institution, written or electronic verification of the previous educational experiences and a statement regarding the Resident’s summative competency-based performance evaluation must be received prior to acceptance into a LSUHSC-S residency program. **SEE RESIDENT TRANSFER POLICY**

5. Physical Examination: All newly-appointed Residents must complete and pass a pre-employment physical examination, which includes a drug screen and background check for any felony convictions. All activities are coordinated by the Human Resources Department.

6. United States Medical Licensing Examinations (USMLE) or Comprehensive Osteopathic Medical Licensing Examination (COMLEX): All Residents must comply with the requirements for passing USMLE Steps 2 and 3 or COMPLEX Levels 2 and 3 as required.

7. Louisiana Medical License: It is the responsibility of all Residents to obtain an unrestricted Louisiana license to practice medicine as soon as they meet the minimum postgraduate training requirements stipulated by the Louisiana Board of Medical Examiners.

**Resident Recruitment and Selection (GME 1.1.a)**

Programs will have an established protocol for the recruitment and selection of their Residents. The protocol should include several members of the teaching medical staff as well as Resident input.

- Each Program is required to establish criteria for specific program recruitment and selection.
- The program director, in conjunction with the program’s Education Committee and/or teaching faculty, reviews all applications, and personal interviews are granted to those applicants thought to possess the most appropriate qualifications, as determined by guidelines established by the program.
- Each applicant must be informed in writing of any accreditation issues of the department as required by the Accreditation Council for Graduate Medical Education (ACGME).
- Each applicant who is invited for an interview must be informed, in writing or by electronic means, of the terms, conditions, and benefits of appointment to the ACGME-accredited program, either in effect at the time of the interview or that will be in effect at the time of their eventual appointment. Information that is provided must include: financial support; vacation; parental, sick, and other leaves of absence; professional liability, hospitalization, health, disability and other insurance accessible to residents/fellows and their dependents.
- An offer for residency training is extended directly to the applicant by the program director or his/her designee, through a letter of offer. All programs will have an established protocol for the recruitment and selection of their Residents.
- When selecting a Resident, programs may also consider the medical school class standing and other honorary academic status. However, Residents selected must meet the requirements as established for licensure/permit as outlined by the Louisiana State Board of Medical Examiners (LSBME).
Immediately following receipt of the results of the Match or the acceptance of an offer for residency training, the program director is responsible for notifying the Graduate Medical Education Department of all candidates accepted and providing a copy of each applicant’s file for the Hospital’s permanent record. Each Resident’s file must include the following:

- Copy of the completed “Application for Graduate Medical Education”
- Documentation of completion of medical school (copy of medical school transcript, dean’s letter, etc.)
- Documentation of any previous residency training (copy of certificate issued, letter of recommendation from program director)
- Copies of three letters of recommendation
- Copy of Louisiana medical or dental license (if applicable)
- Current mailing address
- Inclusive dates of appointment
- Postgraduate year of appointment
- Salary source

**Resident Transfers (GME 1.1.b)**

**Policy**
Before accepting a resident who is transferring from another program, the program director must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation of the transferring resident.

If a House Officer in a training program intends to leave a program prior to his completion to accept an appointment in another graduate training program within the institution, the House Officer’s intentions should be made known to the Program Director in which he is presently serving at least 90 days before the end of his contract period. A program director must provide timely verification of residency education and summative performance evaluations for residents who leave the program prior to completion.

**Definition:**
Residents are considered as transfer residents under several conditions including:

- a. moving from one program to another within the same or different sponsoring institution;
- b. transferring to another program, in the same or different specialty, in the same or a different sponsoring institution
- c. entering a PGY 2 program requiring a preliminary year even if the resident was simultaneously accepted into the preliminary PGY1 program and the PGY2 program as part of the match (e.g., accepted to both programs right out of medical school).

**Procedure**

**Requirements of “Receiving Program”**
Before accepting a transfer resident, the program director of the ‘receiving program’ must use the “Requesting info on Transferring in Resident Template” in order to:

- a. obtain written or electronic verification of previous educational experiences
- 1. Examples could include a list of rotations completed, evaluations** of various educational experiences, procedural/operative experience.
- b. obtain a summative competency-based performance evaluation from the current program director.
c. obtain a letter of good standing from the current program director.

Requirements of “Sending Program”
The “sending” program must use the “Transferring out of LSUHSC Template” in order to provide the “receiving” program a statement regarding:

a. resident’s current standing as of one-two months prior to anticipated transfer
b. a statement indicating when the summative competency-based performance evaluation will be sent to the “receiving” program.

Additional information you may want to consider when you reviewing transfer letters
1. Any gaps in training or time away from the program.
2. Did the overall evaluation include evaluative information helpful to your program?

Requesting info on Transferring in Resident Template

January 1, 2017

To whom it may concern:

Dr. RESIDENT NAME has applied for a PGY X position in our PROGRAM NAME residency program, starting YY/MM/XXXX. In accordance with the ACGME’s requirements to verify previous educational experience and a summative competency-based performance evaluation on all transferring residents, I would appreciate your assessment of this candidate.

For the period YY/MM/XXXX – YY/MM/XXXX, RESIDENT NAME, MD demonstrated to my satisfaction attainment of program objectives for the PROGRAM NAME level of PGY X in the competency domains of:

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<thead>
<tr>
<th>COMPETENCY</th>
<th>YES</th>
<th>NO</th>
<th>IF “NO,” EXPLAIN</th>
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<tbody>
<tr>
<td>Patient Care</td>
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<tr>
<td>Medical Knowledge</td>
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<td>Practice-based Learning</td>
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<td>Systems-based Practice</td>
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Did RESIDENT NAME demonstrate sufficient competence on all evaluations to receive credit for all required rotations and other major educational activities?

_____ YES _____ NO (if “no”, please provide explanation.)

Please attach a record of:

_____ Rotations completed, by year of training

_____ Summary of procedural/operative experience

_____ Letter of good standing
Please provide any additional information pertinent to the specialty or resident.

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If you have any questions or wish to discuss any information in this letter, please feel free to contact me at (318) XXX-XXXX, or XXXXXX@lsuhsc.edu.

Thank you.

PROGRAM DIRECTOR’S NAME
Program Director, PROGRAM NAME
LSU Health Sciences Center-Shreveport

Transferring out of LSUHSC Template
January 1, 2017

To whom it may concern:

RESIDENT NAME, MD is currently a PGY X resident in good standing in the PROGRAM NAME program at Louisiana State University Health Sciences Center in Shreveport. s/he has satisfactorily completed all rotations to date, and we anticipate s/he will satisfactorily complete her/his PGY X year on XX/XX/XXXX. A written or electronic verification of previous educational experiences, rotations by year of training and a summative competency-based performance evaluation will be sent to you by XX/XX/XXXX.

I am taking the liberty to include an assessment of the resident as of this date.

For the period XX/XX/XXXX – XX/XX/XXXX, Dr. RESIDENT NAME demonstrated to my satisfaction attainment of program objectives for the PROGRAM NAME level of PGY X in the competency domains of:

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</table>

Dr. RESIDENT NAME demonstrated sufficient competence on all evaluations to receive credit for all required rotations and other major educational activities?

_____ YES _____ NO (if, “no”, please provide explanation.)

ADDITIONAL COMMENTS

If you have any questions, please feel free to contact me at (318) XXX-XXXX, or
XXXXXXX@lsuhsc.edu.

Thank you,

PROGRAM DIRECTOR’S NAME
Program Director, PROGRAM NAME
LSU Health Sciences Center-Shreveport
Certification of Post-Graduate Training (GME 1.1.c)

Policy
Residency and Fellowship programs must receive verification of each applicant’s level of competency in the required field using ACGME or CanMEDS Milestones assessments or ACGME equivalent assessments from the prior training program. In order to be in compliance with ACGME or ACGME equivalent accreditation body requirements for the eligibility and selection of residents/fellows, training programs must follow the procedure outlined below to obtain verification of post-graduate training. Programs must send the GME Certification of Post-Graduate Training form to applicants’ prior training programs to verify any post-graduate training.

Procedure
- Residency Programs
  - All prerequisite post-graduate clinical education required for initial entry or transfer into ACGME-accredited/CODA-accredited residency programs must be completed in ACGME-accredited/ACGME equivalent residency programs.
  - Any post-graduate training that is not a prerequisite for entry into a residency program should be verified.
  - Upon offering a position to an applicant that has received any post-graduate training, the residency program must request verification from that training program using the GME Certification of Post-Graduate Training form.

- Fellowship Programs
  - All required clinical education for entry into ACGME-accredited/CODA-accredited fellowship programs must be completed in an ACGME-accredited/ACGME equivalent residency program, or in an ECPSC-accredited or SFPC-accredited residency program located in Canada.
  - Upon offering a position to an applicant, the fellowship program must request verification from that training program using the GME Certification of Post-Graduate Training form.

Returned GME Certification of Post-Graduate Training forms are to be forwarded to the GME office to be filed in house officer’s GME record. Programs should also keep a file of the returned GME Certification of Post-Graduate Training forms and documentation of any requests of verifications sent.

Program Interview/Application Requirements

Purpose
The GME office is responsible for ensuring all applicants invited to interview for a resident/fellow position must be informed, in writing or by electronic means, of the terms, conditions, and benefits of appointment to the ACGME-accredited program, either in effect at the time of the interview or that will be in effect at the time of his or her eventual appointment.

Policy
In order to be in compliance with ACGME requirements for the eligibility and selection of residents/fellows, training programs must follow the procedure outlined below. Programs must provide applicants with the required information and obtain all GME required documentation and submit to the GME office by the designated date set by the GME office prior to the hire of house officers.

Procedure
1. Any applicant interviewed for a resident/fellow position must be provided information on the following: (http://lsuhscshreveport.edu/Education/gme/incominghouseofficers/appinfo/index)
   - Sample Contract
   - Financial Support
   - Vacation/Sick and other leaves of absences
   - Professional Liability
   - Hospitalization/Health/Disability and other insurance accessible to residents/fellows and their eligible dependents (http://myhsc.lsuhscshreveport.edu/HResources/HRBenefits.aspx)
   - Certifications that will be required prior to start per department specific requirements (BLS, ACLS, etc.)

2. Applicants must sign LSUHSC-S acknowledge statement. (http://lsuhscshreveport.edu/Education/gme/incominghouseofficers/newhouseofficerforms/index)

3. Any applicant that will need J-1 Visa sponsorship should be informed of the process and requirements to keep obtain and keep J-1 Visa sponsorship. H1-Bs are not accepted for residency/fellowship programs. (ECFMG website: www.ecfmg.org)

4. Applicants must fill out the GME 2 page application. Programs will be responsible for submitting the 2 page application for all residents/fellows offered positions to the GME office at the time of match. (http://lsuhscshreveport.edu/Education/gme/incominghouseofficers/newhouseofficerforms/index)

**Resident Appointment (GME 1.3)**

An “Initial Resident Agreement” must be completed for all Residents upon entry into a residency program and a “ Resident Renewal Agreement” for each year of training thereafter. The agreement must be signed by the Resident/Fellow, Program Director, and the Designated Institutional Official and the original agreements must be maintained as part of the institution’s permanent records.

Any Resident who is not to be reappointed at the end of the contract year should be so notified in writing by the program director at least four months in advance. However, if the primary reason for the non-renewal or non-promotion occurs within four months prior to the end of the agreement/contract, the notice of non-renewal must be provided as soon as circumstances will reasonable allow. Any Resident receiving notice of intent to not renew his/her contract may request a hearing as outlined in the Due Process and Appeals Policies located in the Resident Manual.

Any Resident who elects to not renew his contract for residency training must provide the program director with written notice four months prior to the end of the current contract year. However, if the primary reason for the nonrenewal occurs within the four months prior to the end of the agreement, the notice of nonrenewal may be sent less than four months in advance of the nonrenewal.

1. **Initial Resident/Fellow Appointment**
   - The following guidelines and procedures shall govern the appointment of physicians to graduate medical education programs sponsored by the Hospital:
     - The appointment of a physician to a residency/fellowship program shall be for the sole purpose of pursuing postgraduate medical education.
     - The initial appointment shall be for one year and is made upon recommendation of the program director with approval of the Designated Institutional Official.
     - A Resident shall be responsible for taking USMLE Step 3 before completion of their PGY-1 training.
• A Resident shall be responsible for taking and passing USMLE Step 3 before completion of their PGY-2 training. Failure to obtain a passing score before completion of their PGY-2 training will result in termination and non-renewal of contract.

• The Resident/Fellow must be appointed to the postgraduate year for which he/she is qualified as specified by the certifying board of the specialty. Previous postgraduate training in another specialty will not be taken into consideration unless such training is credited by the certifying board of the specialty of enrollment. The Graduate Medical Education Department must be provided with a letter from the certifying board which indicates the number of months or year’s credit that will be given before a Resident’s postgraduate year can be adjusted.

• The program director, or his/her designee, is responsible for communicating to the Medical Education Office an appointment of a Resident/Fellow. The program must submit a completed application and a completed, signed letter of offer to the Resident/Fellow. The Medical Education Office will then complete a personnel form, PER-1 form (S/N 1239), and Resident/Fellow contract (“Initial Resident/Fellow Agreement”) and coordinate the appropriate approvals. A Resident/Fellow’s appointment is contingent upon receipt of a completed Resident/Fellow Agreement and Resident/Fellow Compliance with requirements outlined in the Resident/Fellow Eligibility and Requirements for Residency/Fellowship Training Policy and Resident/Fellow Responsibilities and Conditions of Appointment Policy located in the House Officer Manual.

• An international medical graduate (IMG) appointed to a residency/fellowship position must meet all applicable educational requirements, possess a visa, if required, which permits participation in a graduate medical education program, and if applicable possess a valid ECFMG certificate, and meet the licensure requirements of the State of Louisiana. These documents must be reviewed and found to be in order by the Graduate Medical Education Department prior to the commencement of any medical activity within the hospital.

• Privileges granted to the Resident/Fellow shall be commensurate with the training, experience, competence, judgment, character, and current capability of the individual. The evaluation shall be determined by the program director of the applicable clinical department. The curtailment of, or imposition of limitation of existing privileges, shall carry with it the right of the individual to petition for a hearing as provided in these policies.

USMLE Step 3/COMLEX Level 3 Requirements (GME 1.3.a)

According to the Louisiana State Board of Medical Examiners, for a resident to be issued a license beyond their PGY1 or PGY2 permit, they must have taken and passed USMLE Step 3/COMLEX Level 3. An applicant who has not taken and passed the USMLE Step 3/COMLEX Level 3 prior to the expiration of the PGY1 or PGY2 permit may not be licensed by the LSBME until such time that the applicant has taken and passed the USMLE Step 3/COMLEX Level 3.

Upon initial appointment as a resident, all residents are required to sign the USMLE STEP 3/COMLEX Level 3 Acknowledgement Form. The form states that all residents shall be responsible for taking USMLE Step 3/COMLEX Level 3 before completion of their PGY-1 training. A Resident shall be responsible for taking and passing USMLE Step 3/COMLEX Level 3 before completion of their PGY-2 training. Failure to obtain a passing score before completion of their PGY-2 training will result in termination and non-renewal of contract.

Applicant Who Does Not Take and Pass USMLE Step 3
The applicant who does not take and pass the USMLE Step 3 may apply for a PGY2 permit for up to 12 months. This has the effect of providing applicants with a 24-month period during the PGY1 and PGY2 years to take and pass the USMLE Step 3. The applicant who has not taken and passed the USMLE Step 3 prior to the
expiration of the PGY1 or PGY2 permit may not be licensed by the LSBME until such time that the applicant has taken and passed the USMLE Step 3. The LSBME does not issue a PGY3 permit in these cases. As such, there is generally no permit or license issued and immediately available to the applicant who has not taken and passed the USMLE Step 3 when the PGY2 permit expires.

Four Strikes and You’re Out (applies to USMLE Steps 2 and 3)
Applicants are limited to 4 attempts to take and pass the USMLE Step 2. Applicants are limited to 4 attempts to take and pass the USMLE Step 3. An applicant who fails USMLE Step 3 after the third attempt must take 6 months of approved training before permitted to take Step 3 for the fourth and final time. This applies to all examinations (FLEX, SPEX, NBME, NBOME, COMLEX-USA, or a combination thereof).

The acknowledgement Residents are required to sign states:

I acknowledge that I have been notified of the requirements of taking and passing USMLE Step 3/COMLEX Level 3 as indicated in the Initial Resident/Fellow Appointment Policy (GME 1.3).

I understand that I am to abide by the following requirements regarding USMLE Step 3/COMLEX Level 3:

- A Resident shall be responsible for taking USMLE Step 3/COMLEX Level 3 before completion of their PGY-1 training.
- A Resident shall be responsible for taking and passing USMLE Step 3/COMLEX Level 3 before completion of their PGY-2 training. Failure to obtain a passing score before completion of their PGY-2 training will result in termination and non-renewal of contract.
- A Resident shall be responsible for providing LSBME an official transcript of all scores directly from the examination board as required by LSBME. (Fee may be required to have scores sent.)
- All Programs shall be compliant with the above stated policy, however, departments may require successful completion of USMLE Step 3/COMLEX Level 3 earlier than their PGY-2 training if indicated in their departmental policy manual.

Resident Promotion/Advancement (GME 2.1)
The promotion/advancement of a Resident from one postgraduate level to another in a graduate medical education program generally occurs following the satisfactory completion of each 12-month period of graduate medical education.

Such promotion/advancement is made upon recommendation by the program director, and is regarded as the same process as the initial appointment award.

For each Resident advanced, the program director is responsible for notifying the Graduate Medical Education Office which will coordinate the completion of the appropriate personnel form indicating the change in postgraduate year, dates of appointment, and adjustment in salary. A Resident contract (“Agreement for Post Graduate Training”) signed by the Resident, Program Director, and Representative of LSUHSC-S/DIO must be completed prior to the Resident being advanced.

House Officer Dismissal/Non-Renewal of Contract (GME 2.1.a)
Policy
In all cases in which revocation of a House Officer’s appointment has been recommended by the program director of a clinical department, the House Officer and the Designated Institutional Official (DIO) shall be notified in writing by the program director. Any House Officer who is not to be reappointed at the end of the contract year should be so notified in writing by the program director at least four months in advance. However, if the primary reason for the non-renewal occurs within the
four months prior to the end of the agreement, the notice of non-renewal may be sent less than four months in advance of the non-renewal.

If the House Officer wishes a hearing, he/she must submit a written request to their specific Department Chairman within ten (10) days after receipt of the notification letter. Otherwise, the Designated Institutional Official will act upon the program director’s recommendation and coordinate the Resident’s dismissal.

Procedure
If at any time the Program Director determines dismissal is warranted, the program director shall notify the House Officer, the DIO and the Graduate Medical Education office in writing. The Program Director shall also provide any written documentation leading to dismissal. Once the GME office receives notification, the GME office will notify the Human Resources department of the termination and the effective date.

Immediate dismissal may occur at any time without prior notification in instances of gross misconduct or illegal conduct.

Dismissal of a House Officer may occur for but are not limited to any of the following:

- Failure to meet the performance standards of the training program
- Failure to comply with the policies and procedures of the training program, GMEC, University Health, or other participating sites
- Failure to comply with regulations of the Louisiana State Board of Medical Examiners
- Failure to obtain appropriate visa or other appropriate work authorization documents
- Inability to pass the requisite examinations for license to practice medicine in the United States
- Illegal, unethical, or unprofessional conduct
- Conduct that is detrimental to patients, self, or others

In addition to notifying the house officer, DIO and GME office, programs will also be required to report to the Louisiana State Board of Medical Examiners in writing when a physician’s training has been terminated.

House Officers must complete the House Officer Clearance Form provided by the GME Office upon dismissal/termination from program. This includes returning all ID Badges, keys, and other equipment issued while in training to appropriate departments on campus and any participating sites.

Any House Officer receiving notice of dismissal or intent to not renew his/her contract may request a hearing as outlined in the Due Process and Appeals Policies located in the House Officer Manual.

Probation (GME 2.1.b)
Probation is the formal notification to the resident/fellow that the residents/fellow’s performance is not satisfactory. Written notification of probation must include the following six elements: 1) Reason for the Extension 2) What did they not do that did not meet expectations 3) Goals and objectives that they should meet 4) Timeframe of meeting the goals and objectives 5) Communication and/or progress report of meetings to communicate progress or lack of progress 6) What happens if they do not meet the goals and objectives. While probation is sometimes divided into “Academic Probation”
and “Conduct Probation”, the University makes no distinction between them. Failure to meet any standard after this formal warning may result in serious consequences up to and including dismissal from the program or nonrenewal of the trainee’s annual contract at expiration. Because probation is a formal warning of substandard performance and is intended to alert the resident/fellow to that effect, it is not appealable beyond the level of the Department Chair. If probation is combined with an adverse action, (e.g. extension of training), any appeal would be on the adverse action.

**Due Process (GME 3.1)**
The LSU Health Sciences Center-Shreveport is committed to the principle of due process. Due process is defined as allowing an individual notice of the proposed action and with the allegations and evidence against him/her, to present his/her side of the story to the decision-maker, and unless the offense is egregious, be given the opportunity for improvement. The DECISION-MAKER for the House Staff is the House Staff’s Department Chair.

The regular periodic evaluations (supplemented by any additional evaluations, counseling, and interactions with faculty) should alert the House Staff to his/her status/performance. Since House Staff are professionals, they have the responsibility to be aware of their status, and to inquire of the faculty concerning their progress in the residency program. Upon receiving ANY negative evaluation, the House Staff should contact his/her program director immediately for advice and counsel.

House Staff who are dissatisfied with departmental actions must, within five (5) business days, request in writing a review by the Departmental Chair. The decision of the chair in matters of oral counseling, written counseling, and suspension of less than thirty (30) days will be considered final.

An appeals process for suspensions of thirty (30) or more days, extension of residency training, or dismissal are allowed under the administrative procedures of the LSU Health Sciences Center-Shreveport. Additionally, although not required by Louisiana law, appeals will also be allowed for contract non-renewal. The decision of the appeals process for all matters will be either to **UPHOLD OR NOT UPHOLD** the departmental action. The full procedure for appeals (including appeals committee membership) is described in the section entitled Appeals Process.

**APPEALS**
House Staff may appeal the Decision of the Department Chair for any disciplinary actions involving 30 or more day’s suspension, extension of residency training, or dismissal. Additionally, although not required by Louisiana law, LSUHSC-S allows appeals for contract non-renewal. The Decision of the Appeals process will be either to **UPHOLD OR NOT UPHOLD** the departmental action.

**APPEALS PROCESS**
House Staff training is a serious responsibility both on the part of the House Staff and the faculty responsible for imparting such training. As medicine has progressed, and specialization has become more complex, the departments providing such training are best equipped to judge the clinical capabilities of the House Staff in their departments. It is expected that the faculty within the department/section sponsoring a residency/fellowship program will be involved in evaluating House Staff within their respective programs.
The role of the appeals process is to ensure that the House Staff has been fairly evaluated according to departmental standards, has been made aware of his/her deficiencies, and unless the offense(s) are egregious, be given the opportunity to correct them. The appeals process is an administrative one, and therefore the strict rules of evidence do not apply.

The appeals process following the decision of the Departmental Chair is as follows:

Step 1. Appeal to the Department Chairman
Step 2. Appeal to an Appeal Review Committee

**THE APPEALS PROCESS IN DETAIL**

1. Upon receiving one or more of these disciplinary/adverse actions, the House Staff desiring to contest this action must **within five (5) working days** request in writing a review by the Departmental Chair. The written request must be delivered to the office of the respective Department Chair by the close of business on the 5th day.

2. The Departmental Chair is the final appeal for all disciplinary matters of oral counseling, written counseling, probation, terminations or contract non-renewal and suspensions of less than thirty (30) days. The Departmental Chair has **five (5) working days** after receipt of the request to render an opinion. In disciplinary/adverse actions involving thirty (30) or more days suspension or for a non-renewal of a training contract as outlined in this section. If the Program Director and Department Chair are the same individual the Designated institutional Official (DIO) shall act as the Department Chair and follow the process as described. The written decision shall be hand delivered or sent by certified mail with signature of receipt.

3. In disciplinary/adverse action(s) involving thirty (30) or more day’s suspension, termination or for a non-renewal of a contract, the House Staff desiring to contest the action must within **five (5) working days** of the action make a written request for a review by the Departmental Chair. The request must clearly state the reason for the appeal, the relief desired and be delivered to the respective Department Chair office.

4. The Department Chair shall have **five (5) working days** from the receipt of the written request to render a decision in writing. The written decision shall be hand delivered or sent by certified mail with signature of receipt.

5. If the House Staff disagrees with the decision of the Department Chair, the resident/fellow may make a final appeal to the Appeals Review Panel. **Within five (5) working days** after receiving the decision of the Department Chair, the House Staff may request a hearing before the Appeals Review Panel. The request must be received in the office of Legal Affairs by 4:30pm on the 5th working day after receipt of the opinion of the Department Chair. The request must be in writing requesting the appeal and submitted to Legal Affairs. The written request must state the factual basis for the request for the appeal in detail, including but not limited to, specific reasons why the House Staff disagrees with the departmental action, other related issues that the House Staff desires to be considered, and the relief sought. The written request must include the House Officer’s appeals panel selection (described in # 6 below). **FAILURE TO COMPLY TIMELY WITH THESE DEADLINES AND REQUIREMENTS WAIVES THE APPEAL RIGHT UNDER THIS SECTION.**
6. Senior In-House Counsel shall schedule a date for the hearing within 5 working days after the receipt of the request, the hearing appeals date shall be within 30 calendar days or less. The committee shall be made up of three LSU Health Shreveport physician members who are not members of the House Staff’s department. One member will be selected by the House Staff, who is either a LSUHSC-S House Staff of the same or higher level as himself, or an LSUHSC Shreveport physician faculty member. The second member of the committee shall be appointed by the Department Chairman. The third member of the committee will be appointed/selected by the Senior In-House Counsel for the Medical School, and will vote only in the event of a tied vote between the other two panel members. An attorney from the office of Legal Affairs or a suitable designee shall serve as the legal adviser to the committee. The attorney shall not vote in the Committee’s voting, but shall be responsible for coordinating the meeting and drafting the report of the Committee for the review and signature of the Committee members (within 5 working days).

7. Each party is responsible for securing the attendance of their respective witness(es). If a witness is not available when called during the hearing their participation will be disallowed.

8. Not later than five (5) working days prior to the hearing, both sides (House Staff and department) shall submit to the office of Legal Affairs 5 copies of any and all documents to be considered by the appeals committee and their list of no more than 3 witnesses. Failure of either party to timely submit documents may preclude consideration of those materials by the panel.

9. The hearing shall be conducted as follows:
   First, the Department Chairman or Program Director may make a 30 minute presentation to the committee, which shall describe the action taken and the reasons for the action(s) taken. Following the presentation by the Department, the House Staff may make a 30 minute presentation to the committee that include his/her version of the events that resulted in the action by the Department, as well as any other relevant information that he/she wishes for the committee to consider. Each side may have up to three witnesses who each may make a presentation up to fifteen (15) minutes in length. At any time during the proceedings, the members of the appeals committee may ask questions of the House Staff or Department Chairman or Program Director or any witness who participates in the hearing.

10. The appeal hearing shall be closed. Witnesses to participate in the proceeding shall be excluded from the hearing and admonished not to discuss the case with anyone until after the hearing has concluded.

11. Both parties may present a brief (less than 10 minutes) closing written summary at the end of the hearing.

12. The Appeals Committee makes a decision whether or not to uphold the action of the Department Chairman. The House Staff will be notified, in writing within 10 working days of the hearing conclusion, of the decision of the Committee whether or not to uphold the action of the Department Chairman. The written decision concludes the administrative appeal process. The written decision shall be hand delivered or sent by certified mail with signature of receipt.

The disciplinary/adverse action shall be carried out after the decision of the Department Chair (who is the decision-maker). Should the House Staff prevail on the appeal to Senior University Official’s, the
House Staff will be entitled to all back pay and allowances from the date of the disciplinary/adverse action. Although the disciplinary/adverse action shall be carried out after the decision of the Department Chair, no notification of the appropriate boards and agencies will occur until the final step in the appeal. An exception to this notification may be made when required by law, rule, regulation, or contract.

Resident/Fellow Receives Disciplinary Action

- Resident/Fellow Contests Action (within 5 working days)

Departmental Chair renders opinion of Resident/Fellow’s appeal

- Suspension of < 30 days: Departmental Chair is final appeal (within 5 working days)
- Suspension of ≥ 30 days or non-renewal of contract, termination: Appeals process may be requested

Suspension of ≥ 30 days or non-renewal of contract

- Written request for review made to Departmental Chair (within 5 working days)

Decision is Rendered

- Departmental Chair renders a written decision (within 5 working days)
- If the Department Chair and the Program Director are the same person, the Designated Institutional Officer will render a written decision (within 5 working days)

Resident/Fellow Disagrees with the decision of the Departmental Decision

- Resident/Fellow requests hearing of the Appeals Review Panel (within 5 working days) which includes the name of their appeals panel selection

Appeals Review Panel

- Resident/Fellow selected member; Departmental Chair selected member; Legal Affairs Attorney (non-voting/deliberating member)
- Departmental Chair shall submit names (within 5 working days)

Submission of Documents to be considered by Appeals Review Panel

- No later than 5 working days prior to hearing and include 5 copies of documents to be considered by the appeals panel
Appeals Hearing is opened

a. Department Chair or Program Chairman makes a presentation

b. Resident/Fellow makes a presentation

c. Each side may have between 1 and 3 witnesses who are only permitted in the room for the 5 minutes they testify

d. Appeals Review Panel may ask questions at any time

Appeal Hearing is closed

Appeals Review Panel notifies Resident/Fellow in writing of the decision (within 10 working days)
Grievance Appeals Process (GME 4.1)

The grievance appeals process is the mechanism for House Staff to address complaints that are not related to their professional performance or contract issues. A grievance is defined as any circumstance thought to be unjust or injurious and grounds for complaint or resentment, or a statement expressing this, against a real or perceived wrong; or a complaint arising from circumstances or conditions relating to one’s employment. A House Staff has several options in which to have a grievance resolved.

House Staff and Program Directors are encouraged to work within their departments to address and resolve any issues of concern to the House Staff, including concerns related to the work environment, faculty, or the House Staff performance in the program. All such concerns should be presented by the House Staff to their Program Directors for resolution. Issues or alleged violation(s) of Title 9 (discrimination) shall be referred to Human Resources.

A grievance procedure for all House Staff was established at Louisiana State University Health Sciences Center so that House Staff who are dissatisfied or who have a personal complaint may discuss their situation freely with appropriate personnel. All House Staff may request to receive proper consideration toward resolving the problem. The House Staff should do so without fear of reprisal from anyone for using the procedure provided the effort to resolve the problem is sincere. The policy may be found in the House Staff Manual, “Grievance Appeals Process” (4.1). The steps of the Grievance Procedure are as follows:

- **Step 1:** The House Staff shall present the grievance in writing to his/her immediate Program Director within five (5) working days beginning with the day after the occurrence of the incident which caused the employee to be aggrieved. The Program Director shall work in concert with the Section Chief, if applicable, to ensure appropriate communication and enhance decision making. The Program Director will promptly establish a meeting with the House Staff to discuss the grievance and/or will render a written answer to the grievance within three (3) working days beginning with the first working day after the grievance is presented to the Program Director.

- **Step 2:** If the House Staff is not satisfied with the decision of his/her Program Director and Section Chief, if applicable, he/she may, within three (3) working days, submit his/her grievance in writing to the Department Chair. The Chair will conduct an investigation within five (5) working days. If the Chair feels that, based on the facts, the employee has a valid grievance; he/she will notify the Program Director of his/her findings. If the Program Director does not concur with the Department, the Department shall render a written decision to the House Staff and the Program Director within three (3) working days after the initial response was rendered. If the Program Director and Chair are the same person, the House Staff shall submit their grievance within three (3) working days to the Designated Institutional Official (DIO). The DIO shall act as the Department Chair and follow the process as described.

- **Step 3:** If the House Staff is not satisfied with the decision at Step 2, he/she shall, within two (2) working days beginning with the first working day after receiving the decision submit his/her grievance in writing to the Senior In-House Counsel. The Senior In-House Counsel shall discuss the grievance with the House Staff within five (5) days and render a written decision within three (3) working days beginning with the first working day after the grievance is discussed with the House Staff.
Decisions rendered by the Office of Legal Affairs, on behalf of the Chancellor are final within the university.

As set forth in the House Staff Manual, the Due Process Policy (GME 3.1) provides additional procedures for House Staff to request review of certain academic or other disciplinary actions taken against House Staff that could result in dismissal, non-renewal of a House Staff’s agreement or other actions that could significantly threaten a House Staff’s intended career development.

**House Officer Leave Policy (GME 5.1) Policy**
Every House Officer is entitled to annual leave (vacation) during the academic year. All residents must submit their vacation requests to their Program Director in as far as advance of the requested week as possible. The House Officer’s Program Director must approve leave requests. If the vacation request is made during an off-service rotation, the Program Director in the department directly responsible for the off-service rotation must also approve the request. Once approved by the appropriate Program Director(s), the House Officer’s approved leave request must be submitted to the GME Office by that House Officer’s department.

**J-1 Visa Sponsored House Officers Requesting Leave**
All House Officers on a J-1 Visa must complete the “All J-1 Visa Holder” section when submitting their leave request to their Department. Any J-1 Visa Sponsored House Officers travelling outside the United States must follow the steps below when requesting and returning from approved leave:

1. Complete and submit leave request on GME approved Leave Request Form with desired dates of leave.

2. Once signed and approved by department, Program Coordinator will submit approved leave form to the GME office.

3. While on leave, any delay in returning to work must be communicated to the Program Director, Program Coordinator and GME Office immediately.

4. Upon re-entry into the United States, J-1 Visa sponsored house officer must report to the GME office on the first day returning back to work from leave. The GME Office will then verify correct visa status at time of re-entry. J-1 Visa sponsored House Officers housed in Monroe or Alexandria must report to their Program Coordinator and contact the GME office at that time to verify status.

**Annual Leave:** First-year house staff are allowed 15 days of vacation (Monday – Friday, not to include weekends) with pay, and second through seventh year house staff are allowed 20 days (Monday – Friday, not to include weekends) of vacation with pay, except where prohibited by specialty ACGME Residency Review Committee or Board regulations. Vacation requests should be in increments of one week ([a seven day period to include 5 weekdays and 2 weekend days]) at a time with one adjoining
weekend free of duty. House Officer should request within program desired weekend to be free of
duty. All requests for annual leave must be approved by the respected Program Director and will be
granted at the discretion of the program needs. Education, meetings, and conference attendance will
be charged as annual unless evidence of true Educational leave is supplied. In such case, it will be at
the Program Director’s discretion whether or not to charge annual leave. Program Directors will be
held accountable for ensuring House Officers meet the minimum days in training for their board.
Vacation is non-cumulative — it must be used during the year earned and cannot be carried forward.

**Sick Leave:** All House Officers are allowed 10 days for sick leave each year. Sick leave may not be used
as vacation time. Sick leave must be approved by the respected Program Director. If sick leave is more
than three (3) consecutive workdays, the employee may be required to bring a physician's certificate.
Sick leave includes personal doctor’s appointments i.e. medical, optical, and dental.

**Education, Military, Civil, and Leave Without Pay** will be arranged between the House Officer and the
Chief of Service. Special Leave will be granted as defined by the Employee Handbook. The House
Officer will notify the Medical Education Office, a minimum of 30 days in advance of the absence as
possible. If Leave Without Pay is granted, it may result in the extension of your contract, depending on
departmental guidelines.

**House Officer Call in Policy (GME 5.1.a)**

**Policy**
All scheduled leave must be recorded in the Graduate Medical Education Office as outlined in the
Leave Policy. Any unscheduled leave, emergency, sick, etc. must be reported immediately to the
assigned service representative.

Upon notification of the need to take leave, the House Officer will be advised to call in daily if sick leave
is being requested. A physician’s excuse may be necessary to return to work. Other emergencies will
require identifying a specific number of days prior to leave being taken to establish a date of return to
service. Any leave taken without following the proper procedure may result in leave without pay
and/or delay in program completion as determined by the Program Director/Chief of Service.

**Procedure**
Upon the need for a House Officer to call in for any reason including but not limited to sick, emergency,
etc., the House Officer must:
- Notify the Program Director or his/her designee of absence and expected duration of absence
- Complete and submit a House Officer Leave Request upon return to work
- Provide a doctor’s excuse if required by program to return to work

House Officers must refer to their program specific policy when calling in and contacting designated
persons in their program. House Officers must also refer to program specific call in policy to ensure
they are using acceptable forms of communication (phone, text, email, etc.).

Programs will forward House Officer Leave Requests to the Graduate Medical Education office to be
kept in the House Officer’s file.
Impaired Physicians (GME 6.1)

1. Policy

Purpose
To provide a mechanism for treatment and rehabilitation of physicians suffering from
impairment that may interfere with optimal professional function and ensuring the protection of
patients.

Policy
• Physicians shall receive ongoing education on impairment recognition, including signs and
symptoms of controlled or mood altering substance impairment. Education shall address prevention of
physical, psychiatric and emotional illness. (Hospital personnel shall receive education about illness and
impairment recognition issues.)
• Any impaired, or suspected impaired, physician, regardless of how identified (including self-
referral), shall be seen by the Physician Director of the LSUHSC Occupational Health Clinic (OHC). The
OHC physician shall evaluate, or cause to be evaluated, the referred physician for suspected
impairment. The evaluation process shall be conducted in a confidential manner.
• Should the OHC physician determine that drug testing is indicated, testing shall be in
accordance with established Occupational Health clinic procedure; cost of all testing shall be borne by
the institution.
• Upon completion of the evaluation, the OHC physician shall report his findings to the
Designated Institutional Official. The Designated Institutional Official shall notify the appropriate
regulatory bodies, department chairman or others as deemed appropriate or mandated by law.
• The Designated Institutional Official, in consultation with other appropriate individuals, shall
provide the impaired physician with options regarding treatment and assistance to aid the physician in
retaining or regaining optimal professional function. Such treatment shall be done in a non-punitive
manner, and shall be based upon the assurance that patient care is at no time compromised.
2. Process for LSUHSC house officers seeking assistance and/or support for substance abuse:

- **PHYSICIAN IMPAIRMENT**
  - If the House Officer chooses not to participate in the LSBME or PHFL program he/she must notify their Program Director and LSBME.
  - House Officers can directly contact the Louisiana State Board of Medical Examiners or Physician Health Foundation of Louisiana at 888-743-5747
  - The PHFL will meet with the House Officer to determine what if any steps need to be taken. If deemed necessary, House Officer is recommended for a 1-5 day confidential evaluation.
  - The House Officer must inform their Program Director immediately of their need to be off from work for extended medical reasons. The Program Director will inform the Medical Education Department.
  - PHFL is required to send a quarterly report to the LSBME board regarding the status of the House Officer's rehabilitation.
  - Once the House Officer has been released from the rehabilitation center, he or she must schedule a meeting with the DIO to return to work.
Resident Supervision (7.1)

The Sponsoring Institution must maintain an institutional policy regarding supervision of residents/fellows. (IR IV.I.1.) Each of its ACGME-accredited programs must establish a written program-specific supervision policy consistent with the institutional policy and the respective ACGME Common and specialty/subspecialty-specific Program Requirements. (IR IV.I.2)

All programs must adhere to the minimum standards put forth in this policy. Programs must supplement this policy with program-level supervision policies, and must have explicit written descriptions of lines of responsibility for the care of patients, which are made clear to all members of the teaching teams. Residents must be provided with rapid, reliable systems for communication with, and appropriate involvement of, supervisory physicians in a manner appropriate for quality patient care and educational programs.

Definitions

Levels of Supervision
To ensure oversight of resident supervision and graded authority and responsibility, the program must use the following classification of supervision:

- Direct Supervision
  - The supervising physician is physically present with the resident and patient.

- Indirect Supervision
  - With direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.
  - With direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.

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

Policy
Each Resident will be assigned a faculty supervisor (supervisor may also be the Program Director). The level and method of supervision will be consistent with the ACGME Program Requirements for each program. The Residents will be supervised by teaching staff in such a way that the Residents assume progressively increasing responsibility according to their level of education, ability, and experience.

Each faculty member with direct teaching assignments must provide a written summary of the assessment of the Resident’s performance during the period that the Resident was under his direct supervision.

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

Senior residents or fellows should serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.
Programs must set guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions.

Each resident must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.

The program faculty (program director) must conduct a semi-annual evaluation of the Resident and discuss any strengths or weaknesses that may be identified. A plan of corrective action must be noted if there is unsatisfactory performance.

The Department or division should meet periodically to review the supervisor’s written comments and the Resident’s clinical performance. This committee determines the adequacy of each Resident’s performance for decisions to advance that Resident.

The program director advances Residents to positions of higher responsibility on the basis of the evaluation of their readiness for advancement. The program director must maintain a personal record of evaluation for each Resident which is accessible to the Resident.

Listings of the re-appointments are forwarded to the Graduate Medical Education Office for preparation of the contracts.

1. Lines of Responsibility
All Residents in training programs function under the supervision of a member of the Medical Staff. Each Clinical Service may have the following levels of supervision:
   Clinical Chair
   Section Chief
   Program Director
   Attending Physician
   Clinical Fellow
   Chief Resident
   Resident
   Medical Student
   Other Allied Health Students and Medical Center Staff

2. Patient and Family supervision
Patients and families should be aware of the roles and responsibilities of the physician providing their care. Patients and families should have adequate contact with the residents/fellows and attending physicians in charge of their care.

Escalation of Care Cards (GME 7.1.a)

Policy
In support of the GME Resident Supervision policy and training program-level supervision policies, training programs are to implement the use of escalation of care cards for house officers. The escalation of care cards
are to make the lines of responsibility clear for the care of patients and guide house officers with conditions that require immediate attending notification.

**Procedure**
- House officers will be issued laminated escalation of care cards for reference for when to communicate with attending or other faculty.
- Escalation of care cards will be distributed for patients being admitted to Medicine services and Surgery services.
- It is expected that house officers will notify attendings or other faculty if attending cannot be reached, as soon as possible after an incident has occurred. Notification of attending should not delay provision of care to the patient.

**Expected communication practices for patients admitted to the Medicine service:**

1. All critical changes in a patient’s condition should be communicated to the attending physician within 1 hour including:
   - Medically unstable admissions or transfers
   - Transfer to the ICU
   - Unplanned intubation
   - Cardiac arrest
   - Hemodynamic instability including unstable arrhythmias
   - Development of significant neurologic changes
   - Medication or treatment errors requiring clinical intervention
   - Development of any clinical problem requiring an invasive procedure or operation

2. The following will be discussed with the attending and approved before they occur:
   - Discharge from the hospital or from the Emergency Department
   - Refusal of transfer request or ED request for admission
   - Transfer out of ICU (ICU faculty to be notified)

3. The attending should also be contacted if:
   - Any trainee feels that a situation is more complicated than he or she can manage
   - Nursing or physician staff, or the patient request that the attending be contacted

**Expected communication practices for patients transferred/admitted for Interventional Radiology services**

1. Attending radiologists are notified of every patient that is transferred/admitted to the Interventional Radiology services and work directly with the resident while the patient is on the service.

**Expected communication practices for patients transferred/admitted for Diagnostic Radiology services**

1. Attending radiologists are to be notified of all pediatric GI examinations
2. Attending radiologists are to be notified when there are potential life threatening imaging findings of which the resident may not be reasonably confident

**Expected communication practices for patients admitted to the Surgery service:**

1. All critical changes in a patient’s condition, the attending physician will be notified promptly (generally within 1 hour following evaluation). These include:
   - Admission to the hospital
   - Transfer to the ICU
   - Unplanned intubation or ventilator support
• Cardiac arrest
• Hemodynamic instability (including arrhythmias)
• Code
• Development of significant neurologic changes (suspected CVA/seizure/new onset paralysis
• Development of major wound complications (dehiscence, evisceration)
• Medication or treatment errors requiring clinical intervention (invasive procedure(s), increased
monitoring, new medications except Narcan)
• First blood transfusion without prior attending knowledge or instruction (before or after operation)
• Development of any clinical problem requiring an invasive procedure or operation
  2. The following will be discussed with the attending and approved before they occur:
• Discharge from the hospital or from the Emergency Department
• Transfer out of ICU
  3. The attending should also be contacted if:
• Any trainee feels that a situation is more complicated than he or she can manage
  Nursing or physician staff, or the patient request that the attending be contacted

• Expected communication practices for patients treated by Residents in the General Psychiatry Residency

1. All critical changes in a patient's condition should be communicated to the attending within 1 hour including:
   • Medically unstable admissions. Call ED attending first from PCU for immediate attention. If it is a CL pt
being admitted to the inpatient unit, discuss any concerns or changes with the transferring resident
first. Call the attending if the resident feels it is not an appropriate admission to the inpatient
unit. Please note the criteria for admission to the inpatient unit and PCU.
   • Any medically ill patient that resident feels should not be admitted to the PCU. Discuss with ED resident
and attending first, and if it is still felt the patient should not be admitted to the PCU, discuss with
attending
   • Any sudden deterioration is a psychiatric patient’s physical condition (inpatient or PCU) necessitating
calling the START team, transfer to another service, or other serious untoward event.
  2. The following will be discussed with the attending and approved before they occur:
   • Discharge from the hospital, Emergency Department, or PCU
   • Transfer from the inpatient unit to another facility
  3. The attending should also be contacted if:
     • Any resident feels that a situation is more complicated than he or she can manage. If there is any doubt
at all, it is better to err on the side of caution and contact the attending
     • Nursing or physician staff request that the attending be contacted
  4. When contacting the attending, verbal communication is preferred

Clinical Experience and Education (GME 8.1)

The Graduate Medical Education Committee (GMEC) is committed to providing Residents with a sound
academic and clinical education that promotes patient safety and Resident well-being. The educational
goals of the Residency Training Program and learning objectives of Residents must not be
compromised by excessive reliance on Residents to fulfill institutional service obligations. Clinical hour
assignments must recognize that faculty and Residents collectively have responsibility for the safety
and welfare of patients. Department Chairpersons and Residency Program Directors must ensure that
Residents are provided appropriate backup support when patient care responsibilities are especially
difficult or prolonged, or if unexpected circumstances create Resident fatigue sufficient to jeopardize
patient care. Residents/Fellows and Faculty will receive proper education in strategies for managing
fatigue and burnout as to ensure quality patient care and safety.
Resident clinical hours and on-call assignment periods must not be excessive. Clinical and educational work hours are defined as all clinical and academic activities related to the residency/fellowship program. This includes inpatient and outpatient clinical care, in-house call, short call, night float and day float, transfer of patient care, and administrative activities related to patient care, such as completing medical records, ordering and reviewing lab tests, and signing orders. For call from home, time devoted to clinical work done from home and time spent in the hospital after being called in to provide patient care count toward the 80-hour weekly limit. Types of work from home that must be counted include using an electronic health record and taking calls. Reading done in preparation for the following day’s cases, studying, and research done from home do not count toward the 80 hours. Hours spent on activities that are required in the accreditation requirements, such as membership on a hospital committee, or that are accepted practice in residency/fellowship programs, such as residents’/fellows’ participation in interviewing residency/fellowship candidates, must be included in the count of clinical and educational work hours. Time residents and fellows devote to military commitments counts toward the 80-hour limit only if that time is spent providing patient care.

If attendance at a conference is required by the program, or if the resident/fellow is a representative for the program (e.g., he/she is presenting a paper or poster), the hours should be included as clinical and educational work hours. Travel time and non-conference hours while away do not meet the definition of “clinical and educational work hours” in the ACGME requirements.

Maximum Hours of Clinical and Educational Work per Week

- Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting.

Mandatory Time Free of Clinical Work and Education

- Residents must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on these free days.

Maximum Clinical Work and Education Period Length

- Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education. Additional patient care responsibilities must not be assigned to a resident during this time.
- In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances: to continue to provide care to a single severely ill or unstable patient; humanistic attention to the needs of a patient or family; or, to attend unique educational events. These additional hours of care or education will be counted toward the 80-hour weekly limit.

Moonlighting

- Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program, and must not interfere with the residents’ fitness for work nor compromise patient safety.
- Internal and External Moonlighting hours must be counted toward the 80-hour maximum weekly hour limit, and monitored by the training program. Internal moonlighting is defined by the ACGME as moonlighting at the sponsoring institution or the non-hospital sponsor’s primary clinical site. External
moonlighting is defined as voluntary, compensated, medically-related work performed outside the institution where the resident is in training or at any of its related participating sites.

- PGY-1 residents are not permitted to moonlight.

**In-House Night Float**

- Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements. (The maximum number of consecutive weeks of night float, and maximum number of months of night float per year may be further specified by the Review Committee.)

**Maximum In-House On-Call Frequency**

- Residents must be scheduled for in-house call no more frequently than every-third-night, averaged over a four-week period.

**At-Home Call**

- At-home call (pager call) is defined as call taken from outside the assigned institutions. Time spent in the hospital by residents on at-home call must count towards the eighty (80) hour maximum weekly hour limit.
- Time spent on patient care activities by residents on at-home call must count towards the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of clinical work and education, when averaged over four weeks.
  - At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
- Residents are permitted to return to the hospital while on at-home call to provide direct care for new or established patients. These hours of inpatient patient care must be included in the 80-hour maximum weekly limit.

In planning the Resident rotation schedules, the schedule must focus on the needs of the patient, continuity of care, and the educational needs of the Resident. The Departmental clinical hours must be in compliance with the Institutional as well as the Program Requirements. Each training program must have written policies and procedures consistent with the Institutional and Program Requirements for Resident clinical hours and the working environment. The policies and procedures must be distributed to all Residents and faculty. Frequent monitoring of clinical hours must occur at the institutional and program level to assure compliance with the standards, and to maintain an appropriate balance between education and service. Monitoring of clinical hours will also help identify any vulnerabilities of resident/fellow fatigue. Indicators of clinical hours will be included in the GMEC Internal Review of Residency Programs to assure that the policy is adhered to and reported to the GMEC, Chancellor/Dean, Department Chairman, and Residency Program Director any findings contrary to meeting full compliance.

In addition, the Graduate Medical Education Department shall monitor clinical hours on an on-going basis and report non-compliance to the GMEC and the Program Director. All programs must adhere to the MyEvaluations Clinical Hour Data Entry Policy regarding the recording and reporting of clinical hours electronically.
Moonlighting (GME 8.1.a)

Policy
The direct provision of patient service for pay (moonlighting) is considered an augmentation and a privilege that should not detract from the goals and objectives of the educational program. House Officers are encouraged to limit the number of moonlighting hours per month as outlined by their Program Directors. House Officers must notify their Program Directors of the average number of external moonlighting hours per month. House Officers are reminded that the Louisiana State Malpractice Plan does not cover malpractice for moonlighting hours outside the LSU System. Under no circumstances should House Officers moonlight during their regular scheduled program hours of service.

Definitions:
Internal Moonlighting: Voluntary, compensated, medically-related work (not related with training requirements) performed within the institution in which the resident is in training or at any of its related participating sites.

External moonlighting: Voluntary, compensated, medically-related work performed outside the institution where the resident is in training or at any of its related participating sites.

Procedure
The Graduate Medical Education Committee (GMEC) adheres to the following standards set forth by the ACGME regarding moonlighting:

- House Officers are not required to engage in moonlighting.
- If moonlighting does occur, each House Officer must have a written statement of permission from the program director that is made part of the House Officer’s file.
- House Officer Performance will be monitored for the effect of moonlighting activities upon performance and that adverse effects may lead to withdrawal of permission.
- The Sponsoring Institution or individual ACGME-accredited programs may prohibit moonlighting by residents/fellows
- PGY-1 residents are not permitted to moonlight.
- Internal and External moonlighting hours must be counted toward the 80-hour weekly limit on duty hours, and monitored by the training program.

Due to Federal Guidelines, individuals with the J-1 VISA are not allowed to moonlight.

House Officers seeking to moonlight must receive signed approval from Program Director. A GME Moonlighting Approval Form should be completed, signed and submitted to the GME office for documentation.

Any House Officer engaging in external or internal moonlighting must accurately and honestly document moonlighting hours in the submission of their clinical hours in MyEvaluations.

Programs are to confirm the entry of moonlighting hours when reviewing and submitting approval of clinical hours entered to the GME office.
Supplemental Pay for Internal Moonlighting

- For programs offering supplemental pay for house officers participating in internal moonlighting, the GME Supplemental Pay Template for internal moonlighting is to be completed and submitted to the GME office by the 4th of each month.
- Clinical Hours entered in MyEvaluations must match supplemental pay submitted in order to receive supplemental pay. Supplemental pay will not be submitted to payroll if any discrepancies are found between clinical hours entered and supplemental pay for submitted.

Training programs may establish moonlighting guidelines more limiting than these, and must have written policies and procedures regarding duty hours and moonlighting.

Restrictive Covenants (9.1)

The Graduate Medical Education Committee (GMEC) recommends to all Residency Programs that no participating Resident shall be required to sign a non-competition guarantee. It is the policy of LSUHSC-Shreveport not to engage in any contractual practices, which restrict the Resident (or any member of the Medical Staff) the ability to fully compete during or after their residency/employment experience.

The Graduate Medical Education Committee (GMEC) will include as part of their questions to the Residents during the Internal Review of the Resident Program verification that the program is compliant with this policy. The Department Chairman and Dean/Chancellor of the Health Sciences Center shall be notified of any indication that the program is non-compliant.

Residency Closure/Reduction (GME 10.1)

The Sponsoring Institution must inform the Graduate Medical Education Committee (GMEC), the Designated Institution Official (DIO) and the affected residents/fellows as soon as possible when it intends to reduce the size of or close one or more ACGME-accredited programs, or when the Sponsoring Institution intends to close.

The Sponsoring Institution must allow residents/fellows already in the affected ACGME-accredited program(s) to complete their education at the Sponsoring Institution, or assist the residents/fellows in enrolling in another ACGME-accredited program(s) in which they can continue their education. The GMEC has delegated the responsibility of communicating results of all Residency Review Committee (RRC) surveys as follows.

Interviewing and potential resident applicants shall also be notified by the Department Chairman and/or Resident Program Director of a reduction or change in the status of the Residency Program. The notification shall be in writing to each resident enrolled in the current program and LSUHSC-Shreveport shall allow the residents already in the ACGME accredited program to complete their education. Further, it is the institution’s policy to both inform Residents of the results of a Residency Review Committee survey and continue their financial support as outlined in the ACGME guidelines for Residency.

Patient Safety (GME 11.1)

The Sponsoring Institution must ensure that residents/fellows have access to systems for reporting errors, adverse events, unsafe conditions, and near misses in a protected manner that is free from reprisal; and, opportunities to contribute to root cause analysis or other similar risk-reduction
processes. (IR III.B.1) All Residents/Fellows, Faculty, and clinical staff are to be aware of their roles in reporting events concerning patient safety.

Policy
Programs will educate Residents/Fellows and Faculty on enhancing patient safety and improving patient quality of care. Residents/Fellows are able to share any ideas and suggestions regarding patient safety to their program in order to improve patient safety processes.

Procedure
- Residents/Fellows and Staff must follow the hospital policy for reporting any event that poses an actual or potential safety risk to patients, families, visitors and staff. (Hospital Policy 2.22). These can be reported electronically at the following link: [http://www.medcom.lsuhscreveport.edu/cfdocs/qm/form-variance.cfm](http://www.medcom.lsuhscreveport.edu/cfdocs/qm/form-variance.cfm)
- Residents/Fellows are to follow policies and procedures for patient safety and patient safety reporting at any/all participating sites where they are engaged in training.
- Residents/Fellows and Staff must follow the guidelines for Transitions of Care/Patient Handoff to ensure and monitor an effective hand-over process to facilitate both continuity of care and patient safety. (GMEC Transitions of Care/Patient Handoff Policy)
- Residents/Fellows and Staff will participate in the quarterly safety training issued by the Safety office to ensure adequate and current education of ongoing safety topics.
- Residents/Fellows are to receive feedback regarding patient safety reports and investigations in order to improve patient safety experiences within programs and clinical sites.

Quality Improvement (GME 11.2)
The Sponsoring Institution must ensure that residents/fellows have access to data to improve systems of care, reduce health care disparities, and improve patient outcomes. They must also be given opportunities to participate in quality improvement initiatives. (IR III.B.2) Residents/Fellows and Faculty are to engage in quality improvement educational activities as to develop skills to be able to identify areas where improvement in patient care is needed.

Policy
- Residents/Fellows must receive proper education and continuous training on quality improvement as it relates to patient care and the hospital environment. Residents/Fellows are expected to develop skills to systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement. (CPR IV.A.5.c).(4)) Programs shall conduct formal quality improvement programs to review complications and deaths, and system issues where adjustments can be made to improve patient care and outcomes. The program director shall ensure residents are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs. (CPR VI.A.3.)

Procedure
- Programs must have a process to ensure quality improvement and patient safety are integrated in the daily education of residents/fellows. Participation can be accomplished through M&M conferences, morning reports, conferences, etc.
- Involvement in patient safety and quality improvement should be carefully documented and reviewed during annual program evaluations.
• Residents/Fellows participate in patient safety plans in order to identify the facility’s systematic approach to improving and sustaining its performance through the prioritization, design, implementation, monitoring, and analysis of performance improvement initiatives.
• Residents/Fellows will participate in Quality Improvement projects where they design, measure, assess, and improve performance.
• Residents/Fellows will participate in Hospital Committees in order to understand quality from a systems-based perspective.
• Residents/Fellows are able to bring to the attention of the program and faculty any areas that need quality improvement. Efforts of Residents/Fellows in quality improvement should be monitored and tracked in order to assess the effectiveness of the quality improvement being implemented.

Transitions of Care/ Patient Handoff (GME 11.3)

The Sponsoring Institution is responsible for oversight and documentation of transitions of care. The Sponsoring Institution must facilitate professional development for core faculty and residents/fellows regarding effective transitions of care. The Sponsoring Institution must also ensure participating sites have standardized transitions of care for residents/fellows that are consistent with the setting and type of patient care. The purpose of this policy is to define a safe process to convey important information about a patient’s care when transferring care from one physician to another physician, nurse, licensed or unlicensed personnel, or when a patient leaves LSUHSC-S/University Health for another site of care. Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.

Policy
When a resident/fellow completes an assigned shift the resident/fellow will follow a standardized approach and allow an opportunity for questions to be asked and responses to be completed. A handoff is a verbal and/or written communication, which provides information to facilitate continuity of care. This policy applies to all house officers who discharge or send a patient to other sites for care. It also affects staff in other areas of LSUHSC-S/University Health who may need to communicate information when a patient changes location of care. House Staff are to comply with the handoff policy and procedures and resolve discrepancies and concerns timely. The guidelines below must be used at a minimum for handling transitions of care/patient handoffs. Individual programs may implement more comprehensive and detailed guidelines to meet specific physician and patient needs.

Procedure
1. Medical Staff and Residents:
   a. Handoff procedures and information transfer forms/guidelines for physicians are developed and implemented by each service according to the needs of that service. The handoff forms or guidelines may be in either paper or electronic format, and must include clinical information agreed upon by physicians in that service as being integral to the provision of safe and effective patient care for that patient population.
   b. Each service develops and implements a handoff process that is in keeping with the shift/rotation change practices of its physicians and that facilitates the smooth transfer of information from physician to physician.
   c. Each handoff process must include the opportunity for the oncoming physician to ask questions and request information from the reporting physician.
d. Within each service, handoffs will be conducted in a consistent manner, using a standardized handoff form or guideline.
e. Handoffs will involve notification to patients and patient families as appropriate.
2. Transferring physician:
Handoff verbal &/or written should include at a minimum (as applicable)
a. Patient name, location, age/date of birth
b. Patient diagnosis/problems, impression
c. Important prior medical history
d. DNR status and advance directives
e. Allergies
f. Medications, fluids, diet
g. Important current labs, vitals, cultures
h. Past and planned significant procedures
i. Specific protocols/resources/treatments in place (DVT/GI prophylaxis, insulin, anticoagulation, restraint use, etc)
j. Plan for next 24+ hours
k. Pending tests and studies which need follow up
l. Important items planned between now and discharge
3. Receiving physician:
Review handoff form or receive verbal handoff, and resolve any questions with transferring physician.
4. Discharge Instructions are incorporated into the After Visit Summary and are printed off by the RN/LPN and give to all patients discharged home. Additional discharge instructions may be communicated via unit/procedure specific documents.
5. Discharge to non acute care
Physician documentation, the discharge summary will be sent to non acute care facilities (e.g. nursing homes, prisons). Included in this discharge summary/information will be the discharge mode and vital signs. The nurse will make a telephone report to the receiving facility as appropriate.
6. Discharge to acute care, Inter-Hospital Transfer
Physician Form – The Memorandum of Inter-Hospital Transfer (both S/N 1303/1330) will be completed by the MD prior to transferring a patient to another acute care facility and will be accompanied by the physician’s discharge summary and all salient portions of the patient medical record. The nurse will make a telephone report to the receiving nurse.

Professionalism (GME 11.4)

The Sponsoring Institution is responsible for educating and monitoring residents’/fellows’ and core faculty members’ fulfillment of educational and professional responsibilities. These responsibilities include accurate reporting of program information, scholarly pursuits, accurate completion of required documentation by residents/fellows, and identification of resident/fellow mistreatment. (IR III.B.6) All employees of LSU Health Sciences Center must conduct all activities in a manner that will promote integrity and compliance while practicing sound, ethical, and professional judgment.

Policy

Programs and sponsoring institutions must educate residents and faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients. (CPR VI.A.1) The program director and institution must ensure a culture of professionalism that supports patient safety and personal responsibility. Residents and
Faculty must recognize their responsibility to display professionalism throughout their education, training, and patient care experiences.

**Procedure**

- Residents/Fellows and Staff must follow hospital guidelines when recording documentation in the Electronic Health Record System. (Hospital Policy Manual 6.5)
- Residents/Fellows and Staff are to refer to the hospital’s policy regarding unprofessional behavior or mistreatment. (Hospital Policy 3.14)
- Residents/Fellows and Staff must follow the Hospital Safety Manual policies and report any unsafe conditions appropriately. (Safety Manual Policy I.A.2)
- Faculty members must engage in the training of Residents/Fellows on professionalism and how it impacts the quality and safety of patient care.
- Residents/Fellows comply with GMEC policy regarding duty hours, reporting accurate hours in a timely manner. (GMEC MyEvaluations Duty Hour Policy)
- Residents/Fellows are to demonstrate professionalism and an adherence to ethical principles as it relates in all aspects of their training and interactions with other residents/fellows, faculty, hospital staff, and patients. This behavior shall be demonstrated at the primary teaching site and any/all participating teaching sites the resident/fellow engages in training.

**MyEvaluations Data Entry Policy (GME 12.1)**

The Sponsoring Institution is responsible for overseeing proper and accurate data is recorded and maintained for all residents/fellows in training at LSU Health Shreveport. To ensure proper management of data, the Sponsoring Institution has made MyEvaluations available to all programs for the purpose of recording and maintaining required data for residents/fellows. All programs are responsible for entering all required information in a consistent and timely manner. Programs are responsible for being in compliance with all policies below.

**Demographic Data Entry**

All House Staff are responsible for providing programs with required demographic information. All training programs must obtain demographic information from each resident/fellow and submit to the GME office along with entering the information into MyEvaluations. To ensure proper entry of demographic information, the Sponsoring Institution has made it mandatory that all programs utilize MyEvaluations when entering demographic information. Program Coordinators or designees must be responsible for obtaining all required demographic information from the resident/fellow prior to beginning training. The Program Coordinator or designee is then responsible for supplying demographic information to the GME office and through MyEvaluations

**Procedure**

- Program Coordinators will receive proper training on entering demographic information in MyEvaluations.
- The program will utilize the ERAS to MyEvaluations import tool. The import tool has a cut off of May 31 of each year so all demographic importing must be completed by this date.
- Program Directors, Coordinators, or program designee will enter demographic information for each resident/fellow ensuring accuracy of the information being entered.

**Clinical Hour Data Entry:**
All House Staff are responsible for accurately and honestly reporting all clinical hours on a weekly basis at a minimum. Daily entry is recommended. All training programs must adhere to the guidelines governing clinical hours as set forth by the ACGME. To ensure proper reporting of clinical hours, the Sponsoring Institution has made it mandatory that all programs utilize MyEvaluations when recording clinical hours. The Program Director must monitor resident clinical hours, according to sponsoring institutional policies on a weekly basis to ensure accurate entry. The Sponsoring Institution has made the program MyEvaluations available to all programs as a tool for data entry and healthcare workflow. (IR III B.5.a-III.B.5.a). This allows the GME office the ability to review programs’ clinical hours for reporting purposes. Rotation names are allowed to vary according to program specific requirements, but activity types shall be reasonably standardized across the institution. This standardization is designed to ensure an appropriate method of tracking leave types as well as ensuring the 2017 At-Home Call rules are tracked accurately. Any new rotation name or activity type the program wishes to implement must be submitted to and approved by the DIO prior to implementation.

**Procedure**

- Programs must educate their Residents/Fellows on how to properly enter and submit clinical hours into MyEvaluations.
- Residents/Fellows must enter clinical hours weekly. Daily is recommended.
- Program Directors, Program Coordinators, or Program designee must confirm clinical hours submitted in MyEvaluations by the 5th of the following month.
- The program must submit a weekly log documenting a weekly review of Residents/Fellows Clinical Hour entry and accuracy. The log template is available from the GME office. This log shall be submitted to the GME office by the 5th of the following month.
- The GME office will run a monthly clinical hour report for all programs. The report will then be presented at the monthly GMEC meeting for compliance.
- Any clinical hour violations will be discussed during the GMEC meeting.
- Programs that do not submit clinical hours by the deadline will receive a violation of “No clinical hours reported.”
- Any changes deemed necessary to previously submitted clinical hours must receive Program Director approval before any changes are made. Immediate notification to the DIO is required for any change to previously submitted clinical hours.
- The program shall review previously submitted clinical hours once weekly to ensure changes have not been made to previously submitted clinical hours. The timeframe for this review is 3 months prior, and must be reflected on the weekly log submitted to the GME Office.

Residents/Fellows or Program Coordinators/Designee should notify the GME office of any changes to demographic information for each Resident/Fellow.

**Evaluations**

All Residency and Fellowship Programs are responsible for evaluating house officers while in training. The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment.

**Procedure**

- The program must provide objective assessments of competence in patient care and procedural skills, medical knowledge, practice-based learning and improvement, interpersonal and
communication skills, professionalism, and systems-based practice based on the specialty-specific Milestones.

- Programs must use multiple evaluators and document progressive resident performance improvement appropriate to educational level.
- Residents must be provided with documented semiannual evaluation of performance with feedback.
- A Semiannual Evaluation memo must be signed by each house officer acknowledging their evaluation. The signed memo must be turned into the Graduate Medical Education office and filed in the house officer’s file.

**Rotation Schedules**

The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and residents currently responsible for each patient’s care. As a part of house officers’ scheduling, time and effort reports are completed based on resident rotations. Contractual agreements are made between University Health and other hospitals (i.e. Willis Knighton, VA, etc.) whereby University Health will be reimbursed for the salaries of residents who rotate to their institutions for specified periods of time. The Graduate Medical Education must compile reports from each program reporting their time and effort at offsite locations by the 5th of each month. The GME office must submit the reports to the Office of Grants Accounting for proper recording and reimbursement by the 10th of each month. These reports are further coupled with the Intern and Resident Information System (IRIS) report for proper Medicare reimbursement.

**Procedure**

- Programs must enter and confirm rotation schedules in MyEvaluations by the 5th of the following month.
- The GME office runs reports gathering time and effort and then submits to Grants Accounting by the 12th of each month for reimbursement.

The GME office inputs data from reports into the IRIS program and submits to the Reimbursement Office quarterly.

**House Officer Social Media Policy (GME 13.1)**

The program director and institution must ensure a culture of professionalism that supports patient safety and personal responsibility. The use of Internet and social communication sites on the Internet can present issues in ethical behavior and professionalism. The Social Media policy is to provide House Officers with guidelines for the appropriate use of social media and to emphasize the responsibilities House Officers have in maintaining an ethical and professional behavior.

**Definitions**

Social media consists of any form of electronic communication, including but not limited to, blogs, wikis, virtual worlds, message boards, chat rooms, electronic newsletters, online forums, social networks, or other tools hosted outside of the LSU Health Sciences Center or University Health. These include such sites as Facebook, Twitter, LinkedIn, Instagram, YouTube, Flikr, Google+, MySpace and any similar site developed in the future.
Policy

- House Officers are not allowed to release, disclose, post, display, communicate or make public any of the following information:
  - Identifiable, confidential protected health information (PHI) regarding any patient associated with LSU Health Sciences Center, University Health, its affiliated hospitals and clinics, or other external affiliated health care organization. This includes, but is not limited to, any information, such as initials, personal activities, room numbers, pictures, or other information that might enable external parties to identify patients. Disclosure of PHI may constitute HIPAA violations and may have personal and/or institutional liability consequences.
  - Confidential information regarding policies and operations, including financial information, regarding LSU Health Sciences Center, University Health and its affiliated hospitals and clinics, or other external affiliated health care organization.

- House Officers should take caution not to post any information that is ambiguous or could be misinterpreted or taken out of context.

Guidelines

House Officers must adhere to the following:

- House Officers should not accept or request “friend” requests from patients or their families on any social media site.
- House Officers must not offer medical advice on any social media site.
- House Officers must not post information on any site that might be considered offensive and reflect negatively on the house officer, colleagues, patients, LSU Health Sciences Center, University Health, its affiliated hospitals and clinics, or other external affiliated health care organization.
- House Officers should routinely monitor their own Internet presence to ensure that the personal and professional information on their own sites, and to the extent possible, content posted about them by others, is accurate and appropriate.
- House Officers should always be aware of their association with participating sites (University Health, Willis Knighton, VA, Shriners, etc.) and LSU Health Sciences Center when posting any social networking site. Personal profiles and content should always be consistent with the professional manner in which house officers are expected to present themselves.
- House Officers are personally responsible for the content they post on social media properties – from blogs, to social networks, list serves, wikis, websites, forums, and other social media platforms.
- House Officers should refrain from posting any pictures, videos or other content concerning fellow House Officers, faculty, staff or other representatives of LSUHSC – Shreveport without their permission.
- House Officers should have no expectation of privacy when using the Internet at work and are reminded that any time spent posting and viewing social media sites or other Internet sites must not interfere with the performance of their duties. House Officers must not engage in any type of social media (facebooking, blogging, tweeting, etc.) while on call or performing routine duties.
- House Officers should maintain appropriate professional boundaries and should separate personal and professional content online.
- If any House Officers or LSUHSC - S employees see content posted by another House Officer that appears to be unprofessional or inappropriate, the content should be brought to the attention of the individual so that he/she can remove it and/or take other appropriate actions. If the individual does not take appropriate action, the content should be reported to the individual’s Program Director.
House Officers should be aware that because of the nature of procedures and operations specific to individual programs, each individual program may have a more restrictive Social Media policy in place.

Any comments/videos/posts made by House Officers that violate the mission and vision of LSUHSC – S or are judged as unprofessional may result in discipline, up to and including termination of the House Officer.

Violations of this policy may jeopardize the House Officer’s standing in his/her program and may result in a written warning, probation, or dismissal from the program.

Program Requests for Change (GME 14.1)

Purpose
The Graduate Medical Education Committee (GMEC) is responsible for the review and approval of institutional GME policies and procedures; applications for ACGME accreditation of new programs; requests for permanent changes in resident/fellow complement; major changes in ACGME-accredited programs’ participating sites; appointment of new program directors; progress reports requested by a Review Committee; responses to Clinical Learning Environment Review (CLER) reports; requests for exceptions to duty hour requirements; voluntary withdrawal of ACGME program accreditation; requests for appeal of an adverse action by a Review Committee; and appeal presentations to an ACGME Appeals Panel. (IR I.B.4.b).1-13).

Policy
In order for the GMEC to properly review and approve training programs’ requests for changes, the GMEC Program Requests Form must be completed, signed, and submitted to the Graduate Medical Education office along with any required documentation as indicated on the form. The form must be submitted to the GME office in order to be placed on the agenda for the GMEC meeting. The GMEC will then review the request at the meeting for approval.

Procedure
1. Programs requesting any changes indicated below will complete the Program Request for Change Form (see sub-policy below regarding details for processing the request):
   - Change in Program Director
   - Additional Outside Rotation/ Participating Site
   - Increase in Complement (Permanent or Temporary)
   - Request to hire Off Cycle
   - Voluntary Withdrawal of Accreditation
   - Review of Progress Report
2. Programs will obtain the Program Director and Department Chair’s signatures and submit the form along with all required documentation to the Executive Director of Medical Services. The Executive Director of Medical Services will meet with the Program Director to review and evaluate the request. In order for a request to be considered at the GMEC meeting, the form and required documents must be submitted by the 3rd Wednesday of the month.
3. Once the program completes the form and all required information has been received the request will be placed on the GMEC meeting agenda.
4. The GMEC will discuss and review the program’s request for approval.
5. If approved by the GMEC, the request will be sent to ACGME for approval if needed.

- **Change in Program Director**
  To request a change in program director the program must submit a current CV and have an effective date for the proposed new program director when submitting the Program.

- **Additional Outside Rotation/ Participating Site**
  1. When the need for an outside rotation arises, the program director shall contact the outside rotation supervisor to inquire if she/he is interested and willing to participate in the outside rotation. The rotations may be mandatory or elective to the training program but must show evidence of being educationally beneficial and a rotation that is not offered at LSUHSC-S. The process must be initiated by the Program Director.

  2. If both parties agree to the rotation, the LSUHSC-S program director will draft a letter outlining the educational and clinical requirements for the outside rotation and their respective supervisor's approval. The educational and clinical requirements shall include but are not limited to the following.
     a. identify the faculty who will assume both educational and supervisory responsibilities for residents;
     b. specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;
     c. specify the duration and content of the educational experience;
     d. state the policies and procedures that will govern resident education during the assignment; and
     e. identify the funding source.

  3. The program director shall first meet with the Executive Director of Medical Services to review and evaluate the need for the outside rotation and how the resident will benefit from the outside rotation.

  4. The Executive Director of Medical Services shall coordinate approval from the DIO and the Dean of the School of Medicine.

  5. The Executive Director of Medical Services shall meet with Legal Affairs to discuss the proposed rotation to ensure there are no identifiable problems that would prohibit the rotation from being approved including the responsibility of coverage of malpractice insurance. Please note contract approval will take approximately 3 months.

  6. The program director shall work with the Executive Director of Medical Services to complete a Program Request for Change to the Graduate Medical Education Committee (GMEC) for approval. The same information listed in #2, a-d shall be presented concerning the outside rotation. The Program Director shall include the educational benefit of the rotation, why the program is seeking to add the rotation, how the rotation shall be funded in addition to those items listed in #2 (and must be reviewed and approved as stated in #3 and #4 as well).
7. Upon approval by the GMEC, the program director shall submit a request for the outside rotation to the appropriate ACGME, Resident Review Committee (RRC) via the ACGME Accreditation Data System (ADS) for approval.

8. After the ACGME, RRC has approved the outside rotation the Executive Director for Medical Services shall meet with Legal Affairs to coordinate the completion of the contract shall include the five points required by the ACGME. The contract may be used in place of the PLA or the Program Director may coordinate the completion of a separate Program Letter of Agreement (PLA) with the rotating site. The Legal Affairs representative will coordinate the completion of the contract. The contract must contain:
   a. Terms and duration of the agreement
   b. Limitations
   c. Scope of Training
   d. Malpractice/Insurance
   e. Accreditation Compliance
   f. University Responsibilities/Affiliate Responsibilities
   g. Compliance
   h. Severability
   i. Financial Responsibilities
   j. Confidentiality/HIPAA
   k. Licensing obligations
   l. Conflict of Interest
   m. Indemnity

9. After the RRC approves the outside rotation, and Legal Affairs has completed the contract and obtained the appropriate approval signatures, residents may schedule and begin the approved outside rotation. The site shall be entered into WebAds as an approved participating site by the Institution and the Program.

10. If applicable, once the residents complete a shift at the outside site, their time and effort must be reported to the Graduate Medical Education office for tracking/reimbursement purposes on a monthly basis.

- Increase in Complement (Permanent or Temporary)/ Request to hire Off Cycle

1. In order for the Sponsoring Institution to ensure proper compliance when offering a resident a position off cycle or anticipating an increase in complement, Program Directors must meet with the Executive Director of Medical Services for review and approval prior to offering the position to a prospective resident. When a program wishes to request an increase in complement due to medical reasons, family reasons, VISA issues, remediation, etc., Program Directors must meet with the Executive Director of Medical Services for review and approval prior to submitting to the GMEC.

2. In the event a program wishes to offer a position to a resident outside the Match on a begin date other than July 1st, the program shall meet with the Executive Director of Medical Services to review and evaluate the need for the position(s).

3. The following issues will be discussed:
   a. Expected start date
b. What level the applicant will start at and whether or not advanced credit is being given  
c. Anticipated promotion dates if given advanced credit  
d. Whether or not an increase in complement will be requested at the time the applicant is to start or when they will be promoted  
e. Program benefit of having resident start off cycle  

4. Once approval has been obtained, the Executive Director of Medical Services shall notify the Graduate Medical Education Office staff of the program’s intention to offer a resident a position off cycle. The GME office shall notify HR and prepare a PER-1 to hire the resident once the resident accepts and completes all HR new employee paperwork.  

5. When a program is made aware for the need to request an increase in complement, the Program Director must meet with the Executive Director of Medical Services to review and evaluate the details of the increase in complement.  

6. The attached template must be completed and submitted for review by the Executive Director of Medical Services:  
   a. Type of request (Permanent or Temporary)  
   b. Brief Explanation of need for increase and duration  
   c. Source of funding for resident requiring increase  
   d. Educational rationale for change  
   e. Major changes in the program since its last review  
   f. Response to previous citations  
   g. Current block diagram  
   h. Proposed block diagram  
   i. Institutional Operative Data for the most recent academic year  

7. The Executive Director of Medical Services will coordinate approval from the DIO and Dean of the School of Medicine. Once the approval has been obtained, the Program Director shall submit the request for an increase in complement to the GMEC for final approval.  

8. The GME office will notify HR and will submit a PER-3 if extension of training is necessary.  

• **Voluntary Withdrawal of Accreditation**  
  1. The program requesting voluntary withdrawal of accreditation shall meet with the Executive Director of Medical Services to discuss the reason for voluntary withdrawal.  
  2. The program shall provide an effective date that should coincide with the end of the current academic year and, an explanation stating whether residents and/or fellows are currently enrolled, and if so, describe a plan for placement.  
  3. The above date and explanation shall be attached to the Program Request for Change Form.  

• **Review of Progress Report**  
  1. The program requesting review of a progress report shall meet with the Executive Director of Medical Services to review and evaluate the progress report.
2. After review, the program shall submit the progress report along with the Program Request for Change Form.

3. The clarifying information must be reviewed by the sponsoring institution’s Graduate Medical Education Committee, and must be signed by the Designated Institutional Official (DIO) prior to submission to the Review Committee.

Program Request Template:

<table>
<thead>
<tr>
<th>Program Requesting Change:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date presented to GMEC:</td>
<td></td>
</tr>
</tbody>
</table>

Please check type of change requested:

- Change in Program Director
  - Current Program Director: [Click here to enter text]
  - Proposed New Program Director: [Click here to enter text]
  - Effective Date: [Click here to enter text]
- Additional Outside Rotation/Participating Site
  - Effective Date: [Click here to enter text]
  - Documents required for submission:
    - Explanation of Purpose/Educational Benefit
    - Program Letter of Agreement
  - Effective Date: [Click here to enter text]
- Increase in Complement
  - Effective Date: [Click here to enter text]
  - Documents/information required for Permanent Increase:
    - Educational rationale for change
    - Major changes in the program since its last review
    - Response to previous citations
    - Current block diagram
    - Proposed block diagram
    - Institutional Operative Data for the most recent academic year
    - Source of Funding
  - Effective Date: [Click here to enter text]
  - Documents/information required for Temporary Increase:
    - Brief explanation of need for temporary increase and duration
    - Source of Funding
    - Effective Date: [Click here to enter text]

- Request for Offcycle Appointment
  - Effective Date: [Click here to enter text]
  - Explanation for need to hire offcycle

- Voluntary Withdrawal of Accreditation
  - Effective Date: [Click here to enter text]
  - Number of Residents/Fellows Currently Enrolled: [Click here to enter text]
  - If Residents/Fellows enrolled, please attach plan for placement
- Review of Progress Report
  - Progress Report/Clarifying Information Due Date: [Click here to enter text]

Program Director Signature

Department Chair Signature

*In order for your request to be considered at the GMEC meeting, this form and required documents must be submitted to the Graduate Medical Education office by the 3rd Wednesday of the month.*

This form can be found on the GME website at
http://www.lsuhschreweport.edu/GME/ResourcesforProgramsandCoordinators.aspx?rcaud=GME
Outside/Inside Rotation Policy (GME 14.1.a)

Purpose
The purpose of this policy is to establish a concise process for implementing training rotations inside/outside of the LSUHSC-S system. The rotations may be mandatory or elective to the training program but must show evidence of being educationally beneficial.

Policy
If the need arises for a rotation that cannot be obtained at LSUHSC-S, the process may be initiated by either the program or the house officer as follows. If an LSUHSC-S program is contacted by an outside program and requests the allowance of an outside trainee to rotate through an LSUHSC-S program, the process may be initiated by the program director as follows.

Procedure

LSUHSC-S Training Program/House Officer requesting outside rotation
1. When the need for an outside rotation arises, the program director shall contact the outside rotation supervisor to inquire if she/he is interested and willing to participate in the outside rotation.
2. If both parties agree to the rotation, the LSUHSC-S program director will draft a letter outlining the educational and clinical requirements for the outside rotation and their respective supervisor's approval. The educational and clinical requirements shall include but are not limited to the following.
   a. identify the faculty who will assume both educational and supervisory responsibilities for residents;
   b. specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;
   c. specify the duration and content of the educational experience; and,
   d. state the policies and procedures that will govern resident education during the assignment.
3. The program director shall first meet with the DIO to review and evaluate the need for the outside rotation and how the resident will benefit from the outside rotation.
4. The program director shall then seek approval from the Dean of the School of Medicine for hospital related issues who must both approve the rotation.
5. The program director shall meet with Legal Affairs to discuss the proposed rotation to ensure there are no identifiable problems that would prohibit the rotation from being approved including the responsibility of coverage of malpractice insurance.
6. The program director shall then submit a Program Request Change for Change to the Graduate Medical Education Committee (GMEC) for approval. The same information listed in #2, a-d shall be presented concerning the outside rotation. The Program Director shall include the educational benefit of the rotation, why the program is seeking to add the rotation, how the rotation shall be funded in addition to those items listed in # 2 (and must be reviewed and approved as stated in #3 and #4 as well).

Outside Training Program requesting rotation at LSUHSC-S
1. When an outside residency/fellowship program requests a rotation be established at LSUHSC-S for an outside trainee, the program director of both training programs must communicate and agree on the rotation and the eligibility of the outside trainee.
   a. Outside trainees based in a training program in Louisiana, must hold a current and valid Louisiana Medical license in order to rotate at LSUHSC-S.
b. Outside trainees based in a training program outside Louisiana, must obtain a LA Medical license in order to rotate at LSUHSC-S.

2. If both parties agree to the rotation, the LSUHSC-S program director will draft a letter outlining the educational and clinical requirements for the outside rotation and their respective supervisor's approval. The educational and clinical requirements shall include but are not limited to the following.
   a. identify the faculty who will assume both educational and supervisory responsibilities for residents;
   b. specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;
   c. specify the duration and content of the educational experience; and,
   d. state the policies and procedures that will govern resident education during the assignment.

3. The program director shall notify the core program director, if necessary, of the request for the outside trainee to rotate at LSUHSC-S.

4. The program director shall then meet with the DIO to review and evaluate the need for the request of the outside trainee to rotate at LSUHSC-S.

5. The program director shall meet with Legal Affairs to discuss the proposed rotation to ensure there are no identifiable problems that would prohibit the rotation from being approved including:
   a. the responsibility of coverage of malpractice insurance
   b. completion of the contract or addendum to existing contract, which will include the five points required by the ACGME. If the contract does not include the five points, the department must coordinate the completion of a separate Program Letter of Agreement (PLA). The Legal Affairs representative will coordinate the completion of the contract. The contract must contain:
      a. Terms and duration of the agreement
      b. Limitations
      c. Scope of Training
      d. Malpractice/Insurance
      e. Accreditation Compliance
      f. University Responsibilities/Affiliate Responsibilities
      g. Compliance
      h. Severability
      i. Financial Responsibilities
      j. Confidentiality/HIPAA
      k. Licensing obligations
      l. Conflict of Interest
      m. Indemnity

6. After all parties have agreed and necessary documentation is completed, residents may schedule and begin the approved rotation at LSUHSC-S.

**Vendor Relations/Interactions Policy (GME 15.1)**

LSUHSC, as the Sponsoring Institution, maintains a policy that addresses interactions between vendor representatives/corporations and residents/fellows and ACGME-accredited programs.

Relations to vendors and other private entities are covered by the LSUHSC Administrative Directive Code of Ethics for Louisiana State Employees (AD 2.8.6) and the University Health Vendor Policy (7.B.1). Residents are required to abide by the rules and policies of any participating sites while in training.
House Officer Food & Nutrition Services Meal Plan Policy (GME 16.1)

Policy
The LSUHSC Meal Card for House Staff participating in the Meal Program is valid throughout one’s Residency/Fellowship training at LSUHSC. One of three food plan options may be selected; the plan will be in effect for one contract year. Plans cannot be changed until the time of contract renewal. Deductions will be taken from the House Officer’s check each pay period and the corresponding amount credited to the meal plan per month. House Officers may also choose to opt out and not receive the discounted meal plan. All House Officers must submit a Meal Plan Form.

<table>
<thead>
<tr>
<th>Meal Plan Options</th>
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<tbody>
<tr>
<td>$125 per month meal plan</td>
<td>$9.25 per pay period</td>
</tr>
<tr>
<td>$200 per month meal plan</td>
<td>$18.50 per pay period</td>
</tr>
<tr>
<td>$250 per month meal plan</td>
<td>$23.00 per pay period</td>
</tr>
</tbody>
</table>

It is the responsibility of the cardholder to take care of his/her ID Badge/Meal Card. In the event the meal card is not presented at the point of sale, the resident or fellow will be required to pay for the meal in cash/personal credit card.

Procedure
- House Officers will enroll in selected meal plan at start of training by completing and submitting the Graduate Medical Education Meal Plan Form. House Officers may also choose to opt out of a meal plan but must still submit the form choosing to opt out.
- Nutritional Services will load House Officers’ ID Badge with selected monthly amount. Amounts are for one month only and start over at the beginning of each month. If the full amount allotted for the month is not used the remaining amount does not roll over.
- Payroll Services will enroll House Officers in selected monthly plan and automatically deduct appropriate amount each pay period (Biweekly).
- House Officers must present their LSUHSC ID Badge at the point of sale at any of the on campus nutritional services sites (Cafeteria, Atrium Deli, and ACC Deli).
- Meal cards are not transferable, i.e., they are personal forms of identification. Cards cannot be loaned to, shared with, or used by any other person but its owner. Any attempt to use another person’s card will be reported to the Medical Education Office. MEAL CARDS MUST BE PRESENTED AT THE POINT OF SALE (CASH REGISTER) TO BE VALID. YOU CANNOT JUST GIVE THE CASHIER YOUR MEAL CARD NUMBER.
- Food purchased with the Meal Card is for Residents and Fellows only -- not for other employees, visitors, family or unauthorized persons. Any abuse of the meal card will be reported and may result in termination of meal privileges.
- Any House Officers rotating to University Health Monroe will be enrolled in the same meal plan amount chosen in Shreveport. Meal allowance is for one month total regardless of the facility meal is being purchased.
- House Officers arriving later than July 1st will need to bring a copy of their completed plan selection signed by a representative in the Medical Education Office to the Cafeteria with their ID badge to have their card activated.
- Meal Plan renewals will be sent out by the GME office prior to the beginning of the new academic year. House Officers must submit a meal plan renewal form into GME Office by assigned due date to enroll in a meal plan for the following academic year.
- House Officers that fail to submit a Meal Plan Form will default to the Opt out Plan and will not be enrolled in any Meal Plan coverage.
House Officer Wellness Policy (GME 17.1)

Policy
A priority of the LSUHSC – Shreveport Graduate Medical Education Committee is to support the well-being of residents/fellows in training. The GMEC is committed to bringing awareness and providing resources and treatment for house officers experiencing physician impairment, burnout, depression, stress, and other problems. Promoting the well-being of house officers is vital to their ability to provide safe and effective care to patients.

Procedure

- The well-being of physicians as caregivers is crucial to their ability to deliver the safest, best possible care to patients.
- All programs should promote awareness and provide education for house officers needing to seek health care. Faculty and staff involved in house officer training should promote a culture of respect and accountability for house officer well-being.
- House Officers receive education and training on physician well-being during the new house staff orientation and through department specific training.
- The following activities and resources are available to all house officers:
  - Mindfulness/Resilience Training (every other month)
  - Electronic Message Board (Daily Matters of the Heart)
  - Fatigue/Stress training (SAFER Module)
  - Referral(s) for needed care
  - Resident Council Socials
  - Resident Council Meetings
  - Comprehensive Public Training Program (CPTP) Classes
  - Follow up/Counseling services for adverse events
- The GMEC shall work together with programs and other campus groups/committees to facilitate prevention, intervention and treatment in alcohol-related, drug-related, stress-related, or behavioral problems of residents/fellows in training.
- The GMEC shall support the Medical School’s “Wellness” Committee, “The Heart of the Matter”
- House Officers wishing to seek counseling or Program Directors requesting referrals for house officers may contact the Designated Institutional Official or Psychiatry department to schedule an appointment.
Evaluations (GME 18.1)

PERFORMANCE RATING REPORTS

Performance Rating Reports are used to evaluate at the end of each service rotation, or in the case of categorical residents and residents 2 through 6, at six-month intervals. The Graduate Medical Education department requires all programs to submit a Semi-Annual House Officer Evaluation Memo form for each house officer acknowledging they have been evaluated and the type of evaluation they received. These memos are kept in the house officers’ files.

The program director must develop and implement program-specific policies and procedures for evaluating Resident performance, the performance of faculty, and the educational effectiveness of the program. Such policies and procedures must include methods for utilizing the results of evaluations to improve Resident performance, the effectiveness of the teaching faculty, and the quality of education provided by the program.

1. Resident Evaluation

   Each Resident’s performance must be evaluated through the training program. The program director must appoint the Clinical Competency Committee. The Clinical Competency Committee should review all resident evaluations semi-annually; prepare and assure the reporting of Milestones evaluations of each resident semi-annually to ACGME; and advise the program director regarding resident progress, including promotion, remediation, and dismissal. The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment. The results of evaluations communicated to each Resident and the results of evaluations are used to improve Resident performance. Each program must:

   • Provide objective assessments of competence in patient care and procedural skills, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice based on the specialty-specific Milestones.

   • Each program must establish procedures for providing regular and timely feedback to Residents regarding their performance. The following policies apply to all programs and Residents.

      o Supervising faculty should complete an evaluation of each Resident’s performance at the completion of each rotation.

      o The program director must maintain a record of each Resident’s evaluations, and the results of evaluations must be made available to each Resident.

      (a) The Resident should review and be given the opportunity to sign his/her evaluation.

      (b) Residents should be granted access to their files for review of evaluations in the presence of the program director, or his designee.

      o The program director must prepare a written semiannual evaluation of each Resident’s performance and communicate this evaluation to the Resident in a timely manner.

      o The program director, or his designee, must meet with each Resident at least twice per year to review evaluations and discuss the Resident’s performance and progress in the program.

      o The program director, in conjunction with the faculty and Residents, must develop a process for use of assessment of results to achieve progressive improvement in the Residents’ competence and performance.

      o The program director must prepare a summative, written evaluation for each Resident completing the program. This evaluation includes a review of the Resident’s performance during the final period of training and verification that the Resident has demonstrated sufficient competence to enter practice without direct supervision.
o The program director must maintain the summative evaluation in each Resident’s permanent record.
o The program director must forward a copy of the summative evaluation for each Resident to the Graduate Medical Education Department for the Resident’s permanent institutional record.

2. Faculty Evaluation
The program director must ensure that evaluation of the teaching faculty is performed in accordance with the ACGME Common Program Requirements and specialty-specific program requirements. The performance of the teaching faculty must be evaluated by the program no less frequently than at the midpoint of the accreditation cycle and again prior to the next site visit. The evaluations should include a review of teaching abilities, commitment to the educational program, clinical knowledge, and scholarly activities. Annual written confidential evaluations by Residents must be included in the process.

3. Program Evaluation
The educational effectiveness of a program must be evaluated at least annually in a systematic manner.
• Education Committee: Program personnel must be organized to review program goals and objectives and the effectiveness of the program in achieving them. The committee must include at a minimum the program director, representative faculty, and one Resident. The group must have regular documented meetings at least annually for this purpose. In the evaluation process, the group must take into consideration written comments from the faculty and the Residents’ confidential written evaluations. If deficiencies are found, the group should prepare an explicit plan of action, which should be approved by the faculty and documented in the minutes.
• Outcome Assessment: The program should use Resident performance and outcome assessment in its evaluation of the educational effectiveness of the residency program. The program should have in place a process for using Resident and performance assessment results together with other program evaluation results to improve the residency program.
• Performance of Graduates: The performance of program graduates on the board certification examination should be used as one measure of evaluating program effectiveness. Consideration should be given to whether performance is improving or decreasing.

Completion of Training (GME 19.1)
The program director, or designated program personnel, is responsible for completing any appropriate personnel form for each Resident completing a program and leaving the employment of LSU Health Sciences Center or being appointed to another position, such as a faculty or fellowship position. A forwarding address must be provided for the Resident, and the appropriate personnel form routed to the Graduate Medical Education Department.

The program director shall complete and submit to the Graduate Medical Education Department a final, written summative evaluation for each Resident completing the program, which will be maintained in the institution’s permanent records.

Each Resident is required to complete the Graduate Medical Education clearance form by their last day of work. The Resident must have all appropriate departments complete the form and return it to the Graduate Medical Education Office before a certificate or final check will be released. Once all Resident responsibilities are completed, a certificate of training will be issued to each Resident completing a
program leading to certification by the American Board of Medical Specialties. It is the responsibility of the program director to certify a Resident as having satisfied the training requirements of a program and as being eligible to sit for the certifying examination of the specialty.

Any requests for duplicate certificates of training will incur a cost of $25 per certificate.

**Clearance/Checkout Process for House Officers (GME 19.1a)**

**Policy**
To ensure House Officers are not indebted to LSUHSC-Shreveport upon leaving, completion and submission of a House Officer Clearance Form is required. Upon completion of training, resignation, or termination of training, all House Officers are required to complete the Graduate Medical Education issued Clearance Form. This includes returning all ID Badges, keys, and other equipment issued while in training to appropriate departments on campus and any participating sites. House Officers staying as faculty are required to complete an abbreviated version of the clearance form.

**Procedure**
- House Officer obtains appropriate House Staff Clearance form from Program Coordinator or GME office.
- House Officers are responsible for visiting each department listed to verify no outstanding items are required of them prior to their leaving LSUHSC-Shreveport. A signature from each department is required as verification nothing is owed by House Officer.
- The Graduate Medical Education office is the last department to visit after all signatures have been acquired and where ID Badges will be turned in.
- Forwarding information should be filled in on the form and supplied to the GME office.
- Failure of House officers to complete and meet required responsibilities regarding the checkout process could result in the holding of completion certificates or final pay check until requirements are met.

The Graduate Medical Education will supply copies of individual clearance forms to programs to file in the program House Officer Record.
When selecting a Resident/Fellow, programs should consider the requirements as established for licensure/permit outlined by the LSBME. It is the responsibility of all House Officers to obtain an unrestricted Louisiana license to practice medicine as soon as they meet the minimum postgraduate training requirements stipulated by the LSBME.

When a Resident/Fellow needs special consideration for licensure from the LSBME, the Program Director should follow the process below to contact the LSBME:

1. Program Directors will prepare a letter to the Executive Director for Medical Services/DIO outlining the need for special consideration for licensure signed by the Department Head.
2. After the Executive Director for Medical Services/DIO has reviewed the request, the letter will be sent to the Chancellor to be placed on letterhead, signed by the Chancellor, and will be addressed to the Executive Director of the LSBME.
3. No direct contact shall be made from individual departments to the LSBME regarding special requests for licensure.
Frequently Referenced LSUHSC – S Administrative Directives

Complete list of Administrative Directives can be found at
http://www.medcom.lsuhscshreveport.edu/cfdocs/policies/Admin_Directives.cfm

LOUISIANA STATE UNIVERSITY
HEALTH SCIENCES CENTER - Shreveport

ADMINISTRATIVE DIRECTIVE

Policy Number: 2.8.6
Effective Date: 1950
Revised Statute

2.8.6 CODE OF ETHICS FOR LOUISIANA STATE EMPLOYEES

A. Requirement
All State employees are subject to Louisiana Revised Statute 1950, Title 42, Chapter 15, “Code of Governmental Ethics.”

B. Preclusions and Authorizations
The Code prohibits public employees from soliciting or accepting, directly or indirectly, anything of economic value as a gift or gratuity, from any person or firm who has or is seeking to obtain contractual or other business or financial relationship with the public employee’s agency. “Things of Economic Value” means money or other thing having economic value, except promotional items having no substantial resale value. Food, drink, or refreshments consumed by a public employee, including reasonable transportation and entertainment incidental thereto, while the personal guest of some person, is not considered a thing of economic value, and may be accepted by public employees. Reasonable discretion and judgement should govern the employee’s action in such matters.

On occasion, off site training of Medical Center employees is necessary and vendors agree to provide such off site training including tuition, room and board and transportation at their expense or at their partial expense. Such offerings must be made to the Institution and accepted or rejected by the Institution rather than individual employees. As such, Medical Center Administration must be informed of all such offers and shall make all final decisions as to acceptance of such offers. Employees attending off site training courses at the expense of others remain on official State business and must follow all State and Medical Center travel regulations, including the prior approval process.

C. Objective
The primary objective of the “Code of Governmental Ethics” is to protect the integrity of state government. Strict adherence to the provisions of the “Code” will insure that the public’s confidence in the integrity of the LSU Medical Center operations will be maintained.

D. Questions
If any employee has a question concerning the legality of an offer or invitation from a vendor, he or she should contact as appropriate one of the following:
The Hospital Administrator
The Assistant Vice Chancellor for Business and Reimbursements.
6.5 LSUHSC Customer Relations Policy

A. PURPOSE
   This policy provides guidelines for the attitudes and actions of all levels of employees empowered to foster favorable relations between employees and patients, patients’ families, visitors, fellow employees, and the medical staff.

B. PHILOSOPHY
   1. Louisiana State University Health Sciences Center is a center of excellence. Every employee is both challenged and empowered to do his or her job in such a way that patient care, medical education, and research consistently and completely meet the standards outlined in the Pledge to Service and the Service Behavior Expectations. (See attached).

   2. Every Louisiana State University Health Sciences Center employee, given maximum opportunity to grow as a person, a professional, and a member of our community, is committed to the Pledge To Service and Service Behavior Expectations.

C. POLICY
   It is the policy of Louisiana State University Health Sciences Center in Shreveport to encourage and expect each person connected with the Health Sciences Center to at all times:
   1. Be aware of and concerned about how his or her attitude and actions affect the customer and fellow coworkers.
   2. Demonstrate appropriate behavior as described in the policy and as contained in the Pledge To Service and Service Behavior Expectations.

D. DEFINITIONS
   1. Appropriate behavior: an attitude or action in interacting with others (patients, patients’ families, visitors, fellow employees, and the medical staff) that include:
      a. Observance of the Pledge to Service and Service Behavior Expectations.
      b. Courtesy and politeness.
      c. Friendliness.
      d. Concern for the customer’s well being.
      e. Sensitivity and prompt responsiveness to the customer’s wants and needs.
      f. Cooperation with and helpfulness to the patient, members of the patients’ family, visitors, and co-workers.
      g. Pride in self, job/profession, and the Health Sciences Center.
2. Favorable customer perceptions: A customer’s favorable perceptions reflects the following:
   a. He or she is treated as a welcomed guest of our Health Sciences Center.
   b. The needs or wants of the customers are provided for with sensitivity and promptness.
   c. All staff of the Health Sciences Center are courteous, concerned, and professionally competent.
   d. Respect and cooperation exist between employees to ensure optimum care and support service and services.
   e. The environment is clean, quiet, comfortable, secure, and properly equipped.

A. RESPONSIBILITIES

1. It is the responsibility of each employee/supervisor to:
   a. Ensure that his or her attitude and actions are at all times consistent with the Pledge To Service and Service Behavior Expectations as described within this policy.
   b. Compliment a co-worker when his or her actions comply with this policy.
   c. Remind a co-worker when his or her attitude or actions are inconsistent with these standards.
   d. Call instances of excellence or noncompliance to the attention of the appropriate supervisor or department head.

2. It is the responsibility of each department head and supervisor to:
   a. Ensure that each employee under his or her jurisdiction upholds the Pledge To Service and Service Behavior Expectations.
   b. Investigate reports of and document instances of violation of the Pledge To Service and Service Behavior Expectations and take appropriate corrective actions, especially when behavior is shown to repeatedly and willfully disregard the Pledge To Service and Service Behavior Expectations. Such appropriate action may include verbal or written counseling and guidance. If disciplinary action of is warranted, it will be taken pursuant to and in conformity with applicable rules and regulations.
   c. Command an employee under his or her jurisdiction who upholds the Pledge To Service and Service Behavior Expectations.
   d. Evaluate an employee’s compliance with the Pledge To Service and Service Behavior Expectations as part of conducting regularly scheduled performance appraisals and at other times as may be needed for the effective operation of the work unit.
   e. Bring to the attention of the appropriate supervisor or department head instances of behavior contrary to or consistently in excess of these standards by an employee under the jurisdiction of another supervisor or department head.
Louisiana State University
Health Sciences Center – Shreveport

Team Member Pledge To Service

I ____________________________, employee of Louisiana State University Health Sciences Center, do hereby pledge that I will demonstrate compassion and respect for the dignity of individual persons, both in serving our patients and their families and in relating to fellow employees. I will be considerate and lend assistance to all people entering the institution. I understand that I am to conduct myself in a manner that will protect the interests and safety of patients, employees and the institution.

I do hereby acknowledge that any actions or conduct exhibited by an employee that brings discredit, and/or is offensive to patients or coworkers will not be tolerated. I pledge that I will not tolerate offensive behavior from other employees and will report such behavior to the appropriate supervisor. I understand that such behavior may result in disciplinary action that could result in termination of employment. I acknowledge and understand that it is my responsibility to provide a service and that I will conduct myself in a manner that will represent LSUHSC in a positive light. I understand that I am an ambassador for this institution.

I certify that I have received the LSUHSC Pledge to Service and the LSU Service Behavior Expectations. I certify that I understand that they represent mandatory policies of the organization and agree to abide by them.

Employee’s Signature: ____________________________ Date: ____________________________

Manager’s Signature: ____________________________ Date: ____________________________
2. Team Leader Pledge to Service

Louisiana State University
Health Sciences Center – Shreveport

Team Leader Pledge To Service

I ____________________________, a member of the management team of Louisiana State University Health Sciences Center, do hereby pledge that I will demonstrate compassion and respect for the dignity of individual persons, both in serving our patients and their families and in relating to fellow employees. I will be considerate and lend assistance to all people entering the institution. I understand that I am to conduct myself in a manner that will protect the interests and safety of patients, employees and the institution. I will conduct myself in a manner that serves as a role model for my employees in providing excellence in customer service.

I do hereby acknowledge that any actions or conduct exhibited by an employee or manager that brings discredit, and/or is offensive to patients or coworkers will not be tolerated. I pledge that I will not tolerate offensive behavior from other managers and employees and will report such behavior to the appropriate supervisor. I will immediately address inappropriate behavior. I understand that such behavior may result in disciplinary action that could result in termination of employment. I acknowledge and understand that it is my responsibility to provide a service and that I will conduct myself in a manner that will represent LSUSC in a positive light. I understand that I am an ambassador for this institution.

I certify that I have received the LSUSC Pledge to Service and the LSU Service Behavior Expectations. I certify that I understand that they represent mandatory policies of the organization and agree to abide by them.

____________________________  _______________________
Management Team Signature        Date

____________________________  _______________________
Director/Administrator's Signature  Date
2.1.4 VIOLENCE IN THE WORKPLACE

A. Policy

Employees are the State’s most valuable resource and their safety and security are essential to carrying out their responsibilities. Every employee has a reasonable expectation to perform his/her assigned duties in an atmosphere free of threats and assaults. Recognizing the increasing incidence of violence in the workplace, the Governor of the State of Louisiana issued an executive order that workplace for state employees should be free of violence. Louisiana State University Medical Center-Shreveport fully is committed to a violence free workplace.

B. Purpose

The purposes of this plan are to:

• Direct implementation of effective security measures and administrative work practices to minimize exposure to conditions that could result in harm to state workers;
• Promote a positive, respectful and safe work environment that fosters employees’ security, safety and health;
• Require ongoing analysis of the workforce and each work site for hazard prevention and control.

C. Definitions

1. Assault is an attempt to commit a battery, or the intentional placing of another in reasonable apprehension of receiving a battery. (Example: I may have a stick raised and know that I have no intention of striking you, but, based on the circumstances, you have a reasonable apprehension that I plan to strike you.)

2. Battery is the intentional use of force or violence upon another, or the intentional administration of a poison or other noxious liquid or substance to another.

3. A credible threat is a statement or action that would cause a reasonable person to fear for the safety of him/herself or that of another person and does, in fact, cause such fear.

4. Intentional refers to conduct when the circumstances indicate that the offender, in the ordinary course of human experience, must have considered the criminal consequences as reasonably certain to result from his act or failure to act.

5. Violence is the commission of an assault or battery or the making of a credible threat.

6. The workplace is any site where an employee is placed for the purpose of completing job assignments.

7. Workplace violence is violence that takes place in the workplace.
D. Responsibilities

1. Managers

Louisiana State University Medical Center Shreveport shall comply with federal and state statutes, rules, regulations and/or guidelines in making reasonable efforts to:

a. hire, train, supervise and discipline employees;
b. intervene in situations of harassment in the workplace where the employer is aware of the harassment;
c. ensure employees and/or independent contractors are fit for duty, and do not pose unnecessary risks to others;
d. provide security precautions and other measures to minimize the risk of foreseeable criminal intrusion based upon prior experience or location in a dangerous area;
e. maintain an adequate level of security;
f. establish and implement a written policy and plan dealing with violence in the workplace;
g. provide employee training on the agency plan, warning signs of potential for violent behavior and precautions which may enhance the personal safety of the employee at work;
h. warn an employee of a credible threat made by another to harm that employee;
i. support the application of sanctions and/or prosecution of offenders, as appropriate;
j. accommodate, after appropriate evaluation, employees who require special assistance following incident(s) of workplace violence;
k. cooperate with law enforcement agencies;
l. establish a uniform violence reporting system with regular review of submitted reports;
m. initiate procedures to protect from retaliation employees who report credible threats;
n. keep up-to-date records to evaluate the effectiveness of administrative and work practice changes initiated to prevent workplace violence.

2. Management Commitment

Louisiana State University Medical Center Shreveport's management is committed, including the endorsement and visible involvement of top levels of supervision, to provide the motivation and resources to deal effectively with workplace violence, and includes:

a. organizational concern for employee emotional and physical safety and health;
b. commitment to the safety and security of all persons at the workplace;
c. assigned responsibility for the various aspects of the workplace violence prevention program to ensure that all supervisors and employees understand their roles and responsibilities;
d. allocation of authority and resources to all responsible parties;
e. accountability for involved supervisors and employees;
f. debriefing/counseling for employees experiencing or witnessing assaults and other violent incidents;
g. support and implementation of appropriate recommendations from violence prevention committees;
h. treat workplace violence, incidents, complaints and concerns with seriousness, keeping confidential all reports and the identification of parties, except to those who have a legitimate need to know and to the extent required by law.
3. Employee
   a. Employees are required to report to the immediate supervisor and/or department head all threats or incidents of violent behavior in the workplace which they observe or of which they are informed. Examples of inappropriate behavior which shall be reported include:
      • unwelcome name-calling, obscene language, and other abusive behavior;
      • intimidation through direct or veiled verbal threats;
      • physically touching another employee in an intimidating, malicious, or sexually harassing manner, including such acts as hitting, slapping, poking, kicking, pinching, grabbing, and pushing;
      • physically intimidating others including such acts as obscene gestures, "getting in your face," fist-shaking, throwing any object.
   b. Employee involvement and feedback enable workers to develop and express their own commitment to safety and security and provide useful information to design, implement, and evaluate the program. At Louisiana State University Medical Center-Shreveport employee involvement includes, but is not limited to:
      • understanding and complying with the workplace violence prevention program and other safety and security measures;
      • participating in employee complaint or suggestion procedures covering safety and security concerns;
      • providing prompt and accurate reporting of violent incidents;
      • cooperating with the safety and security committee that reviews violent incidents and security problems and makes security inspections; and
      • participating in continuing education covering techniques to recognize and abate escalating agitation, assaultive behavior or criminal intent.

E. Workplace Analysis
   The process of workplace analysis involves a step-by-step, common-sense look at the workplace to find existing or potential hazards for the occurrence of workplace violence. The workplace analysis entails reviewing specific procedures or operations that contribute to hazards and specific locales where hazards may develop. The workplace analysis program includes, but is not limited to: analyzing and tracking records; monitoring trends; analyzing incidents; analyzing workplace security.

   At Louisiana State University Medical Center-Shreveport the responsibility for conducting and maintaining workplace analysis is assigned to the University Police Department.

   Workplace analysis for Louisiana State University Medical Center-Shreveport shall be performed by the University Police Department and reviewed by the Workplace Violence Prevention Committee within 90 days of the publication of this policy.

F. Hazard Prevention and Control
   After the completed workplace analysis is reviewed and approved, workplace adaptations, engineering controls, administrative controls, and work practice controls shall be implemented by Louisiana State University Medical Center-Shreveport to prevent or control, to the extent possible, any discovered hazards. If workplace violence does occur, the post-incident response and evaluation section of this policy (Section G) shall be implemented.

   Engineering controls and workplace adaptations remove the hazard from the workplace or create a barrier between the worker and the hazard.

   Administrative and work practice controls affect the way jobs or tasks are performed and, therefore, affect the security of the workplace.

   At Louisiana State University Medical Center-Shreveport the responsibility for hazard prevention and control is assigned to Workplace Violence Prevention Committee.
G. Incident Response and Evaluation

Assistance for victimized employees and employees who may be affected by witnessing a workplace violence incident will be provided. Whenever an incident takes place, injured employees will receive appropriate medical treatment and psychological evaluation as necessary, in accordance with existing statutes. At Louisiana State University Medical Center-Shreveport this assistance is provided through the Employee Assistance Program.

An employee who has been threatened or assaulted by another at the workplace will immediately report the situation to his/her supervisor. The supervisor to whom the incident is reported will immediately notify the University Police Department, appropriate Administrative Staff and Human Resource Management to discuss further action.

Written statements shall be obtained from all involved, including those who witnessed the incident. Concurrent with obtaining the written statements or as soon as possible thereafter, the University Police Department shall interview all parties to the incident, including victims, subjects and witnesses, and prepare written summaries of the interviews. The summaries shall be the basis on which to determine the facts of the event.

The following actions should be taken in accordance with the severity of the incident:

1. The situation is not dangerous:
   • separate employees involved and isolate until they are interviewed and their statements are taken;
   • separate witnesses until they are interviewed and their statements are taken;
   • document all actions and statements.

2. The situation is dangerous:
   • contact the University Police Department at 6165;
   • do not attempt to physically remove an individual (leave it to the University Police Department);
   • document all actions and statements.

H. Records

Records associated with violence in the workplace need to be kept in a permanent, secure, and confidential manner. It shall be the responsibility of the University Police Department to help evaluate security, methods of hazard control, and identify training needs. The following records are important and shall be maintained in accordance with pertinent statutes as part of the violence prevention program:
- a. reports of work injury, including workers’ compensation injuries, if necessary;
- b. reports for each reported assault, incidents of abuse, verbal attack, or aggressive behavior occurring between persons in the workplace;
- c. police reports of incidents occurring in the workplace;
- d. minutes of safety meetings, records of hazards’ analysis, and corrective actions recommended;
- e. violence in the workplace training, including subjects covered, attendees, and qualifications of trainers;
- f. other appropriate reports.
I. Evaluation

Regular evaluation of safety and security measures affecting the violence prevention program shall be conducted at least annually. At the Louisiana State University Health Sciences Center-Shreveport this evaluation shall be the responsibility of the University Police Department.

The evaluation program consists of, but is not limited to:

- reviewing reports and minutes from staff meetings on safety and security issues;
- analyzing trends in illness/injury or fatalities caused by violence;
- measuring improvement based on lowering the frequency and severity of workplace violence;
- surveying employees before and after making job or workplace changes such as, installing security measures or new systems to determine their effectiveness;
- requesting periodic outside review of the workplace for recommendations on improving employee safety.

J. Communication

At Louisiana State University Health Sciences Center-Shreveport we recognize that to maintain a safe, healthy and secure workplace, we must have open communication among employees, including all levels of supervision, on these issues. The open communication process includes but is not limited to:

- periodic review of this policy with all employees;
- discussions of violence in the workplace during scheduled safety meetings;
- posting or distributing information on violence in the workplace; and
- procedures to inform supervisors about violence in the workplace, hazards, or threats of violence.

The supervisor shall provide an appropriate place for employees to discuss security concerns with assurance that necessary confidences will be maintained.

K. Training and Education

1. At Louisiana State University Health Sciences Center-Shreveport, all employees, including all levels of supervision, shall have training and instruction on general, job-specific, and work site-specific safety and security practices;
   - training and instruction shall be provided within one year of policy implementation and regularly thereafter.
   - training shall begin with orientation of new employees within three months of employment and regularly thereafter.

2. At Louisiana State University Medical Center-Shreveport, workplace violence training shall be the responsibility of the Workplace Violence Protection Committee.
3. General violence in the workplace training and instruction address, but are not limited to, the following areas:

- explanation of the violence in the workplace policy as established by Louisiana State University Health Sciences Center-Shreveport;
- measures for reporting any violent acts or threats of violence;
- recognition of hazards including associated risk factors;
- measures to prevent workplace violence, including procedures for reporting workplace hazards or threats to appropriate supervision;
- ways to defuse hostile or threatening situations;
- measures to summon others for assistance;
- routes of escapes available to employees;
- procedures for notification of law enforcement authorities when a criminal act may have occurred;
- procedures for obtaining emergency medical care in the event of a violent act upon an employee;
- information on securing post-event trauma counseling for those employees desiring or needing such assistance.
2.1.1 SEXUAL HARASSMENT

A. Policy

LSU Health Sciences Center - Shreveport is committed to providing a professional work environment that maintains equality, dignity and respect for all members of its community. In keeping with this commitment, the Health Sciences Center prohibits discriminatory practices, including sexual harassment. Any sexual harassment, whether verbal, physical or environmental, is unacceptable and will not be tolerated. The purpose of this policy is to define sexual harassment and to establish a procedure whereby alleged sexually harassed employees, staff and students may lodge a complaint immediately.

B. Definition

Sexual harassment is illegal under federal (section 703 of Title VII of the Civil Rights Act of 1964), state and local law. It is defined as any unwelcome sexual advance, request for sexual favors or other verbal or physical conduct of a sexual nature when:

1. Submission to the conduct is made either explicitly or implicitly a term or condition of an individual's employment;
2. Submission to or rejection of such conduct by an individual is used as basis for an employment decision affecting the individual; or
3. The conduct has the purpose or effect of unreasonable interfering with the individual's performance or of creating an intimidating, hostile or offensive working environment.

Types of behavior that constitute sexual harassment may include, but are not limited to:

- unwelcome sexual flirtations, advances or propositions;
- derogatory, vulgar or graphic written or oral statements regarding one's sexuality, gender or sexual experience;
- unnecessary touching, patting, pinching or attention to an individual's body;
- physical assault;
- unwanted sexual compliments, innuendo, suggestions or jokes; or the display of sexually suggestive pictures or objects

C. Procedures

Any member of the Health Sciences Center Community who has a sexual harassment complaint against a supervisor, co-worker, visitor, faculty member, student or other person, has the right and obligation to bring the problem to Health Sciences Center's attention. Any supervisor who witnesses such
conduct or receives a complaint must report the incident to Human Resource Management, an appropriate administrator or the Dean of the respective school. It is the responsibility of all LSU Health Sciences Center employees in a supervisory capacity to ensure that the work/academic environment is free from sexual harassment.

A staff member who believes he or she has been sexually harassed should immediately report the incident to the Assistant Director of Employee Relations, Human Resource Management (318-675-5611) or to the Director of Human Resource Management (318-675-5610) or to an appropriate administrator or the Dean of the respective school. In addition, staff members may report the incident to any supervisor. Any recipient of such a complaint shall notify Human Resource Management.

The Department of Human Resource Management will be responsible for investigating complaints of sexual harassment occurring between staff members; complaints made by staff against students; and complaints made by staff against other third parties. Human Resource Management will either investigate or assist those responsible for investigating complaints made by or against faculty members, students or House Staff Officers.

Actions taken to investigate and resolve sexual harassment complaints shall be conducted confidentially to the extent practicable and appropriate in order to protect the privacy of persons involved. An investigation may include interviews with the parties involved, and if necessary, with individuals who may have observed the incident or conduct or who have other relevant knowledge. The individuals involved in the complaint will be notified of the results of the investigation.

The Health Sciences Center will not tolerate discrimination or retaliation against any individual who makes a good-faith sexual harassment complaint, even if the investigation produces insufficient evidence to support the complaint, or any other individual who participates in the investigation of a sexual harassment complaint. If the investigation substantiates the complaint, appropriate corrective measures and/or disciplinary action, up to and including termination, will be taken swiftly.

LSU Health Sciences Center – Shreveport will make every reasonable effort to ensure that all members of the Health Sciences Center community are familiar with this policy. You are encouraged to address questions or concerns regarding this policy with the Assistant Director for Employee Relations, Human Resource Management.
ADMINISTRATIVE DIRECTIVE

2.1.3 HARRASSMENT

A. Definition

Harassment is conduct that creates a hostile or threatening work environment. It can include age, sex, race, color, religion, marital status, veteran status, national origin, or mental or physical handicap. It has the effect of offending employees and hindering their work performance. No one should be expected to tolerate harassment in the workplace.

Harassment can occur as a single act or as action over a period of time. Harassment is a broad range of physical or verbal behavior. Some examples follow:

- Physical or mental abuse
- Insults about age or race
- Ethnic jokes
- Religious slurs
- Taunting that provokes an employee
- Ostracizing or excluding an employee
- Imposing special work burdens

One specific kind of harassment is sexual harassment (see Administrative Directive 2.1.1). Rudeness or impolite behavior directed against any staff member or employee, although not acceptable, is not covered in this policy.

B. Policy

LSUHSC-S strictly prohibits any form of harassment.

Employees should make every effort to resolve any issues of harassment when they occur. A neutral party will assist. Management shall attempt to resolve such issues. If any issue cannot be resolved, these procedures will be followed:

C. Procedures

1. Complaints may be made by a witness or a victim of harassment by an employee.
   First, the complaint may be made verbally. A written statement
should follow as soon as possible. Information should be submitted as soon as possible. Information should contain:

• Date and time of incident

• Location of act

• Name of alleged who began the harassment

• A factual, unbiased description of the conduct

• Names of witnesses to the incident

• What results are being sought

2. Complaints alleging harassment shall be submitted by the victim or his/her supervisor to the Manager of Employee Relations in Human Resource Management.

3. (a) The Manager of Employee Relations shall conduct a confidential investigation. Information and recommendations on the incident will be given to the proper management of the person charged with harassment.

(b) If the individual is on faculty, medical staff or a house officer, the information and recommendations shall be given to a review committee. The Committee shall be the Chair of the Department, the Chancellor/Dean of the Medical School and a Hospital Administrator or their designee.

4. If it is found that harassment did occur, action ranging from a letter of reprimand to termination of employment will be applied.
1.1.6 TAKING STATE PROPERTY OFF CAMPUS

A. Purpose

The following policy establishes procedures that will enable the tracking of equipment off campus, prevent losses to departments, and reduce missing equipment reported to the State. Through the remainder of this policy, property is referring to LSUHSC–Shreveport or State owned property. The campus is defined as the facilities owned or leased by LSUHSC-S.

This policy is not intended to circumvent any State Law or policy nor is it intended to be interpreted to replace any existing contract or purchasing policy or procedures. The established procedures and policies for removing property for repairs remain in effect.

All property (including property not tagged with an LSU inventory number) taken off campus must comply with these procedures. If the individual requesting to take property off campus is not willing to comply with the provisions of this policy, the property cannot be taken off campus. The unauthorized removal of property from LSUHSC-S facilities is considered theft of State property; therefore, it is important that these procedures are followed.

Pagers are exempt from this policy and the current pager policy remains in effect.

B. Individuals Taking Property Off Campus

Department Heads may authorize individual LSUHSC-Shreveport employees to take property off campus for the purpose of conducting LSUHSC-S business. This includes an individual’s residence. However, before property is taken off campus, it must be approved by the Property Manager.

Taking property off campus requires a Notice of Change in Movable Equipment (CME) form or a memo signed by the individual and the Department Head authorizing the item’s removal. This authority shall not be delegated. The signed CME or Memo shall be sent to the Property Manager for approval. The property can be taken off campus once the Property Manager approves the CME. (Note: It is felt that the Department Head must be aware of any property off campus. The Department Head is fiscally responsible for the property; therefore, must be aware of the status of all property under their control.)

The CME or memo must include:

1. LSU inventory numbers and descriptions of the property (CME can include more than one item).
2. Name of individual responsible for the equipment.
3. Complete address where the property is to be located.
For an item to be taken off campus the following criteria must be met:

1. The item is to be used by an LSUHSC-S employee. (The property cannot be loaned to another individual or entity.)

2. The item's use at the off-campus location will benefit LSUHSC-S and help forward the LSUHSC-S goals and its mission.

3. The item must remain at the location stated on the Change in Movable Equipment form. However, once approved to be off campus, laptop computers, dictation machines, pocket organizers or other equipment designed to be mobile can be temporarily relocated for its intended use without further notification to the Property Manager.

Note: Property to be loaned or otherwise alienated from LSUHSC-S or its authorized users must be done through a Cooperative Endeavor contract, subcontract, or other legal binding agreement which identifies specific property requirements. All other property disposition requests (trade-ins, surplus, scrap, stolen or transfers) must be sent to the Property Manager for State approval.

The individuals holding custodian responsibility of off-campus property must be insured or accept personal responsibility if the property is lost, stolen, or damaged through negligence. All losses must be reported, when known, to the Property Manager.

C. Yearly Certification and Inventory of Property

The State requires a yearly inventory of all LSUHSC-S property and off-campus property is not exempt. The following procedures will be used to inventory authorized off-campus property.

The Property Manager will have an inventory list prepared for each individual having property off campus. The lists are sent to the Department Heads for distribution to the individuals. The cover letter accompanying department's off-campus location lists will contain a specific completion date. The individual will certify, by signing the list, that the property is at the authorized location. The Department Head will also sign signifying that the individual has the department's continued authorization to have the property located off campus. If the Department Head is unwilling to sign the list, the individual must return the property to LSUHSC-Shreveport without delay. (Note: Again, it is important that the Department Head be continually aware of the department's property. Some individuals may have the property off campus for over 10 years. The Department Head is not kept aware, it may get away.)

If the property is no longer at the authorized location, the individual will line through and initial the entry and give the current location. The individual remains responsible until the property's return to a campus location has been verified.

The department will have the signed lists returned to the Property Manager by the completion date. The list becomes a part of the State required annual inventory certification.

D. Required Return of Property

LSUHSC-Shreveport off-campus property still belongs to the state and must be returned prior to an individual's separation from the University or it is no longer being used in an official capacity. It is the responsibility of the Department Head to ensure the return of property prior to an individual's departure. Failure of the individual to return the property is considered theft of State property. This includes properly purchased with grant funds not specifically included in a grant transfer. (Note: The Property Manager is not always made aware of an individual's departure; therefore, this responsibility belongs to the Department Head.)
The individual is required to produce the property (bring the property back to campus) at the request of the Department Head, Dean, Vice Chancellor for Business and Reimbursement, Hospital Administrator, or Property Manager without reason or justification. The individual does not have to be given any prior notice to produce the property. Failure to produce the property could result in the individual reimbursing LSUHSC-Shreveport the cost of the property.

A CME is sent to the Property Manager when the property is returned or moved to another location. A member of the inventory team will validate the property’s return. Property records will reflect individual’s off campus location until verified that the item has been returned.

E. Property Taken Off Campus through Cooperative Endeavors or Other Contracts.

Cooperative Endeavors, contracts, subcontracts, or other legal binding agreements are required to loan specific property to another state or political subdivision, public or private corporation, or association. The contract must be signed by all parties and approved by the Division of Administration before any property is taken from LSUHSC-Shreveport. The above contracts must meet established criteria and be negotiated through the Office of Legal Affairs. However, the following procedures have been established to ensure compliance with State property laws:

1. The Property Manager will have the property inventoried prior to it being taken from LSUHSC-S.

2. The location of the contract will be assigned a location identification index number.

3. To comply with the State’s yearly inventory requirement, the Property Manager will send the contract institution a list of the property for certification by that institution’s representative. If the property is located in the local area, the Property Manager may have LSUHSC-S inventory personnel complete an inventory.

4. Lost or missing property will be reimbursed per the contract.

5. Unless the contract is renewed, the property is to be returned to LSUHSC-Shreveport per the contract requirements.

F. University Police

The University Police have the right and responsibility to stop anyone taking LSUHSC-S property off campus. University Police officers can, at their discretion, prevent property from being taken off campus until authorization has been determined.

It is also the responsibility of each LSUHSC-Shreveport employee and staff member to report any suspected unauthorized removal of LSUHSC-S property from campus. Report suspicion directly to the University Police for investigation.
2.8.2 EMERGENCY - REDUCTION OF OPERATIONS
AND STAFF/INCLEMENT WEATHER

A. Policy
The Dean and management staff recognize that emergency situations can create
difficulties for some Medical Center personnel. It is necessary, however, that essential
campus functions are maintained at all times. The campus never closes.

B. Procedure
1. Each Department Head will establish a department or section emergency plan that
is approved by the Dean, School of Medicine, through the responsible Campus
Administrators: the Associate Dean, the Executive Associate Dean for Allied Health
Professions, the Vice Chancellor for Business and Reimbursements, and the Hospital
Administrator. Each plan will define the departmental operation to be maintained
during emergencies and identify, by numbers and classifications, staff personnel
required for that level of operation. The plan should make appropriate allowances
for contingency personnel—those whose presence may be required in the event
of disaster or failure of a facility system and whose ability to reach the campus in a
timely manner would be adversely affected by emergency conditions.

2. The Dean of the Medical School (or in his absence, the Associate Dean or designee)
may declare an emergency. Such declaration may cancel classes, close nonessential
offices, and reduce staffing to the level necessary to support essential operations in
the Schools and Hospital. Personnel whose presence is not required to maintain this
reduced operation may, according to the plan for their Department or Section, be
excused from work. During such periods of emergency, personnel who were scheduled
for work but excused because of the minimum staffing requirement may be given
annual leave, if requested and available.

3. Personnel who are required by their Departmental Emergency Plan to work on
emergency days are not excused for any reason other than illness. Others who fail to
report as scheduled will be considered unexcused absentees and will receive leave
without pay for the work period and face possible disciplinary action. Those essential
employees who work on official emergency days will be paid appropriately for hours
worked. No special pay will be authorized.

4. If the Governor declares an inclement weather emergency for the area, an official
inclement weather day may be declared by the Dean of the Medical School (or
in his absence, the Associate Dean or designee). Such declaration has the effect
of establishing holiday routine (See Administrative Directive 2.2.1, Section B) in
the Medical Center. The declaration cancels classes, closes nonessential offices, and
reduces staffing to the level necessary to support essential operations in the School
and Hospital. Personnel whose presence is not required to maintain this reduced
operation may, according to the plan for their Department or Section, be excused
from work. During such periods of declared weather emergency, personnel who were
scheduled for work but excused because of the minimum staffing requirement will
be given special leave. Special leave will be allowed only when an emergency is
declared by the governor.
Personnel who are required by their Departmental Inclement Weather Plan to work on weather emergency days are not excused for any reason other than illness. Others who fail to report as scheduled will be considered unexcused absentees and will receive leave without pay for the work period and face possible disciplinary action. By 4:00 p.m. on Monday following the end of the pay period, the Payroll Office must receive written notification of any employee who should receive leave without pay for a declared inclement weather day. Those essential employees who work on officially declared weather emergency days will be paid appropriately for hours worked plus appropriate special pay based on a holiday routine.

5. Regardless of weather conditions, the campus is considered to be on a normal operating routine until an emergency is declared by the Dean or his designee. Each departmental head is responsible for ensuring adequate staffing to provide scheduled services and to meet routine workloads. The department head determines the appropriate leave to be utilized (i.e., annual, sick, or leave without pay), under normal conditions.
2.8.5 SUBSTANCE AND ALCOHOL ABUSE POLICY

A. PURPOSE

Louisiana State University Health Sciences Center is committed to maintaining an environment which supports the research, teaching, and service mission of the Health Sciences Center. Although the Health Sciences Center respects an employee’s right to privacy, the illegal use of drugs or alcohol within the Health Sciences Center community interferes with the accomplishment of the Health Sciences Center’s mission.

Louisiana State law prohibits the consumption, possession, distribution, and possession with intent to distribute, or manufacture of drugs described as controlled substances in the Louisiana Revised Statutes 40:964; and other statutes define the illegal possession and/or use of alcohol. Further, various federal and state laws and regulations apply to the employees of Louisiana State Health Sciences Center, including the Federal Drug Free Workplace Act of 1988, the Drug-Free Schools and Communities Act Amendments of 1989 (Public Law 101-226), Revised Statutes of the State of Louisiana and Executive Order MUF 93-38. This policy is specifically directed at illegal actors involving alcohol and controlled drugs. Other Health Sciences Center policies govern the legal use of alcoholic beverages in its facilities and on its premises.

B. DEFINITIONS

"drug free workplace" means a site for the performance of work at which employees are prohibited from engaging in the unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance in accordance with the requirements of the Federal Drug Free Workplace Act of 1988.


"criminal drug statute" means a criminal statute involving manufacture, distribution, dispensation, use, or possession of any controlled substance.

"misuse of alcohol" means any possession, consumption or other use of an alcoholic beverage in violation of this policy.

"conviction" means a finding of guilt (including a plea of nolo contendere) or imposition of sentences, or both, by any judicial body charged with the responsibility to determine violations of the federal or state criminal drug statutes.

"employee" includes faculty, other academic, unclassified, classified, graduate assistants, and student employees and any other person having an employment relationship with the Health Sciences Center.

C. GENERAL POLICY

Louisiana State University Health Sciences Center is committed to providing a workplace free from the illegal use of drugs and alcohol and seeks to make its employees aware of the dangers of drug and alcohol abuse as well as the availability of drug counseling, rehabilitation, and employee assistance through various communications media available to it, the unlawful manufacture, distribution, dispensation, possession or use of a controlled substance in the workplace is prohibited as is the illegal possession and/or consumption of alcohol. Workplace shall include any location on Health Sciences Center property in addition to any location from which an individual conducts Health Sciences Center business while such business is being conducted. Without reference to any sanctions, which may be assessed through criminal justice processes, violators of this policy will be subject to Health Sciences Center disciplinary action up to and including termination of employment.
Employee Education, Prevention, Counseling

Human Resource Management will notify all employees at least once each year of its policies and procedures governing the illegal use of alcoholic beverages and drugs and through appropriate media, make employees aware of the dangers of abusive or illegal use of alcohol or drugs. Specific attention is directed to the harmful effects of certain illegal controlled substances described in Exhibit II. Through the Health Sciences Center Employee Assistance Program, employees with drug and alcohol related problems may seek help.

D. PROHIBITIONS

To establish and maintain a safe work environment, LSUHSC-SHREVEPORT prohibits an employee being on the job while having alcohol in his/her body that is above the prohibited alcohol concentration levels, prohibit the use of or presence of illegal drugs or other dangerous substances in the bodies of its employees while on duty, on call and/or engaged in LSUHSC-SHREVEPORT business on or off LSUHSC-SHREVEPORT premises. LSUHSC-SHREVEPORT further prohibits the sale, purchase, transfer, concealment, transportation, storage, possession, distribution, cultivation, manufacture, and dispensing of illegal or unauthorized drugs or related paraphernalia while on duty, on call and/or engaged in LSUHSC-SHREVEPORT business on or off LSUHSC-SHREVEPORT premises.

The prohibitions of this policy extend to the following:

A. Illegal drugs, unauthorized controlled substances, abuse of inhalants, look-alike drugs, designer and synthetic drugs, and any other unauthorized drugs, abnormal or dangerous substances which may affect an employee’s mood, senses, responses, motor functions, or alter or affect a person’s perception, performance, judgment or reactions while working, including those drugs identified in Schedules I through V of Louisiana R.S. 40:964 or Section 202 of the Controlled Substances Act, 21 U.S.C. 812.

NOTE: Illegal drugs include:

1. Any drug which is not legally obtainable.
2. Any drug which is legally obtainable but has not been legally obtained; or
3. Legally obtained (prescription) drugs not being used for prescribed purposes or in excess of prescribed dosages.
4. Misuse of alcoholic or intoxicating beverages; and
5. Drug related paraphernalia as defined in R.S. 40:1031, including any unauthorized material or equipment or items used or designated for use in testing, packaging, storing, injecting, ingesting, inhaling, or otherwise introducing into the human body those substances covered by this policy.
E. ALCOHOL MISUSE POLICY

Alcohol misuse is prohibited. This prohibition extends to 1) use of alcohol on the job; 2) having a prohibited alcohol concentration level in the individual's blood system while on the job. Any employee exhibiting behavior and/or appearance characteristic of alcohol misuse or whose job performance appears to be impaired by alcohol or who is involved in an accident in which the misuse of alcohol is suspected may be required to submit to a test for the presence of alcohol.

F. PRESCRIPTION/LEGAL DRUGS

The use of drugs/medications prescribed by a licensed physician is permitted provided that it will not affect the employee's work performance. The employee shall notify his/her direct supervisor of any drugs/medications prescribed by a licensed physician in those instances when the physician or pharmacy advises that the employee's performance could be impaired or when the employee believes use of the prescribed drugs/medications will impair his/her ability to perform his/her usual duties and responsibilities. Employees are encouraged to utilize accrued leave, with approval, in those instances where impaired functioning is a distinct possibility.

Employees are encouraged to maintain prescribed drugs/medications in the original prescription containers, which properly identify the employee's name, medication name, issuing physician, and dosage.

LSUHSC-SHREVEPORT reserves the right to have the Medical Director for Occupational Health determine if use of a prescription drug/medication produces effects which may impair the employee's performance or increase the risk of injury to the employee or others.

If such is the case, LSUHSC-SHREVEPORT reserves the right to suspend the work activity of the employee during the period in which the employee's ability to safely perform his/her job may be adversely affected by the consumption of such medication.

G. DRUG TESTS/SCREENS

LSUHSC-SHREVEPORT reserves the right to require drug screening for pre-employment, re-employment or reinstatement. All employees are subject to being tested for drugs under the following circumstances:

1. Post-Accident/Incident - following an accident that occurs during the course and scope of an employee's employment that a) involves circumstances leading to a reasonable suspicion of the employee's drug use, b) results in a fatality, c) results in or causes the release of hazardous waste or materials, or d) involves an on-the-job injury or potentially serious accident, injury, or incident in which safety precautions were violated, equipment or property was damaged, or unusually careless acts were performed. Such testing is required of any employee who is directly involved in such an incident and whose action or inaction may have been a causative factor.
2. **Reasonable Suspicion** - a supervisor’s belief, based upon reliable, objective, and articulable facts that a person is violating this policy. A decision to test must be based on direct observation of specific physical, behavioral, or performance indicators based on, but not limited to, any of the following:

- Observable behavior or physical symptoms
- A pattern of abnormal or erratic behavior
- Arrest of a drug-related offense
- Being identified as the subject of a criminal investigation regarding drugs
- Evidence of drug tampering or misappropriation
- Patterns of absenteeism or tardiness
- Drowsiness or sleepiness
- Alcohol or drug odors on the breath
- Confusion, slurred or incoherent speech
- Unusually aggressive behavior
- Unexplained mood changes
- Lack of manual dexterity or excessive sloppiness
- Unexplained work/school-related accidents or injuries
- Illegible or errant charting
- Leaving work areas for extended periods or unexplained reasons

3. **Rehabilitative** - required for those employees participating in substance abuse after-care treatment, pursuant to the terms of the rehabilitation agreement.

4. **Random Testing** – randomly performed for those employees whose responsibilities of employment include operating a public vehicle, performing maintenance on a public vehicle or supervising any public employee who operates or maintains a public vehicle (the Office of Human Resource Management maintains a complete list of designated positions).

   Individuals will have an equal chance of being chosen, regardless of whether they have been previously tested.

   Once an individual is notified they have been chosen for random testing, they must report to the Occupational Health Clinic within two (2) hours of notification. Failure to report and submit to the drug screen may result in immediate termination of employment.

**H. TARGET DRUGS**

Drug testing of LSUHSC-SHREVEPORT employees pursuant to this policy shall target the presence of the following drugs or their metabolites in the body:

1. Cannabinoids (marijuana);
2. Opiates;
3. Methamphetamine;
4. Cocaine metabolite; and
5. Phencyclidine (PCP)

Additional tests for additional drugs or their metabolites may be performed if circumstances warrant. Further, LSUHSC-SHREVEPORT will test for the presence of alcohol through breath or blood testing methodologies if circumstances warrant.
I. TESTING PROCEDURE

LSUHSC-Shreveport requires any individual who observes an LSUHSC-Shreveport affiliated individual whose behavior appears impaired or unsafe due to the possible use/abuse of alcohol or drugs to report the observations to their supervisor immediately. An individual whose behavior is impaired or unsafe while at work is required to immediately submit to alcohol and drug testing. Refusal to submit for testing when requested may result in immediate termination of employment.

Supervisors who observe or receive any information about an individual's impairment or unsafe conditions from alcohol or drugs or who have an individual involved in an accident for which testing is appropriate should proceed as follows: (1) If possible, have a witness observe the individual's behavior or physical condition. (2) Inform the individual that refusal to submit to the alcohol/drug test is a terminable offense. (3) Escort the individual to the Occupational Health Clinic or if after hours contact the House Supervisor on duty for the administration of the alcohol/drug screen. (4) The individual will be sent home by taxi and suspended without pay pending the test results. (5) Should an individual refuse to be tested, the supervisor in charge will suspend the individual without pay; notify Human Resource Management, Employee Relations, so that the process for termination can be initiated.

Procedures to account for the integrity of each urine specimen by tracking its handling and storage from point of specimen collection to final disposition of the specimen:

These procedures shall require that an appropriate chain of custody form be used from the time of collection to receipt by the laboratory and that, upon receipt in the laboratory, an appropriate laboratory chain of custody forms shall, at a minimum, include the entry documenting date and purpose each time a specimen or aliquot is handled or transferred and shall identify each individual in the chain of custody.

Test results shall be documented and maintained with strict confidentiality. Positive test results and samples will be maintained in accordance with law and applicable medical standards.

J. SEARCHES/INSPECTIONS

In furtherance of this policy, employees are hereby notified that Health Sciences Center offices and work sites are the property of the Health Sciences Center and there is no expectation of privacy with regard to Health Sciences Center offices and work sites. Under appropriate circumstances and in accordance with the law, the Health Sciences Center, in conjunction with law enforcement authorities, reserves the right to conduct unannounced searches and inspection of LSUHSC-SHREVEPORT facilities and properties, including vehicles.

K. ENFORCEMENT

Each alleged violation of this policy will be handled on a case-by-case basis. Certain employees may be rehabilitated, while others may have manifested total disregard for the health, welfare, and safety of themselves or others. Participation in the LSUHSC-SHREVEPORT Employee Assistance Program may be treated by the Health Sciences Center as a positive attempt by the employee to combat his/her substance abuse problem and indicative of a future desire to adhere to this policy. However, participation in the EAP will not shield the employee from enforcement of this policy and disciplinary action, where appropriate. After a review of all data, including any offenses or additional test results produced by the employee, appropriate action will be taken, up to and including termination.
L. DRUG AND ALCOHOL ARRESTS/CONVICTIONS

Any LSUHC-SHREVEPORT employee convicted of a criminal drug or drug-related offense, which occurs on or off duty, must notify his/her immediate supervisor within the next workday or immediately upon the employee’s return to the workplace. Upon final disposition of the criminal proceedings, LSUHC-SHREVEPORT will review all evidence to determine whether disciplinary action, including termination, is warranted. In all cases involving an employee’s arrest on a drug or drug-related offense, which occurs on the job or on LSUHC-SHREVEPORT premises, prompt investigation will be conducted, and disciplinary action taken, if warranted.

The Federal Drug-Free Workplace Act of 1988 requires that each employee notify his/her supervisor within five (5) days of conviction of any criminal drug statutes when such offense occurred in the workplace, while on official business, during work hours, or when in on-call duty status. Federal law requires that LSUHC-SHREVEPORT report within ten (10) days any such criminal drug statute conviction to each Federal Agency from which grants or contracts are received.

Employees whose jobs require driving, are required to notify their immediate supervisor if their driving privileges are suspended or revoked. Supervisors are required to report all suspensions and/or revocations to the Employee Relations Section of Human Resource Management. DUI convictions create a distinct problem in the workplace as a result of the driver’s license forfeiture provisions of Louisiana R.S. 32:414 and Louisiana R.S. 32:661 ET SEQ.

Employees who operate department vehicles on a regular and recurring basis may be forced to utilize accrued annual leave or be placed in leave without pay status during the pendency of any period of suspension. Affected employees are encouraged to seek restricted/hardship licenses, which authorize driving for employment purposes. Employees returning to work after any such suspension shall be required to provide proof of restoration of driving privileges.

M. CRIMINAL PENALTIES

Employees are responsible under both Health Sciences Center policy and state law for their conduct. It is the policy of the LSUHC-Shreveport to arrest and refer for prosecution any person who violates state or federal law concerning alcohol or drugs while within the jurisdiction of the LSUHC-Shreveport Police Department.

It is unlawful in Louisiana to produce, manufacture, distribute or dispense or possess with intent to produce, manufacture, distribute, or dispense controlled dangerous substance classified in Schedule I, Schedule II, Schedule III, Schedule IV or Schedule IV unless such substance was obtained directly or pursuant to a valid prescription or order from a practitioner or as a provider in R.S. 40:978, while acting in the course of his or her professional practice, or except otherwise authorized by law.

Penalties under Louisiana law for violation of laws regulating controlled dangerous substances are as follows:

Schedule I (R.S. 40:966 includes various opiates, hallucinogens, depressants, and stimulants). The maximum penalty provided by law for possession of Schedule I drugs, upon conviction, is imprisonment at hard labor for not less than four years nor more than ten years without benefit of probation or suspension of sentence and, in addition, may require a fine to be paid up to $5,000.

Schedule II (R.S. 40:967 includes other opiates and depressants). The maximum penalty for violating Louisiana law concerning controlled dangerous substances under Schedule II, upon conviction, is imprisonment at hard labor for not less than 5 years nor more than 30 years and, in addition, may require a fine of not more than $15,000.
Schedule III and IV (R.S. 40:968 and 40:969 includes stimulants, depressants, and other narcotics). The maximum penalty for violating Louisiana law concerning controlled dangerous substances under Schedules III and IV, upon conviction, shall be a maximum term of imprisonment at hard labor for not more than 10 years, and in addition, may be sentenced to pay a fine of not more than $15,000.

Schedule V (R.S. 40:970). The maximum penalty for violating Louisiana law concerning controlled dangerous substances under Schedule V, upon conviction, is a term of imprisonment at hard labor for not more than 5 years and, in addition, may be sentenced to pay a fine of not more than $5,000.

The Revised Louisiana Criminal Code carries specific penalties for possession of marijuana. For a first conviction, the offender shall be fined not more than $500, imprisoned in the parish jail for not more than 6 months, or both. For a second conviction of possession of marijuana, the offender shall be fined not more than $2,000 and imprisoned with or without hard labor for not more than 5 years, or both.

For a third conviction of possession of marijuana, the offender shall be sentenced to imprisonment with or without hard labor for not more than 20 years. More severe penalties exist for possession of marijuana with the intent to distribute and for the actual distribution of marijuana.

The Louisiana Criminal Code (R.S. 14:91.5) defines the unlawful purchase, consumption and public possession of alcoholic beverages by any person under the age of twenty-one years (except under narrowly specified exceptions). A fifty dollar fine is assessed for violation of this statute. For the unlawful purchase of alcoholic beverages by adults on behalf of minors (R.S. 14:91.3), the penalty is a fine of not more than $300 or imprisonment for not more than 30 days. For operating a vehicle while intoxicated (R.S. 14:98), the penalty for a first conviction is a fine of not less than $125 nor more than $500 and imprisonment for not less than ten days nor more than six months which may be modified by imposing a court-approved substance abuse program and driver improvement program. For second and third convictions, more serious penalties are imposed.

**N. REHABILITATION**

Management may, as a condition of continued employment, require the employee to enter a treatment/rehabilitation program. If time off is required for the treatment program, the Medical Center’s leave policies will apply. The employee must provide permission for the treatment center to provide continuing communication and regular reports to the Medical Center’s Medical Review Officer.

After successful completion of the treatment/rehabilitation program, the employee must continue with an appropriate follow-up program that usually runs one to three years. The Medical Center’s Medical Review Officer will determine the follow-up treatment program.

Withdrawal or failure to successfully complete the treatment program may result in termination.

Submission to periodic random drug screen upon request is required and is a condition for continued employment.
Personnel returning to work will not be allowed to have possession of narcotic keys or to work with controlled substances until the employee demonstrate to the satisfaction of management that he/she can administer narcotics.

Any continuing evidence of chemical abuse will result in notification to state or federal law enforcement agencies and/or National Licensing Boards, if appropriate.

O. REPORTING
In accordance with Executive Order MJF 98-38, the LSU System Office will report to the Office of Governor the number of employees affected by the drug testing program, the categories of testing being conducted, the costs of testing, and the effectiveness of the program annually. Source: Drug-Free Workplace Act of 1988, Drug-Free Schools and Communities Act Amendments of 1989, Executive Order MJF 98-38.

P. CONFIDENTIALITY
LSUHSC-SHREVEPORT respects the individual rights of its employees. Any employee involvement in the LSUHSC-SHREVEPORT Employee Assistance Program (EAP) or other rehabilitative program for substance abuse problems will be handled with confidentiality. Employees seeking such assistance shall be protected from abuse, ridicule, retribution, and retaliatory action. All medical information obtained will be protected as confidential unless otherwise required by law or overriding public health and safety concerns.

The results of all drug screens obtained in compliance with this policy will be confidential, except on a need to know basis. LSUHSC-SHREVEPORT may deliver any illegal drug, controlled dangerous substance, or other substance prohibited by this policy, discovered on LSUHSC-SHREVEPORT property or on the person of a LSUHSC-SHREVEPORT employee to appropriate law enforcement agencies. Likewise, any employee engaged in the sale, attempted sale, distribution, or transfer of illegal drugs or controlled substances while on duty or on LSUHSC-SHREVEPORT property will be referred to appropriate law enforcement authorities.

Q. CONCLUSION
The use of illegal drugs and abuse of alcohol or other controlled substances, on or off duty, is inconsistent with law-abiding behavior expected of the citizens of the State of Louisiana. LSUHSC-SHREVEPORT will not tolerate substance abuse or use, which imperils the health and well being of its employees and the public, or threatens its service to the public. LSUHSC-Shreveport's intention, through this policy, is to adhere to the Federal Drug-Free Workplace Act of 1988, The Drug-Free Schools and Communities Act Amendments of 1989 (Public Law 101-226), Revised Statutes of the State of Louisiana and Executive Order No. MJF 98-38 all in an effort to maintain a safe, healthful, and productive work environment for its employees and to promote public safety.
EXHIBIT I

Drug Free Workplace

The Federal Drug Free Workplace Act of 1988 contains specific requirements relating to Health Sciences Center employees who are engaged in the performance of a federal grant or contract as follows:

Each such employee must receive a copy of the Health Sciences Center policy providing a drug free workplace, which shall be provided through the official promulgation of this Policy Statement and such other means as may be appropriate, and each such employee:

1. Agrees as a condition of employment to abide by the terms of the drug free workplace policy.
2. Must notify the LSUHSC-SHREVEPORT Office of Human Resource Management of any criminal drug statute conviction for a violation occurring in the workplace no later than 5 days after such conviction.

The Health Sciences Center is required to:

1. Notify the granting agency, within 10 days after receiving notice of conviction as above, or otherwise receiving notice of such conviction which notification shall be by the LSUHSC-SHREVEPORT Office of Human Resource Management.
2. Within 30 days after receiving such notice, impose a sanction on, up to and including termination, or require satisfactory participation in a drug abuse assistance or rehabilitation program approved for such purposes by a federal, state, or local health, law enforcement, or other appropriate agency by any employee so convicted with such sanction or required participation to be coordinated by the Office of Human Resource Management through the normal LSUHSC-SHREVEPORT administrative processes.
3. Make a good faith effort to continue to maintain a drug free workplace through implementation of the requirements of the Act.

EXHIBIT II

Alcohol - Uses and Effects

Alcohol consumption causes a number of marked changes in behavior. Even low doses significantly impair the judgment and coordination required to drive a car safely, increasing the likelihood that the driver will be involved in an accident. Low to moderate doses of alcohol also increase the incidence of a variety of aggressive acts, including peer, spouse, and child abuse. Moderate to high doses of alcohol cause marked impairments in higher mental functions, severely altering a person’s ability to learn and remember information. Very high doses cause respiratory depression and death. If combined with other depressants of the central nervous system, much lower doses of alcohol will produce the effects just described.

Repeated use of alcohol can lead to dependence. Sudden cessation of alcohol intake is likely to produce withdrawal symptoms, including severe anxiety, tremors, hallucinations, and convulsions. Alcohol withdrawal can be life threatening. Long-term consumption of large quantities of alcohol, particularly when combined with poor nutrition, can also lead to permanent damage to vital organs such as the brain, liver, and digestive system.

Mothers who drink alcohol during pregnancy may give birth to infants with fetal alcohol syndrome. These infants have irreversible physical abnormalities and mental retardation. In addition, research indicates that children of alcoholic parents are at greater risk than other children of becoming alcoholics.
6.6 AMERICANS WITH DISABILITIES ACT OF 1990

A. GENERAL

Louisiana State University (LSU) Medical Center is an equal opportunity employer and makes employment decisions on the basis of merit. We want to have the best available persons in every job. LSU Medical Center policy prohibits unlawful discrimination based on race, color, creed, sex, age, national origin, physical handicap, disability, medical condition, sexual orientation, or any other consideration made unlawful by federal, state or local laws. All such discrimination is unlawful.

LSU Medical Center is committed to complying with all applicable laws providing equal employment opportunities to all individuals. That commitment applies to all persons employed by LSU Medical Center and prohibits unlawful discrimination by all employees, including supervisors and co-workers.

B. ACCOMMODATION FOR PHYSICAL OR MENTAL LIMITATIONS

To comply with applicable laws insuring equal employment opportunities to qualified individuals with a disability, LSU Medical Center will make reasonable accommodations for the known physical or mental limitations of an otherwise qualified individual with a disability who is an applicant or an employee unless undue hardship would result.

a. Any applicant or employee who requires an accommodation in order to perform the essential functions of the job should contact the Department of Human Resource Management and request such an accommodation.

b. The individual with the disability should specify what accommodation he or she needs to perform the job. LSU Medical Center will identify the barriers that make it difficult for the applicant or employee to have an equal opportunity to perform his or her job.

c. LSU Medical Center will identify possible accommodations, if any, that will help eliminate the limitation. If the accommodation is reasonable and will not impose an undue hardship, LSU Medical Center will make the accommodation.

C. DISCRIMINATION

If you believe you have been subjected to any form of unlawful discrimination, provide a written complaint to the Department of Human Resource Management within 180 days of the alleged discriminatory act. If the complaint relates to personnel of the Department of Human Resource Management, provide your complaint to the Vice Chancellor of Business and Reimbursements or to the Chancellor. Your complaint should be specific and should include the names of the individuals involved and the names of any witnesses. LSU Medical Center will immediately undertake an effective, thorough and objective investigation and attempt to resolve the situation.
7.2 ACCIDENT REPORTING

A. General

An essential element of the safety program at LSUHSC-S is the prompt investigation and reporting of all illnesses and accidents resulting in injury to persons or damages to property and equipment. Timely and thorough accident reporting and investigation is a primary responsibility for all supervisors. Through this process supervisors discharge their responsibilities to their employees by insuring that injuries are treated, compensation or insurance claims are submitted promptly and hazardous conditions are corrected.

B. Injuries to Employees

1. Procedures

(a) All on-the-job injuries must be reported to assure coverage by workman’s compensation.

(b) At the time of injury, an On-the-Job Injury Record Form LSUHSC-S 1147 (Attachment 1), should be completed by the supervisor or designee and the injured employee and should accompany the injured employee to the Occupational Health Clinic located on the 8th floor in the hospital, room H-8-8 (this is the only form that must come with the employee at the time of injury). The completed form should be routed (by the immediate supervisor) to the Safety Office and the Department of Human Resources.

(c) Employee injuries are seen in the Occupational Health Clinic Monday through Friday from 7:00 a.m. to 4:30 p.m. with the exception of LSUHSC holidays.

(d) After clinic hours, weekends, and holidays, injured employees are seen in the Emergency Care Center on the 1st floor of the hospital.

(e) Follow up on employee injuries is done in the Occupational Health Clinic or by a personal physician.

2. Required Reports

The following list of reports must be completed by the supervisor of the injured employee and returned to the Benefits Office in Human Resource Management and the Safety Office. The reports may be handwritten or typed, and the supervisor or designee must complete the forms within forty-eight hours of the report of the employee injury:

(a) Supervisors must complete an Accident Investigation Form DA-2000 for each injured employee (Attachment 2), attach a copy of the completed On-the-Job Injury Record Form (Attachment 1), and send to the Benefits Office in Human Resource Management and the Safety Office.

(b) All information fields on the Accident Investigation Form DA-2000 must be completed. (including the root cause analysis section). Completed forms shall be reviewed for
accuracy by the submitting supervisor and Safety Office. Notations such as N/A (not applicable) are not acceptable on this form. All blanks must be completed or reviewed for accuracy by the submitting supervisor and Safety Office. Notations such as N/A (not applicable) are not acceptable on this form. All blanks must be completed.

(c) All forms are available from the Safety Office, Benefits Office in Human Resource Management, or Print Shop. They can also be found online under Administrative Directive 7.2 or on the Safety Office or Human Resources webpage. When using the online fillable On-the-Job Injury, extra copies will need to be made after medical diagnosis is added to this report and copies sent to HR and Safety Office.

3. Loss of Time by Injured Employee
   (a) Should the employee's injury result in any temporary or long-term release from work, the supervisor must verbally inform the Department of Human Resources as soon as possible of the time of the accident, time and date the employee was released from work, and date the employee is expected to return to work. This should be followed by a brief written statement to the Department of Human Resources providing the same information.
   (b) If loss of work time occurs because of an on-the-job injury, a doctor's release must be submitted to the Department of Human Resources before an employee can return to work. It is the supervisor's responsibility to assure that this requirement is met.

4. Supervisor Responsibility
   (a) Timely and proper reporting of all employee injuries, as specified by this policy, is an important responsibility of supervisors. The LSU Health Sciences Center must depend on supervisors to comply with specified deadlines for completing reports to meet its legal obligations to the Office of Worker's Compensation Administration. This Office requires a completed "Employer's Report of Occupational Injury or Disease" report within 5 days of actual knowledge of the employee injury. A punitive fine may be levied against the LSU Health Sciences Center for non-compliance.
   (b) Failure on the part of supervisors to meet reporting requirements within the specified time limits will be cause for disciplinary action.
   (c) All reports submitted by supervisors may be subject to investigation by the Safety Office.

C. General Liability Claims - Injuries to Visitors and Property Damage

If a visitor is injured or property damages occur, the appropriate supervisor within the area in which the injury or damages occurrence must complete a "Variance Report" or DA-3000 Form (Attachment 3) within two working days and forward to the Safety Office.

1. The variance report form or DA-3000 Form should be used for incidents affecting members of the general public or others while on State property which you believe could reasonably result in a claim against the State.

2. If a visitor injury or property damage occurs in a common area, such as a stairwell, lobby, or outside area, the University Police will be responsible for completing the necessary reports using a variance report, DA-3000 Form, or UPD report system.

3. The Variance reporting process can be accessed by using the following web link; http://www.medcom.lsuhealthreport.edu/cfdocs/qm/
4. The DA-3000 form can be found in the appendices of this policy and on the Safety Office website.

5. All general liability reports shall be forwarded to the Safety Office Room O-300 for proper reporting to the State of Louisiana Office of Risk Management.

6. Do not use a variance report or DA-3000 form for reporting auto accidents or Workers Compensation claims.

D. Motor Vehicle Accidents

All accidents involving a LSUHSC motor vehicle must be reported to the Safety Office.

The operator of the vehicle involved in an accident and supervisor shall complete the following:

1. Employee shall report to the local police or appropriate law enforcement agency and to their supervisor on the day of the accident or as soon as possible thereafter.

2. An Accident Report Form DA-2041 (Attachment 4) shall be completed by the driver and/or his supervisor and delivered to the Safety Office within 24 hours of the accident. A blank copy of the Accident Report Form should be located in the glove compartment of each Medical Center motor vehicle or may be obtained on-line or from the Safety Office.

3. A copy of the Uniform Motor Vehicle Traffic Accident Report (police report), if one is completed, should be attached to the Accident Report Form and sent to the Safety Office when it becomes available from law enforcement agencies.

4. Employees using personally owned vehicles or rented motor vehicles who become involved in an accident while on official and approved state business will report accidents in the same manner as above. A copy of the Accident Report Form DA-2041 may be obtained from the Safety Office or on-line.

5. The supervisor and/or department head of the employee having the accident will, after reviewing the accident report, make a determination of whether the accident was preventable. The supervisor must consider what corrective action is necessary for accidents determined to be preventable. For complex accidents, the supervisor should request assistance from the Safety Office.

E. Coordinating Department

The Department of Human Resources will be responsible for the administration of the Worker’s Compensation program at the LSUHSC. Additionally, the Department of Human Resources will have full authority to assure employee compliance to this policy.

The Safety Office will be responsible for reviewing the accident investigation, reporting to proper authorities, and assuring compliance with this policy.

Appendix (A) 1147 OJI Form 1147 On the Job Injury Record fillable Appendix A.pdf

Appendix (B) DA2000 Form DA-2000 fillable Appendix B.pdf

Appendix (C) DA 3000 Form DA3000 fillable Appendix C.pdf

Appendix (D) DA2041 Form DA 2041 fillable Appendix D.pdf
LOUISIANA STATE UNIVERSITY
HEALTH SCIENCES CENTER - Shreveport
ADMINISTRATIVE DIRECTIVE
Policy Number: 8.4
Effective Date: January 1, 2013
Supersedes Policy: 06/01/05 (10/01/07)

8.4 RECOUPMENT OF OVERPAYMENT

A. Policy

It is the policy of LSU Health Sciences Center - Shreveport, EA Conway Medical Center - Monroe, or Huey P. Long Medical Center - Pineville (hereafter referred to as the "Health Sciences Center") to establish consistent procedures to recoup overpayments. Overpayments occur when compensation and/or reimbursements that are not owed to the employee are paid in error. This includes, but is not limited to, overpayment of wages, annual leave paid in error, erroneous refunds or the lack of deductions. This policy is in accordance with LA R.S. 42:460.

B. Definitions

1. ACTIVE EMPLOYEE. Any employee currently working for the Health Sciences Center, including, but not limited to, staff, faculty, and house officers.

2. DEDUCTIONS. Any voluntary/involuntary reduction in net pay (e.g., health insurance, United Way, taxes).

3. NET PAY. The amount of compensation due to the employee after withholding all voluntary and involuntary deductions from wages and compensation earned.

4. OVERPAYMENT. Unearned compensation of state funds to employees.

5. RECOUPMENT. Reimbursement of overpayment that was not due an employee.

6. PROSPECTIVE EMPLOYEES. All new hires and employees who have transferred from another state agency to the Health Sciences Center.

C. Notification of Overpayment

The Health Sciences Center will notify the employee immediately once an overpayment has been determined. Written notification will be provided from the Payroll Department prior to withholding the recoupment from a future payment. The notification to the employee will include:

1. Pay date(s) of when overpayment occurred

2. Amount of the overpayment
3. Reason for overpayment

4. Employee options for reimbursement of overpayment

5. Procedure by which the proposed recoupment can be disputed

**D. Recoupment from Active Employee**

The institution will recoup the overpayment in one of the following ways:

1. Direct deposit reversal

2. One-time deduction from subsequent paycheck

3. Repayment plan
   
   a. The employee and the Director of Accounting or designee must agree to a repayment plan. All repayment plans must be approved by the Vice Chancellor for Administration.
   
   b. The payment plan terms cannot exceed 36 months. If the overpayment occurred over multiple pay periods, the repayment plan terms should be extended over an equal number of pay periods, not to exceed 36 months.

4. Personal payment from employee by check or money order

5. Forfeiture of accrued annual leave

A response must be made to Payroll within ten days of receiving the notification of overpayment. If a response is not received within this time frame, then Payroll will contact Human Resource Management. At that point, HRM will seek legal advice to determine if legal recourse will be taken.

If the employee decides to terminate their employment and owes an overpayment, the employee will repay any unpaid balance of the overpayment in full from the employee’s final paycheck upon separation.

The amount to be recouped shall not reduce the employee’s biweekly gross hourly wage amount below the federal minimum wage.

**E. Recoupment from Employees Transferring to Another State Agency**

If an overpaid employee is transferring from the Health Sciences Center to another state agency, the Health Sciences Center cannot forgive the debt. The Health Sciences Center will work with the new agency and the employee to collect the remainder of the outstanding balance due. In addition, the Health Sciences Center will work with other state agencies to recoup overpayments of their former employees that currently work for the institution.
F. Recoupment from Separated Employees

If an overpaid employee is separating from the Health Sciences Center the institution cannot forgive the debt. Written notice will be sent indicating demand for repayment.

Repayment options are as follows:

1. One-time personal payment from employee by certified check or money order
2. Payment plan as agreed upon and not to exceed 36 months
3. Forfeiture of any accrued annual leave time prior to separation.
4. A combination of the above listed options (#s 1, 2 and/or 3).

A response must be made to the Health Sciences Center within ten days of receiving the notification of overpayment letter. If a response is not received within this time frame, then Payroll will contact Human Resource Management. At that point, HRM will seek legal advice to determine if legal recourse will be taken.

G. Variance

Any variance from this directive shall be for good cause shown and must be approved by the Vice Chancellor for Administration.

H. Notification of Recoupment Policy

All current employees will be notified of the policy. As a condition of employment, all prospective employees will sign a statement acknowledging their understanding of the recoupment policy and that, if overpaid, the overpayment may be recouped after notification from the institution. Job offers will be withheld to prospective employees failing to comply with this rule.

I. Dispute Procedure

If an employee does not agree with the recoupment, the employee can file an appeal with the Director of Human Resource Management (HRM). The appeal should be received in HRM no later than 10 working days from receiving the written notification from the Payroll Department. The appeal should be in writing with explanation as to why the employee believes the recoupment is not warranted, and the employee must attach any supporting documentation to be considered in the review. The Director of Human Resource Management or his designee will notify the employee and the Payroll Department in writing of the decision rendered. This decision may be appealed to the Vice Chancellor for Administration whose decision shall be final.
Frequently referenced Chancellor’s Memoranda
Complete list of Chancellor’s Memoranda can be found at
http://www.medcom.lsuhschsreveport.edu/cfdocs/policies/Chancellors_Index.cfm

LSU Health Sciences Center of Shreveport
Chancellor’s Memoranda 10 – No Smoking Policy

Effective Date: July 13, 2010
Supersedes: July 1, 2010

It is the policy of Louisiana State University Health Sciences Center (HSC) to respect the rights of smokers and non-smokers alike. In addition, in accordance with laws and regulations cited below, the LSU Health Sciences Center reserves the right to prohibit smoking on its premises for reasons of public health and safety, improved customer satisfaction, the protection of environmentally sensitive materials and to address the concerns of individual non-smokers.

Effective July 1, 2010, LSUHSC-Shreveport properties is a smoke free organization. Smoking will be prohibited on all properties, leased or owned, of the Health Sciences Center. This policy is in effect for all employees, students, patients, and visitors of the Health Sciences Center.

On an ongoing basis, the Health Sciences Center will make resources available to help employees with their personal smoking cessation efforts. Furthermore, and as it relates to employees, it is the responsibility of supervisors to ensure that employees comply with the No Smoking Policy. Employees who violate the No Smoking Policy may be subject to disciplinary action, up to and including termination.

Clinical staff will inform patients of the policy and ensure they are in compliance. Health Sciences Center administrative and supervisory personnel are directed to advise persons of the no smoking policy when they encounter violations and to inform Human Resources and/or the LSUHSCS University Police Department (UPD) as appropriate.

UPD is authorized to enforce the smoking policy as police officers deem appropriate. Violators will be encouraged to extinguish smoking material and/or to smoke on the public sidewalks. In dealing with violators, police officers are authorized to:

- remind violators that second-hand smoke is harmful to patients and employees
- issue verbal warnings
- issue written citations
- prohibit non-emergency readmission to HSC facilities
- bar persons from HSC property, and ultimately to
- arrest/prosecute persons who refuse to comply.
CM-14 Usage of Electronic Mail (revised)

The use of electronic mail shall be consistent with the instructional, research, public service, patient care and administrative goals and mission of the Health Sciences Center. Incidental and occasional personal use of electronic mail may occur when such use does not generate a direct cost to the Health Sciences Center. A tutorial regarding email usage appears online at http://training.lsuhssehreepport.edu/email

The following examples are prohibited uses of E-Mail:

1. Personal use that creates a direct cost to the Health Sciences Center.
2. Personal use for monetary gain or for commercial purposes not directly related to Health Sciences Center business.
3. Sending copies of documents or including the work of others in E-Mail communications that are in violation of copyright law.
4. Obtaining or attempting to access the files or electronic mail of others. Capturing or attempting to open the electronic mail of others except as required to diagnose and correct delivery problems.
5. Harassing, intimidating or threatening others through electronic messages.
6. Constructing a false communication that appears to be from someone else. This is called Aspoofing.
7. Sending or forwarding unsolicited E-mail to lists of people you do not know. This is called Aspamming. Bulk mailing is almost always considered Aspam. It places considerable strain on the E-mail system. Bulk mailing of information can be selectively used for business related communication but must be approved at a level appropriate to the scope and content of the information. Authorized bulk mailings will be tagged with the statement, "This message has been authorized by LSU Health Sciences Center administration for mass distribution as a service to our faculty, staff and students."
8. Sending or forwarding chain letters.

In regards to E-mail auto-signatures and footers:

1. The LSUHSCSC email system allows employees and students to customize footers and auto-signatures for outgoing messages. Users may modify the settings to add their name and contact info to outgoing messages — which is the intended purpose and entirely appropriate.
2. It is inappropriate for faculty and staff to add personalized comments such as animations, cartoons, humorous statements, religious or sports references, Biblical verses, political statements, and other quotations — etc. to the footer / auto-signature.¹

Violation of the above policy in any part may be sufficient grounds for disciplinary action and/or termination.

Signed: Robert A. Barish, MD MBA
Chancellor
May 12, 2010

¹ While these are appropriate for personal communication with private (non-LSUHSC) email accounts, they are inappropriate in some work settings - especially publicly-supported institutions like LSUHSCS. Please note that this directive does not interfere with an individual's Constitutionally-protected freedoms of expression and speech. Outside of one's employment, those freedoms are much broader than they are in workplace settings.
CM-17 Delinquent Medical Records

DELIQUENT MEDICAL RECORDS

I. SCOPE

This policy applies to all LSUHSC physicians, both faculty and house staff.

II. PURPOSE

The purpose of this memorandum is to reduce the number of delinquent medical records.

III. POLICY

All discharge summaries are to be dictated within ten (10) days of the discharge of a patient, all operative reports are to be dictated immediately following the procedure’s completion. All verbal orders, and other physician signatures, including medication reconciliation forms shall be signed and dated within 5 days. All death certificates shall be completed within seven (7) days of a patient’s death.

- A list of the delinquent medical records will be compiled by the Health Information Management Department and delivered to the appropriate faculty member’s office and placed in the appropriate house officer’s mailbox/email on Tuesday morning. Should a holiday fall on Monday, the list will be delivered and/or placed in the mailbox on Wednesday and the physician will have until the following Wednesday to correct any deficiency.
- The physician will have until the following Tuesday morning at 8:00 a.m. to dictate the discharge summaries. If the physician fails to do so, they will be immediately placed on leave without pay until the discharge summary is dictated.
- After the dictation is completed it is the physician’s responsibility to notify the Manager, Incomplete Charts, at extension 54201 that the discharge summary has been dictated.
- At 8:00 a.m. each day Medical Records will determine which operative reports have not been dictated from the proceeding day. Physicians who have un-dictated operative reports will be called and requested to complete the dictation no later than 11:00 am that day.
- The list of delinquent operative reports will be re-examined at noon. If the physician has not dictated by noon the Hospital Administrator will be notified and he/she shall notify the appropriate Department Chairman and the Physician. The Physician will immediately be placed on leave without pay for a minimum of one day or until the appropriate action is taken.
- After the dictation is completed it the physician’s responsibility to notify the Manager, Incomplete Charts at extension 54201 that the dictation is complete.
- All verbal orders, operative reports, discharge summaries and medication reconciliation forms shall be signed and dated within 5 days. All death certificates must be completed with 7 days. If a physician is notified of a delinquent signature, date or incomplete death certificate, he/she shall have 7 days to correct the deficiency and failure to do so he/she shall be placed on leave without pay until the deficiency is corrected. If the physician has been placed on leave without pay at any time during the fiscal year, any subsequent failure to sign and date verbal orders, operative reports, discharge summaries and/or medication reconciliation forms or failure to complete death certificates will be treated as second, third and fourth suspensions.
- On the second suspension during any fiscal year, failure to correct the deficient record will cause the physician to be placed on two (2) weeks leave without pay, and if the record is not brought current during that two (2) weeks, the leave without pay will continue until the record is current.
- On a third suspension during any fiscal year, failure to correct the deficient record will cause the physician to be placed on leave without pay for a period of thirty (30) days and will remain on leave without pay until the record is corrected.

- On the fourth suspension during any fiscal year, the non-tenured faculty and house officers will be terminated. Tenured faculty will be disciplined as may be appropriate.
- It is the responsibility of each physician to make certain that his or her records are current before taking annual leave or making a rotation to an off-campus facility. It is the responsibility of the Health Information Management Department to notify the Hospital Administrator and the clinical department head of the names of any physician who has not corrected their delinquent medical record within the time prescribed above. and the Hospital Administrator or the administrator on call will notify Human Resource Management to place the individual on leave without pay as may be appropriate.

This memorandum is effective November 15, 2002.

Signed: Robert Barish, M.D., Chancellor
Amended April 1, 2007; August 2009
CM-20 Employment of Impaired Healthcare Professionals

It is not the practice or responsibility of LSU Health Sciences Center Shreveport (LSUHSC-S), to employ impaired health care professionals, however, in some unique circumstances, LSUHSC-S may participate in the recovery process of impaired health care professionals in cooperation with regulatory board and impaired professional committees. The purpose of this document is to define specific guidelines that control the employment of a recovering, impaired health care professional, and accordingly, ensure the safety of patients under our care.

STATEMENT OF POLICY:

The decision to employ/reemploy/retain an impaired health care professional is based on a case by case consideration. This consideration utilizes information obtained from pre-employment screening (criminal background check, drug screen, and compliance background check), review by the duly appointed Impaired Professional Monitor, references, information from regulatory boards, and a review of the contract with the professional health committees assigned to monitor the impaired professional by the responsible regulatory board.

No department or component of LSUHSC-S may extend an offer for employment/re-employment to a person with a history of impairment without the prior written approval of the Chancellor or his designee.

To be considered for employment, the impaired and recovering health care professional must have completed any criminal sentence, including probation or diversion, and all pending charges must have been resolved. The appropriate regulatory board must have agreed to the impaired professional’s return to work and specified conditions for such return.

If applicable, the impaired professional must have entered into a contract with an appropriate monitoring committee or designated by the professional’s regulatory board. The recovering, impaired health care professional must enter into a contract with LSUHSC-S stating the terms and conditions of employment as outlined below. All terms of that contract must be satisfied, with a zero tolerance for infractions.

All employment will be probational until formally removed in writing by the Chancellor or his designee.

All employees must, at all times, abide by all rules and regulations of the University, and all state and federal statutes related to compliance.

The Chancellor shall appoint an Impaired Professional Monitor who will be responsible for monitoring and oversight of the recovering, impaired professional’s sobriety and adherence to the terms of the contract governing their employment. The recovering, impaired professional must cooperate fully with the Impaired Professional Monitor,
including, but not limited to meetings and random drug screens, regardless of where located.

**TERMS AND CONDITIONS OF CONTRACT:**

- I understand that these terms and conditions are in addition to any contract or agreement that I have with any law enforcement agency, court licensing board, Physician’s Health Committee (PHC) or any other governmental or non-governmental entity.
- I understand that I am being employed/retained in a monitored status and will be on probation, which will continue until such time as it is formally removed in writing by the Chancellor or his designee.
- I understand that there is a zero tolerance policy in effect, and that the finding of any mood altering substances of any kind (excluding those prescribed by my approved primary care physician) in any bodily sample, shall result in my immediate dismissal from the program and the University.
- I shall have a primary care physician who is experienced in addiction medicine, and shall seek ALL medical care through this physician. I agree to provide written notification of the primary care physician to the Associate Dean for Clinical Affairs within 30 days of my employment and such physician is subject to the approval of the Associate Dean for Clinical Affairs.
- I will cooperate with the Impaired Professional Monitor, and shall submit to random drug screenings at such time and at such place that the Impaired Professional Monitor shall determine. These screenings shall be at my expense.
- I agree to meet with and cooperate with the University counselors and monitors at such times and places as the University may specify.
- I agree not to work in the delivery of health care at any other facility without the prior written approval of the Chancellor or his designee.
- I understand and agree that a copy of this document will be furnished to the Medical Director of the PHC, the Impaired Professional Monitor, the appropriate state licensing board, the Associate Dean for Clinical Affairs and my approved primary care physician.
- I will execute appropriate releases that authorize the release of any and all information obtained by any and all parties involved in my supervision, testing, monitoring, treatment and counseling to the Associate Dean for Clinical Affairs, Program Chairs and Program Directors or Supervisors, the PHC Medical Director and my primary care physician.
- I further understand that failure to comply with the PHC contract, or the failure to meet all terms and conditions of this agreement will result in my immediate dismissal from the Program and from the University, as well as the immediate reporting to all appropriate boards, committees and data banks.

This policy shall be amended or revised as needed.

This memorandum is effective August 5, 2004.
Use of broadcast e-mail

Electronic mail (e-mail) is the most efficient means for communicating with large numbers of faculty, staff, and students. LSUHSC-S cadre will use broadcast e-mail increasingly for matters of import to the institution and members of our campus community.

1. There are three general forms of broadcast e-mail messages at LSUHSC-S: School, Hospital and Institutional. The message audience determines the level of the individual or office from which approval must be obtained.

   • School: School-wide broadcast message approval remains the prerogative of the respective Doans or their delegates. They may use distribution channels like the Doan's Corner messages and other means.

   • Hospital: Hospital-wide broadcast message approval remains the prerogative of the respective Hospital Administrators or their delegates.

   • Institutional: All Institution-wide (across Hospitals and Schools) broadcast email must be approved by the Chancellor's Office before being sent. Approval is typically provided on a per-message basis, although blanket authorization may be provided. Campus-wide messages will need to be approved by either the Chancellor or a Vice Chancellor.

   Use of these distribution lists by other than the persons authorized above is prohibited.

2. All non-emergent Institutional Broadcast E-mail must be approved by the Chancellor's Office before being sent. Approval is typically provided on a per-message basis, although blanket authorization may be provided. Campus wide messages will need to be approved by a Vice Chancellor and coordinated with other messages from the Chancellor's Office.

3. There will be no opt-out provisions for broadcast messages sent to LSUHSC-S e-mail accounts. If a recipient chooses not to read selected e-mail correspondence, that remains their prerogative.

4. Issues likely to attract media calls require coordination with the Office of Information Services. A message addressing an issue that has already attracted or is likely to attract media coverage should be composed in a manner consistent with LSUHSC-S news releases and other statements regarding the matter.

5. Broadcast E-mail should refrain from containing attachments. Attachments present several potential problems: they may strain system resources affecting other services and subscribers; the programs needed to open them are not available on all recipient systems; they consume valuable computer storage space and may unwittingly be a potential distribution mechanism for computer viruses.
6. The sender and approver are responsible for evaluating message appropriateness and form. The individual or office with approval authority will make the final determination regarding whether or not a broadcast e-mail message may be sent. That determination should take these broadcast e-mail guidelines into account. It is important to keep in mind the audience, format, and frequency of mailings in order to avoid e-mails having the appearance of spam.

7. Limiting length of messages. Broadcast e-mail messages should be no more than a few reasonably short paragraphs in length. When it is necessary to communicate a large amount of information, send a brief message that includes the main point(s) and a reference to a Web page containing the detail.

8. If a broadcast e-mail message is not the most appropriate choice for distribution, consider the approved alternatives.
   - LSUHSC-S Web page Events ... Event which is sponsored by either the institution as a whole or a component thereof and is of general public interest is eligible to be listed.
   - E-announcements ... Announcements, meetings, lectures, etc. which are sponsored by the institution as a whole or component thereof can be placed on e-announcements.
   - On the Inside ... Both print and online versions of the monthly campus newsletter produced by the Office of Information Services.
   - Traditional paper-based means

Robert A. Barish, MD, MBA, Chancellor
January 4, 2010
Frequently referenced University Health Policies

Please visit http://team.uhsystem.com/ for all University Health Policies & Procedures.

**University Health**

<table>
<thead>
<tr>
<th>POLICY#: 4.A.8</th>
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<tbody>
<tr>
<td>SUBJECT: Informed Consent for Medical/Surgical Treatment</td>
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<tr>
<td>Effective: 10/13</td>
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<td>Revised: 04/16, 11/16</td>
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<td>APPROVED BY: MEC and Governing Board</td>
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<td>Page 1 of 10</td>
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**Purpose:** To assure that informed consent is obtained from patients in compliance with Louisiana State and Federal law and to protect our patients’ rights to give informed consent.

**Scope:** All University Health Facilities.

**Responsibility:** All personnel who complete/review informed consents.

Informed Consent must be obtained prior to the performance of any invasive procedure involving the puncture and/or incision of the skin or insertion of an instrument or foreign material into the body.

**Procedure:**

A. **General Consent**
   All patients at University Health must have a valid consent prior to receiving treatment. The patient’s signature verifies that the patient has read and understand the consent.

B. **The University Health Informed consent has been designed:**
   1. To provide patients with enough information to make a well informed decision to consent or not for treatment/procedure.
   2. To meet legal requirement
   3. Utilizes the format designated by the Louisiana Department of Health and Hospitals Medical Disclosure Panel.
   4. Is required for procedures/treatments specified by the Louisiana Medical Disclosure Panel and required by University Health for other procedures/treatments.
   5. A specific consent should include:
      a. Specific treatment/procedure
      b. Documentation of the licensed practitioner who will perform the procedure
      c. Purpose of the treatment/procedure
      d. Specific site, including left or right when appropriate
      e. Patient’s diagnosis or condition for which the treatment/procedure is indicated
      f. Risks identified by the Louisiana Medical Disclosure Panel
      g. Risks determined by the patient’s physician
      h. Additional risk particular to the patient due to a complicating medical condition
      i. Reasonable therapeutic alternatives
      j. Patient’s acknowledgment that:
         i. No guarantees have been made
         ii. No information that is inconsistent with the information in the consent documentation has been presented
         iii. An opportunity to disclose and discuss particular concerns/risks/sequences with the physician, and
         iv. An opportunity to ask and have answered any questions has been provided
         v. Presence of a technical representative in the patient care area to provide information on a specific instrument and/or product.
C. Who may give consent In Order of Priority?
   1. Any adult, for himself.
      a. Judicially appointed tutor or curator of the patient, if one has been appointed
      b. An agent acting pursuant to a valid mandate, specifically authorizing the agent to
         make health care decisions (power of attorney)
      c. The patient's spouse, not judicially separated
      d. Adult child of patient
      e. Any parent, whether adult or minor, for a minor child
      f. The patient's sibling
      g. The patient's other ascendants or descendants
      h. In the absence of a-g, an adult friend of the patient my consent as defined by
         Louisiana RS 40: 1159.4(A)3
      i. Any other person temporarily standing in loco parentis whether formally serving or
         not, for the minor under his care and any guardian for his ward with a properly
         executed affidavit. (A copy of the affidavit should be attached to the record.)
      j. A person chosen by the interdisciplinary team, as defined in R.S. 28:451.2
      k. A person chosen by an ad hoc team assembled by an interested person for the
         purpose of addressing the medical decision at issue for any individual with a
         development disability.

* Note: If there is more than one person within the above named class, the consent is given
by a majority of those class members for consultation.

D. Who may obtain consent?
   1. General Consent Medical Treatment is obtained by Admitting or registration staff
   2. Specific Providers
      a. Physicians

      b. Nurse Practitioners may obtain consents for procedures they are credentialed to
         perform.
      c. Physician Assistants may obtain consents when that duty/responsibility for
         performing the procedure has been delegated to him/her by his supervising physician.
      d. Licensed practitioners may obtain consent for procedures that are within their scope
         of practice.

   3. Specific Procedure
      a) Blood Transfusions
         1) Transfusion consents may be obtained by the physician or other health care
            provider who will perform the procedure (give the transfusion).
         2) Transfusion consents are valid for 30 days in an outpatient setting, and for the
            duration of an inpatient hospital stay.

      b) Radiological Procedures
         1) Consent for radiological studies requiring the injection of radiopaque contrast
            media should be obtained by the provider of the medical service or the person
            performing the procedure. For instance: the radiology technician if he/she is
            injecting contrast and performing the study (e.g. CT Scan with contrast, IVPs, etc.).

      c) Immunizations
         1) An immunization consent (Vaccine Administration Record) must be obtained
            before the first immunization is provided to either an adult or child and remains in
            effect until cancelled in writing.
         2) Before each immunization, appropriate written information, specific to the vaccine
            to be administered, must be provided to the patient or parent, appropriately
            documented, and all questions answered.
         3) Patients and parents have the right to refuse any immunization, as long as that
            refusal is documented and the dangers of contracting the specific disease
            explained.
E. Who may witness consent?
   1. Another physician
   2. Medical student
   3. Nurse
   4. Secretary
   5. Clinical Assistant
   6. Any adult

*Note: Being a witness to the signing of the consent means that the patient’s identity has been verified and that the patient was not coerced. Witnessing does not indicate or imply responsibility for informed consent.

F. Minors (Age <18)
   1. When can minors consent to treatment without parental authorization?
      a. Treatment of self for substance abuse
      b. Treatment of self for venereal disease
      c. Treatment of self for any procedure associated with pregnancy or childbirth
      d. Donation of blood – Must be seventeen years old and must not receive compensation for the donation of blood
      e. Emancipated minors may consent without parental consent for all procedures/treatments
   2. R.S. 40:1079.1 states no suit may be brought under the Minor Consent Law expect for negligence, thus, obtaining only the minor’s consent in legal liability for any defect in obtaining consent to perform a procedure.
   3. A minor cannot consent to be sterilized.
   4. The physician may choose to give information to or withhold information from the spouse, parent, or legal guardian without the minor’s consent and over the express objection of the minor.
   5. The physician assures that the minor understands the content of the consent.
   6. When a parent is present and the minor objects a minor has no right to refuse treatment when that treatment is consented to by his parents and proposed by a licensed physician.

G. Prisoners
   1. When can prisoners consent to treatment?
      a. Consents for procedures should be obtained from prisoners for all procedures that require informed consent just like all other patients.
      b. Juvenile Offenders – Juvenile offenders have the same rights as other juvenile patients. Consents should be dealt with in the same manner as any other minor with consent obtained from the parent, when possible.
2. When can prisoners refuse treatment?
   Prisoners may refuse any and all treatment, except in exceptional circumstances:
   a. Inmates condition relates to certain contagious or infectious diseases
   b. Inmates with Mental illness and/or intellectually disabled may be treated for 15 days if necessary to prevent harm or injury to the inmate or others. This is allowed after a properly completed physician’s emergency commitment (PEC) declaration has been completed. Beyond 15 days, a court order is required (R.S. 15:830). Additionally a court order is always required before a major surgical procedure or for electroshock therapy.
   c. If a prisoner refused health care examination, testing, or treatment, a qualified health care professional should discuss the matter with the prisoner and document in the prisoner’s health care record both the discussion and the refusal.

H. Patients with Mental Illness
   When can patients with mental illness refuse treatment?
   Patients under Physician Emergency Commitment (PEC) are not required to agree to medical treatment or procedures, with the exception of shock or surgical procedures. These exceptions require a court order. Routine medical and psychiatric procedures and/or treatments may be performed without the patient’s consent.
I. How long is the consent valid?
   1. Treatment protocols, such as chemotherapy, radiation therapy, or outpatient dialysis require consent prior to initiation but not with each subsequent visit for the same treatment protocol.
   2. The General Consent for Medical Treatment is valid for the entire hospital stay.
   3. Outpatient General Consents for Medical Treatment and Surgical procedures are valid for twelve months.

J. When must a new consent be obtained?
   1. Different Operation – When the planned procedure is different from the original operation or changes in a material way.
   2. Cancelled Procedure – If the procedure is cancelled following the induction of anesthesia.
   3. New Operative Event – If the patient returns to the OR for a procedure related or unrelated to the original procedure or due to complications of the original procedure, this is a new operational event and a new consent would be required.

K. How long must one wait to obtain consent if the patient has received a narcotic or sedative?
   There is no set time. The provider uses his/her judgment to determine if the patient is capable of making an informed consent decision and documents that fact in the medical record.

L. How is consent obtained if the patient cannot give consent and no authorized person is present?
   1. You may obtain the consent by fax, telephone, or e-mail.
   2. These routes may be used only in an emergency and the person authorized to consent for the patient cannot timely come in and sign consent.
      a. Provider who is capable and credentialed to do the procedure must provide information to the person who is going to give consent.
      b. The person giving consent must:
         1) Identify himself/herself
         2) Affirm his/her relationship to the patient
         3) Grant or deny his/her approval of the proposed procedure
         4) State any restrictions
      c. For telephone consents, the provider making the call and another staff member (physician or nurse) must hear and document the information listed above.
      d. The information in the written, informed consent should be included in the information provided to the person giving the consent.
      e. The person giving consent must be given the opportunity to ask any questions and have those questions answered.

M. Where are completed consents kept?
   Consents are scanned into the EHR and then placed in the medical record as soon as possible after signing and become a part of the patient’s permanent record.

N. Changes in Consent
   What procedure is used to make changes to the informed consent?
   a. Any alteration is acceptable as long as it is legible.
   b. Any alteration is made by drawing a single line through the text to be changed and writing the corrected text. (No text is to be obliterated)
   c. Both the patient and the physician or other staff member must initial, date and time any alterations prior to the procedure.
   d. The nurse who identifies a need for a change in the consent should call the physician who obtained consent as soon as possible and prior to the start of the planned procedure.
O. Special Situations

1. Emergency Consents
   What procedure is followed in an emergency when the patient or someone authorized to consent for him/her is not able/available to give written, telephone, facsimile, or e-mail consent?
   a. A licensed independent practitioner must sign the consent.
   b. The nature of the emergency must be documented in the patient’s progress notes.

2. Withdrawal of Consent
   What if the patient has reservations or is hesitant about the procedure or indicates he/she was not informed?
   Report the situation promptly to the provider planning to perform the procedure. The patient may refuse the procedure at any time. Patients should know that there are no consequences for changing their mind.

3. HIV Testing
   HIV diagnostic testing does not require a separate informed consent when it is a part of routine medical screening, unless the patient declines or “opts out” of testing. If a patient declines testing, it shall be noted in the medical record. Before routine testing, oral or written information should be provided to the patient including an explanation of HIV infection and the meanings of positive and negative test results, and the patient shall be offered an opportunity to ask questions.

4. Tubal Sterilizations
   a. In order to meet the requirements of informed consent and federal requirements, every patient must receive an informational session by a non-physician counselor in addition to any information she may have received from a physician. This information session will include discussion of all methods of birth control and the advantages and disadvantages of each.
   b. The patient will also receive information about the permanence of sterilization and the incidence of regret which may accompany the procedure.
   c. The patient will be informed, as required by federal regulations, that her consent may be withdrawn at any time prior to the procedure without threat of loss of health services or other benefits. The patient will also reaffirm her understanding of the reproductive sterilization procedure and its implications by signing a second consent which must be signed within 48 hours prior to the procedure. The consent will be scanned into the “Media Manager” section of the EHR after the patient has signed and dated the consent.

1) Eligibility for Sterilization
   Patients eligible for reproductive sterilization must be at least 21 years of age and legally competent.
   Patients requiring reproductive sterilization will not be denied sterilization because of their marital status, number of children, age, ethnicity, religion, as long as they are over 21 and are legally competent.
   Spouses are encouraged to participate in the decision for sterilization; however, you cannot require that a married individual have a spouse present or sign the consent as a prerequisite to the performance of the procedure.
   The procedure must not be medically contraindicated.
   Initial consent may not be elicited from a patient during admission or hospitalization for childbirth or abortion or other medical treatment. Consent obtained during these times will be presumed involuntary.
2) Consent Time Line

Consent for reproductive sterilization is unique among consents because it has specific time requirements.
Reproductive sterilization may not be performed sooner than thirty (30) days following the giving of the initial informed consent by the patient except in special circumstances.
Note: A woman who has completed the appropriate forms and information sessions and who signs the required consent form thirty (30) days prior to her anticipated delivery date may be sterilized in less than thirty (30) days if she delivers prior to her anticipated date or she is undergoing abdominal surgery, as long as the consent was signed seventy-two (72) hours before the procedure or delivery.
The consent is good from 30 to 180 days after its proper completion.

3) 2nd Consent

All patients must sign a statement reaffirming their request and consent to reproductive sterilization upon admission for the procedure.

4) Right to Refuse Sterilization

All patients must be given assurance orally and in writing that if they choose not to be sterilized, they will not lose any benefits or medical services and that they can change their mind at any time prior to the operation.
Medical services cannot be delayed or withheld while a person is considering reproductive sterilization.

5) Form Requirements

The federally approved consent form must be used.
All counseling forms should be documented in the patient’s medical record.
The consent forms should be placed in the patient’s permanent record.
The federally approved consent form must be read orally in the presence and hearing of a witness. If a woman appears for delivery, full-term or pre-term, at a hospital other than that at which she has completed the appropriate forms and information session, the receiving hospital shall contact the hospital at which the forms and procedures were completed for verification. This must be noted in the record, with the name and title of the person providing the information, the date that the consent form was signed, and the anticipated delivery date. If the consent form was signed thirty (30) days prior to the anticipated delivery date, this will be sufficient to enable the receiving hospital to perform the sterilization. If the patient presents a duplicate copy of the initial consent duly signed, witnessed and dated at least thirty (30) days prior to the anticipated delivery date, verification may be waived. After completion of procedure, the consent is signed and dated by the attending physician and scanned again into the “Media Management” section of the EHR.

P. Consents for Investigational Research and/or Clinical Trial

1. All participants in a research project or clinical trial must have an informed consent specific to the project present in the medical record.
2. Informed consent is an individual’s voluntary agreement to become a subject of research after having been informed of:
   a. the purpose of the study,
   b. the procedures that are experimental, and
   c. potential discomforts, risks or benefits to reasonable be expected.
3. A legally effective consent form is read to or by the subject and signed by the subject or his/her legally authorized representative.
4. Additional information which must be given to the patient includes:
   a. expected duration of the patient’s participation
   b. selection of patients
   c. alternative treatment procedures available
   d. all financial issues, and
   e. that they may refuse and refusal will not compromise their access to the hospital’s services.

Q. References:

Title 48 Chapter 23
Purpose: To provide guidelines for the transfer and acceptance of patients from other hospitals.

Scope: All University Health Shreveport Facilities.

Responsibility: All departments who receive requests for transfers.

Definitions:

1. An “appropriate transfer” is one in which:
   a. the patient has received an appropriate medical screening exam by a physician and it has been determined that no emergency condition exists or that the patient has received stabilizing treatment.
   b. the receiving facility has available resources and agrees to accept the transfer and provide necessary treatment, and
   c. the transferring facility provides the receiving hospital with a complete copy of the patient’s records and other information (such as copies of X-rays, etc.), and
   d. the transfer is effected through qualified personnel and transportation equipment, including use of necessary and medically appropriate life support measures during the transfer.

2. Emergency medical condition:—
   a. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:
      1. placing the health of the individual (or, with respect to a pregnant women, the health of the woman or her unborn child) in serious jeopardy, or
      2. serious impairment of bodily functions, or
      3. serious dysfunction of any bodily organ or part
   b. With respect to a pregnant women who is having contractions:
      1. that there is inadequate time to effect a safe transfer to another hospital before delivery, or
      2. that transfer may pose a threat to the health or safety of the woman or the unborn child.
   c. Stabilized: with respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to a woman in labor, she has delivered (including the placenta).

Procedure:

A. Transfer of Unstable Emergency and Trauma Patients
   1. Requests from other health care providers to transfer patients who have an emergency medical condition as defined by EMTALA and require emergency and tertiary level medical care not available at that facility should be immediately approved when services, space, facilities, and personnel are available to provide appropriate care.
   a. When the facility making the transfer request is capable of providing the necessary care, that facility must stabilize the emergency medical condition as defined by EMTALA prior to transfer.
   b. If the referring facility is greater than 50 miles from University Health, the Transfer Center RNExpediter will refer the caller to the Louisiana Emergency Response Network (LERN) for all Trauma referrals.
   c. When the transferring facility is requesting the transfer of an unstable patient, the following conditions must be met:
      1. The physician requesting the transfer will verify that the expected benefits of transfer outweigh the risks of transfer and the Transfer Center Nurse accepting this call will document this verification in the Central Logic Log.
      2. There must be patient or family consent when possible.
      3. Attempts made by the transferring hospital, within its capability, to stabilize the patient in order to minimize any risks of the individual during transfer.
      4. Agreement by University Health to accept the transfer, ensuring our capacity and capability to treat the transferred patient.
      5. Delivery of all appropriate medical records to University Health;
      6. The transfer must be made with qualified personnel and transportation equipment.
2. If an emergency patient requires services not available at University Health, the transfer shall be refused with a recommendation to contact another facility with the necessary capability.

3. Request for transfer of a patient shall be initiated by the referring physician contacting the Transfer Center or the LERN Communication Center. The Transfer Center shall facilitate inter-hospital consultations and transfer requests. Transfer requests to the Emergency Department or main hospital switchboard should be routed to the Transfer Center.

4. Consulting the on-call schedule, the Transfer Center RN-Expeditor shall obtain the details of the patient’s medical condition and link the calling physician with the appropriate service at University Health.

5. Once the patient has been accepted by the physician, the Transfer Center shall obtain the necessary information (i.e., demographics, identification card, and insurance information) from the transferring facility. If the patient will be a Direct Admit, the patient’s information will be sent to the Admitting Department. The demographics for Trauma’s /Emergent admissions will be given directly to the Emergency Department charge nurse. The Admitting Department/ House Supervisor shall verify that the necessary resources for admission are available and notify the Transfer Center of such. The Transfer Center shall communicate this to the referring facility.

6. All departments who receive requests for transfer of patients are requested to maintain this policy and procedure statement in a place accessible to faculty, residents, and other personnel to ensure that physicians who are involved in transfers adhere to its content. Questions should be referred to Hospital Administration.

**B. Transfer and Acceptance of Stable Patients**

1. It is the policy of University Health to accept the transfer of stable, non-emergent patients when capacity, facilities, and personnel are available and eligibility guidelines are met (See Hospital Policy 4.B.3 - “Access to Care”). Every effort shall be made to accept patients when the sending facility does not have the capacity, facilities or personnel to provide safe and appropriate care.

2. Transfers of stable, non-emergent patients to University Health may be made by contacting the University Health Transfer Center who will put the requesting physician in contact with a physician.

3. Decisions to refuse a transfer shall be made by or in consultation with an active faculty member and be documented/recorded by the Transfer Center staff.

4. Acceptance of stable, non-emergent patients for transfer to University Health shall be made contingent upon verification of available resources through the House Supervisor or Admissions Coordinator and patient eligibility for access to care at University Health. These patients should be directly admitted to hospital units when the capability and capacity are available.

5. **Exceptions to direct admissions should be rare and must be approved by the Emergency Department faculty.**

6. The University Health Transfer Center RN-Expeditor who facilitated the direct admission to a patient care unit will ensure that report regarding the patient’s medical condition is given to an RN on the patient care unit where the patient will be admitted.

7. Active members of the medical staff may designate other members of the medical staff to accept transfers on their behalf.

8. For non-emergent, non-state residents see Hospital Policy 4.C.5.
Purpose: To prevent wrong patient, wrong procedure, or wrong site surgeries by providing patient care providers with specific expectations and procedures to follow throughout the perioperative process. To assure availability of all relevant documents, implants, equipment and supplies to prevent delays and cancellation of surgeries. To improve overall patient care and safety by improving communication among patient care providers.

Scope: All University Health Shreveport Facilities.

Responsibility: All staff and partners responsible for providing care during operative procedures.

Procedure:
A. Pre-Procedural Verification
   1. Pre-procedural verification requires a review and documentation of all necessary requirements that includes:
      a. Verification:
         1) The correct patient with two identifiers (name and date of birth)
         2) The correct site
         3) The correct procedure to be performed
      b. History and Physical examination (H&P) for patients receiving moderate sedation or anesthesia and validation as needed.
         1) An appropriate H&P clearly documents the reason for the procedure and must have been completed within thirty (30) days of the procedure.
         2) For all Inpatients, Outpatients and Same Day admissions, H&Ps are validated the day of admission, or within 24 hours.
      c. Consistency between the OR/procedure schedule, MD order/progress note and signed consent.
      d. Consent with correct patient, procedure, and site.
         1) The consent form must specify laterality (right/left distinction), multiple structures (such as fingers and toes), or multiple levels (as in spinal procedures).
         2) If the anesthesia department is not involved, the type of anesthesia/analgesia/sedation to be used by the physician performing the procedure must be indicated.
         3) No abbreviations are permitted.
         4) Follow the consent policy 4.A.8: Informed Consent.
      e. Labeled diagnostic and radiology test results properly displayed (i.e. radiology images and scans, pathology and biopsy results, etc.)
      f. Any required blood products, implants, devices and/or special equipment for the procedure.
B. Pre-Procedure Site Marking

1. At a minimum, pre-procedure sites are marked when there is more than one possible location for the procedure and when performing the procedure in a different location would negatively affect quality or safety.

2. The procedures that require site marking include:
   a. Laterality (right/left distinction)
   b. Multiple structures (such as finger and toes)
   c. Multiple levels (such as the spine)

3. Exceptions for marking include:
   a. Procedures involving single organs (such as the uterus, bladder, or gallbladder).
   b. Bilateral procedures will not be marked.
   c. Procedures that do not involve laterality, multiple structures or multiple levels.
   d. Gynecological and urological procedures entering a natural orifice and involving laterality (i.e. right or left ureteroscopy) when a mark may not be visible after positioning and draping or when it is impractical to mark the site.
   e. C-sections do not need to be marked.
   f. Teeth are not marked, but the operative tooth name/number must be included on documentation, X-rays, and site confirmation.
   g. When the insertion site is not predetermined as with a Portacath, Groshong, pacemaker, triple lumen catheters, or any central line when both sides are prepped.
   h. Open wound or lesion. If there is an open wound or lesion that is the site of the intended procedure, site marking is not required unless there are multiple wounds or lesions and only some of them are to be treated. If the decision as to which ones are to be treated will be made prior to the procedure itself, then the specific sites to be treated will be marked before the patient is taken to the OR. The mark(s) will be made as close the lesion(s) as possible.

4. Marking the procedure site includes the following:
   a. The physician performing the procedure is responsible for assuring the site is appropriately marked. An attending physician may delegate the responsibility to a resident (House Officer Level) or Advanced Practice Nurse (APN) under his supervision who is to participate in the procedure, the attending physician is ultimately accountable for the procedure.
   b. The site must be marked with the word “SS”.
   c. The mark with remain visible after the site is prepped and when draped.
   d. The site is marked prior to the procedure.
      1) Operative and interventional areas must have the site marked prior to entering suite.
   e. When possible, the patient should be involved in the marking of the site.
   f. Any exception to surgical site marking such as patient refusal or impracticality (i.e., seriously burned patient) is documented in the progress note by the physician.

5. If the patient refuses site marking:
   a. Provide the patient with information describing the importance of site marking.
   b. If the patient still refuses site marking after describing the importance, the patient’s refusal and verification will be documented in the medical record.
C. Time-Out

1. The physician performing the procedure is responsible for assuring the time-out is completed correctly. An attending physician may delegate the responsibility to a designated member of the team; however he/she is ultimately accountable for the process.

2. The time-out requires a pause in activity and must be conducted in the location where the procedure is done just prior to starting the procedure.

3. In the OR, the time-out is initiated by the circulating nurse and at a minimum includes:
   a. Attending Surgeon or designee which is a member of the surgical team that is capable of initiating the procedure.
   b. Anesthesiologist/CRNA
   c. Scrub Tech/Nurse
   d. Circulating Nurse

4. In non-operating sites, the person performing the procedure is responsible for initiating the time-out and includes health care personnel present.

5. The following elements must be verbally verified during the time-out process.
   Correct patient identity
   a. Correct site and side (site(s) marking is visible)
   b. Correct surgery/procedure to be performed (informed consent document matches the intended procedure)
   c. Correct patient position
   d. Correct implant and equipment availability
   e. Correct imaging data reviewed
   f. Prophylactic antibiotics have been infused within the appropriate time frame when applicable.

6. If the person performing the procedure or if the surgical site changes, another time-out is to be performed to confirm each subsequent procedure before it is initiated.

7. If there is a discrepancy at the time-out, the procedure must not start or proceed until all discrepancies are resolved.

8. Document the completion of the time-out.

D. The time out procedure is not required in emergent situations where delay of care may result in patient harm.

References


Purpose: All medical record entries, including handwritten and electronic (EHR), must be legible, complete, dated, timed and authenticated by the person responsible for providing care for every individual who is evaluated or treated as an inpatient, outpatient, or emergency patient at University Health.

Scope: All University Health Facilities.

Responsibility: All providers of patient care at University Health Facilities.

Procedure:
A. Content of the Medical Record
1. The content of the medical record, which includes written and electronic documentation, must enable:
   a. the practitioner responsible for the patient to identify the patient, provide continuing care, determine the patient’s condition at a specific time, review the diagnosis and therapeutic procedures performed and the patient’s response to treatment
   b. a consultant to render an opinion after a patient examination and review of the medical record
   c. another practitioner to assume patient care at any time
   d. the review of information required for case management, utilization review, quality review, transfer recommendations, etc.

2. Standard Terminology and Discrete Data: Use standard medical terminology to support using the database for population management and research and promote consistent coding.

3. Smart Documentation: Use of preference lists, Smart Text, Lists, Forms, and letter templates within clinical specialties will insure consistency of documentation.

4. Foster Preventative Services: All clinicians and staff should take an active role in documenting completion of preventative services and encouraging patient compliance with recommendation.

5. Feedback: Clinician feedback is needed to continually improve documentation and maximize appropriate use of best practice alerts, and other decision support tools.

6. The medical record contains the following demographic information:
   a. Patient’s name, address, date of birth and the name of any legally authorized representative
   b. Patient’s sex
   c. Legal status of any patient receiving behavioral health care services
   d. Patient’s communication needs, including preferred language for discussing health care.
7. The medical record contains the following clinical information:
   a. The Problem List should be actively managed by specialist and primary care clinicians. Inactive
      problems should be "retired" to the PMH or PSH and either deleted or resolved in the Problem List.
      Any clinician may refine the problem to the most specific diagnosis based on best clinical judgment. A
      brief note in the "overview" section should be used to provide highlights, status of workup or key
      additional information for each problem.
   b. The patient’s initial diagnosis, diagnostic impression(s) or condition(s), and any changes throughout
      stay
   c. Any findings of assessments and reassessments
   d. All allergies to include, food, latex and medications
      i. Update of medications and allergies must be documented by specialists and primary care
         clinicians in the medication section and allergy sections respectively for each change presented
         by the patient. Duplicate and inactive medications should be appropriately deleted.
   e. Any observations, responses, conclusions, impressions, or consultations drawn from the patient’s
      medical history and physical examination
   f. All inpatient, Emergency Department and outpatient encounter documentation
   g. Any operative or other high risk procedure or administration of moderate/deep sedation/anesthesia.
   h. Any medications ordered, prescribed, administered including the strength, dose, frequency and route
   i. Any adverse drug reactions
   j. Treatment goals, plan of care, patients response to treatment, and revisions to the plan of care
   k. Results of diagnostic and therapeutic tests and procedures
   l. All airway, drains and lines
   m. Discharge diagnosis, plan and discharge planning evaluation. Any medications dispensed or prescribed
      on discharge
   n. Any advance directives, DNR
   o. Any informed consent, when required by hospital policy
   p. Any records of communication with the patient, such as telephone calls or email
   q. Any patient-generated information

8. A summary list (Snapshot) is initiated for the patient by his or her third visit and updated with changes.
   The patient’s summary list contains the following information:
   a. Any significant medical diagnoses and conditions
   b. Any significant operative and invasive procedures
   c. Any adverse or allergic drug reaction
   d. Any current medications, over-the-counter medications and herbal preparations
B. Chart Rules and Regulations

1. **Timeliness:** The complete history and physical examination shall be completed within the first 24 hours of admission, this includes observation patients. Medical records should be completed within four (4) business days or immediately for urgent and evolving cases. Where dictation is used, the clinician should complete the initial dictation with this timeframe. Records not completed within 30 days of discharge are considered delinquent.

2. **History and Physical Examination**
   a. H&P’s not completed at the time of admission, (i.e., old H&P up to 30 days) must be updated within 24 hours of the inpatient admission, and prior to surgery or a procedure requiring anesthesia services.
   b. Upon admission, the patient shall be examined and the following entered into the EHR: patient examined, H & P reviewed and no changes noted or document any changes or additions to H&P.
   c. The history should include the following:
      1) Chief complaint
      2) Present illness
      3) Relevant past, family, and social histories, appropriate for age (including tobacco, alcohol and other substance use)
      4) Review of body systems, including the presence of preexisting medical devices (e.g. indwelling catheter, central line), the devices’ condition and current impact on the patient; ordering the appropriate lab to verify preexisting infections, etc.
      5) Immunization status for the adult patient with a preliminary diagnosis of Heart Failure or Pneumonia, the vaccine history related to pneumococcal and influenza shall be documented
   d. The physical examination shall reflect the following minimum documentation requirements: A general multi-system examination and/or an extended examination of the affected body area(s) and other symptomatic related organ(s).
   e. The recorded history and physical examination must be authenticated by a practitioner privileged to do so.
   f. When a patient is readmitted within 30 days for the same or related problem, an interval history and physical examination reflecting any subsequent changes may be used in the medical record.

C. **History and Physical Examination (Outpatient Surgery)**

1. The outpatient history must include the following for outpatient surgery:
   a. Complete H&P
   b. Indications/symptoms for surgical procedure
   c. Current medications (dosages/frequency)
   d. Any known allergies, including medication reactions
   e. Existing co-morbid conditions, if any.
2. The extent to which the patient’s physical status must be entered is to be reflective of the type of anesthesia planned and/or given, according to the following:
   a. No Anesthesia or Local/Topical or Regional Block:
      i. Vital signs
      ii. Assessment of mental status; and
      iii. An examination specific to the procedure proposed to be performed and any co-morbid conditions.
   b. Procedural Sedation must comply with policy 4.D.3: Sedation

D. Complete Physical Examination
   Note: Anesthesia combinations require a physical relevant to the highest level of anesthesia provided.

E. Informed Consent must be present and comply with policy 4.A.8: Informed Consent.

F. Operative Reports or Other High Risk Procedure
   1. An operative or other high-risk procedure report is entered into the EHR or dictated upon completion of the operative or other high-risk procedure and before the patient is transferred to the next level of care.
   2. When a full operative or other high-risk procedure report cannot be entered immediately into the patient’s medical record after the operation or procedure, a brief progress note is entered into the medical record. The progress note and the dictated operative report must include the following:
      a. The name(s) of the licensed independent practitioner(s) who performed the procedure and his or her assistant(s)
      b. Procedure performed
      c. A description of the procedure
      d. Findings of the procedure
      e. estimated blood loss
      f. specimens removed
      g. The Postoperative diagnosis
   3. The surgeon must authenticate the completed operative report as soon as possible following surgery.

G. Postoperative information:
   1. The patient’s vital signs and level of consciousness
   2. Any medications, including intravenous fluids and any administered blood, blood products and blood components
   3. Any unanticipated events or complications and the management of those events
   4. The patient was discharged from the post-sedation or post anesthesia care area either by the licensed independent practitioner responsible for his or her care or according to discharge criteria. The medical record contains the use of approved discharge criteria that determine the patient’s readiness for discharge
   5. The postoperative documentation contains the name of the licensed independent practitioner responsible for discharge.
H. Progress Notes
1. The admission progress note should summarize the present illness, pertinent past history, the pertinent physical and laboratory findings, the initial impressions of the physician and the initial diagnostic and therapeutic plan.
2. Progress notes (reassessments) should give a pertinent chronological report of the patient’s course in the hospital and should reflect any change in condition, the result of treatment and plans for future care.
3. An authenticated progress note is required daily to document medical necessity and acute level of care.
4. Progress notes should reflect the involvement of the attending physician in the patient’s care.

I. Consultations
1. Consultation reports shall be a part of the patient’s medical record and shall show evidence of a review of the patient’s record by the consultant, pertinent findings on examination of the patient, the consultant’s opinion, the consultant’s recommendations and the signature of the consultant.
2. An order for a routine consultation shall be entered into the EHR. The reason for the consultation must be entered. The physician or his/her designee requesting the consultation is responsible for contacting the service to be consulted. A monthly listing of designated consultants for each Clinical Service is published and distributed each month to all patient care areas for utilization by the requesting physicians. Problems obtaining consultations should be directed to the attention of Hospital Administration. Inpatient consultations shall be answered within 24-hours.
3. An order for an outpatient ambulatory referral shall be entered into the electronic medical record. The outpatient ambulatory referral does not require physician to physician contact.
4. An order for an Emergency or ‘stat’ consultation shall be entered into the electronic medical record. The physician will notify the Clinical Service directly of the need for the consultation, giving the patient’s name and location. Emergency or “stat” consultations should be answered within one hour of notification.
5. Professional Consulting Services (i.e. Nutritional Services, PT/OT, WOCN) may Save orders for physicians to review and release once a consult is complete. The service will Save orders that are within their scope of practice. All other recommendations that require orders shall be placed in the Physician Sticky Note.
6. To Save an order the end users chooses “Save” rather than “Sign” and must designate a reason for Saving. The MD then may view “Saved Orders”, open and either delete or release as appropriate.

J. Diagnostic and Therapeutic Orders (Verbal and Telephone Orders)
1. Verbal Orders shall be minimized and authenticated within five days of the date authorized.
2. It is prohibited for physicians and other practitioners to text orders for patient.

K. Transfers
When a patient is transferred within University Health, from one service to another or from one level of care to another, a transfer note shall be entered into the EHR. This note should briefly describe the patient’s condition at the time of transfer and the reason for the transfer.
L. Discharge Summary

1. The discharge summary should be completed before or shortly after the time (10 days) of inpatient discharge from the facility and should follow the following approved format:
   a. Hospital Service
   b. Attending/Resident Physician
   c. Referring Physician or Clinic
   d. Admission/Discharge Date
   e. Discharge Diagnosis (documented without the use of abbreviations or symbols):
   f. Reason for Hospitalization
   g. Significant Findings (physical and laboratory)
   h. Hospital Course
   i. Procedures performed and care, treatment and services provided
   j. Condition on discharge (measurable comparison with condition on admission - able to swallow with minimum difficulty; afebrile and ambulating with crutch, no signs of infection, etc.)
   k. Information provided to the patient and family (i.e., diet, medication, activity and follow-up, other discharge instructions)
   l. Provisions of the follow-up care
2. A final progress note can be substituted for the discharge summary only for those patients with problems and interventions of a minor nature who require less than a 48-hour period of hospitalization and in the case of normal newborn infants and uncomplicated obstetric deliveries. The progress note documents the patient’s condition at discharge, discharge instructions and required follow up.

3. In the case of death, the discharge summary is replaced by a death summary stating essentially the same information, plus a summary of events immediately prior to death, including the cause of death as well as the date and time of death.

4. In the case of a patient leaving "Against Medical Advise" (AMA), the summary or progress note should include the same information, including events leading up to the patient’s departure.

5. All discharge summaries shall be authenticated by the responsible practitioner.

M. Countersignatures
1. All written or electronic entries by physician extenders (physician assistants, advance practice nurses, etc.) shall be reviewed, and authenticated by the supervising physician when required by licensing board and or the department within 24 hours for inpatients and within 72 hours for clinic and other practice settings.
2. The physician extender (physician assistant, advance practice nurse, etc.) and the supervising physician shall insure that all activities, functions, services, treatment measures, medical devices or medications prescribed or delivered to the patient by the physician extender are properly documented into the EHR.

N. Scanned Documents
1. Paper documents may be scanned into the EHR under Media Manager.
2. Documents may be scanned to the Patient, Encounter or Order level.
3. Documents should be scanned with the magnification of Actual size. Other options may cause the image to appear blurry and unreadable.

O. Achieving Mastery: Every Clinician should strive to improve their efficiency of practice by achieving Epic Basic User status within 6 months and progressing to Epic Master User within two years of joining the group practice.

P. Entries in the electronic health record may be corrected only by the ‘user’ (the individual who documented incorrectly).
1. Medical record entries shall be entered in the electronic health record at or near the time services are provided, except when the system is unavailable.
2. During downtime, the electronic health record downtime procedures shall be followed along with these record keeping practices.
   a. All medical record entries must be legible, dated, timed and signed
   b. Black or blue ink is recommended
   c. Signatures shall include the first name, last name, licensure status and page number
   d. Errors shall be corrected by drawing a single, thin line through each line of incorrect information, dating and initialing the error and entering the corrected information in chronological order indicating which enter the correction is replacing.
Purpose: To provide accurate communication among health care providers at University Health by providing a standard abbreviation process and defining a list of “Do Not Use” abbreviations.

Scope: All University Health Shreveport Facilities.

Responsibility: All staff and partners of University Health.

Procedure:

1. The Pharmacy and Therapeutic Committee and the Medical Records Committee, approves and publishes a list of ‘Do Not Use’ Abbreviations in medical record documentation.

2. The use of abbreviations in making entries in the paper or electronic health record is not recommended. The facility recognizes Neil Davis, Medical Abbreviations as a guide for abbreviations and symbols.

3. The Governing Board has adopted the following abbreviations as prohibited abbreviations (applies to all medical record entries – paper and electronic)

<table>
<thead>
<tr>
<th>Prohibited Abbreviations</th>
<th>Potential Problem</th>
<th>Preferred Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>U, u (unit)</td>
<td>Mistaken as zero, four, or cc</td>
<td>Write unit</td>
</tr>
<tr>
<td>IU (international unit)</td>
<td>Mistaken as IV or 10</td>
<td>Write international unit</td>
</tr>
<tr>
<td>QD, Q.D., q.d, q.d., Q.O.D., QOD, q.o.d., qod (Latin abbreviation for once daily and every other day)</td>
<td>Mistaken for each other. The period after the Q can be mistaken for an “IV” and the “O” can be mistaken for “IV”</td>
<td>Write daily and every other day.</td>
</tr>
<tr>
<td>X.O - trailing zero . X mg – lack of leading zero</td>
<td>Decimal point missing</td>
<td></td>
</tr>
<tr>
<td>MS, MSO₄, MgSO₄</td>
<td>Confused for one another. Can mean morphine sulfate or magnesium sulfate.</td>
<td>Write morphine sulfate or magnesium sulfate</td>
</tr>
</tbody>
</table>

4. The prohibited list applies to all orders, preprinted forms, and medication-related documentation. Medication-related documentation can be either handwritten or electronic.
Overview: The Information Security HIPAA Policy is intended to ensure compliance with the Health Insurance and Accountability Act. This policy will increase protection of Protected Health Information and Electronic Protected Health Information.

Purpose: In compliance with the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d), University Health has adopted the following Information Security Policy to ensure reasonable protection of Protected Health Information ("PHI") and Electronic Protected Health Information ("EPHI"). It is the intent of this Policy to act as a supplement to, not a replacement for, the University Health's data and computer security policies.

Scope: This Policy is limited to University Health employees, contractors, agents, and applies to the security of PHI and EPHI (as defined by the Code of Federal Regulations 45 C.F.R. 160.103) as well as the security of any Information Systems that store or process EPHI. This Policy also applies to technology service providers, either internal or external to University Health.

Maintenance
These Policies will be reviewed by the University Health Information Security Director on an annual basis or as deemed necessary based on changes in technology that effect the protection of PHI and EPHI or as needed to mitigate identified risks. In accordance with the Code of Federal Regulations, 45 C.F.R. 164.316(b)(2)(i), all iterations of this Policy will be retained for a minimum of 6 years.

Enforcement
Violations of this Policy may result in suspension or loss of the violator’s user privileges, with respect to University Health Information Systems, and/or discipline up to and including termination of employment or contractor status with University Health. Reporting to law enforcement may be required where as additional civil, criminal and equitable remedies may apply.

Roles and Responsibilities

Compliance Officer:
The Compliance Officer is a University Health employee who is responsible for coordinating compliance with the HIPAA Security Rule as defined by the Code of Federal Regulations, 45 C.F.R. 160, 162 and 164. Each Covered Entity must designate a Compliance Officer as required by the Affordable Care Act. The Compliance Officer may delegate his or her responsibilities to other University Health employees.

The Compliance Officer is responsible for:
1. Understanding how PHI and EPHI are used within University Health and by any Business Associate of University Health.
2. Understanding relevant security and privacy requirements dictated by HIPAA and other applicable laws.
3. Implementing appropriate procedures to support this Policy.
4. Implementing a recurring awareness program to ensure University Health personnel understand their obligations under this Policy.
5. Ensuring University Health adheres to this Policy and its supporting procedures.
6. Ensuring that any exceptions to this Policy or its supporting procedures are acknowledged by the Information Security Director and formally documented.
7. Coordinating with the Information Security Director to identify and evaluate threats to the confidentiality and integrity of PHI and EPHI.
8. Coordinating with the Information Security Director to respond to actual or suspected breaches in the confidentiality or integrity of PHI and EPHI.

Information Security Director:
The Information Security Director is responsible for development and implementation of Information Security Policies. University Health shall appoint an Information Security Director as required by 45 C.F.R. 164.308(a)(2).

The Information Security Director is responsible for:
1. Understanding how PHI and EPHI are used within University Health and by any Business Associate of University Health.
2. Understanding relevant security and privacy requirements dictated by HIPAA and other applicable laws.
5. Ensuring University Health adheres to this Policy and its supporting procedures.
6. Ensuring that any exceptions to this Policy or its supporting procedures are acknowledged by the Compliance Officer and formally documented.
7. Coordinating with the Compliance Officer to identify and evaluate threats to the confidentiality and integrity of PHI and EPHI.
8. Coordinating with the Compliance Officer to respond to actual or suspected breaches in the confidentiality or integrity of PHI and EPHI.

User:
For the purpose of this Policy, a User is any University Health employee, contractor, or agent who is authorized to access University Health Information Systems provided by or for University Health.

A User is responsible for:
1. Abiding by this Policy and its supporting procedures.
2. Reporting actual or suspected vulnerabilities in the confidentiality or integrity of PHI and EPHI to the Compliance Officer.
3. Reporting actual or suspected breaches in the confidentiality or integrity of PHI and EPHI to the Compliance Officer.
4. Reporting suspicious requests, uses, or disclosures for PHI or EPHI to the Compliance Officer.

Principle Information Security Policies:
University Health shall:
1. Issue specific Information Security Policies.
2. Utilize risk management processes to include conducting an annual risk analysis that involves a risk
assessment, at a minimum, to measure the potential risks and vulnerabilities to the confidentiality, integrity and availability of PHI and EPHI.
3. Implement reasonable, appropriate, and compliant administrative, technical and physical safeguards to protect the confidentiality, integrity and availability of PHI and EPHI.
4. Deploy virus and malware protection across the University Health network which houses EPHI.
5. Prior to conducting business with a third party that involves the storage or processing of PHI and EPHI, University Health must coordinate with the third-party to sign a Business Associate Agreement that includes provisions for the third-party to reasonably safeguard PHI and EPHI.

Access Control:
Access to PHI and EPHI must be:
1. Authenticated in such a manner as to positively and uniquely identify the user.
2. Authorized by a designated Data Owner.
3. Consistent with the rule of least privilege, meaning a user is granted the minimum level of access necessary to perform authorized job responsibilities.
4. Logged.
5. Reviewed and audited annually, at a minimum, to ensure such access is still appropriate.
6. Revoked when such access is no longer necessary to perform authorized job responsibilities.
7. University Health does not own or operate a healthcare clearing house.
8. All accounts that can be used to access PHI and EPHI must be protected with a strong password as defined by the Information Security Director.
9. All Information Systems that store, process or otherwise access PHI and EPHI, including User workstations, must be configured such that:
   a. A screen saver is activated after a period of inactivity.
   b. The Information System locks, requiring re-authentication, after a period of inactivity.
   c. Open sessions are automatically disconnected after a period of inactivity.

Business Continuity Management
University Health shall:
1. Maintain retrievable backup copies of all PHI and EPHI that must also meet the requirements of this Policy.
2. Periodically test the effectiveness of backup copies of PHI and EPHI.
3. Develop, implement and maintain a Business Continuity and Disaster Recovery Plan that includes provisions for the continuity of Information Systems that store or process PHI and EPHI.

Employee Owned Assets:
1. Employee owned Information Systems must not be used to store or process EPHI.
2. Encryption - All PHI and EPHI must be encrypted during transmission over public networks such as the Internet.
3. University Health must take reasonable compliant measures to encrypt stored EPHI.
4. Information Security Awareness - All employee, contractor, or agents of University Health must undergo
periodic security awareness training specific to the requirements of HIPAA.

Information Security Breaches:
1. University Health must regularly monitor Information Systems, that store or process EPHI, for security events.
2. All security incidents must be addressed in a manner that is consistent with state laws, federal laws and procedures published by the Information Security Director.

Physical Security:
1. All employee, contractor, or agents of University Health must be positively and uniquely identified prior to gaining physical access to Information Systems that store or process EPHI.
2. Physical access to Information Systems that store or process EPHI must be controlled in a manner that prevents unauthorized physical access.
3. All repairs and alterations to physical security controls that aid in the protection of PHI and/or EPHI must be documented and available for review by the Compliance Officer.
4. All recycling and disposal of electronic storage media that is used to store EPHI or that was previously used to store EPHI must be consistent with NIST guidance and procedures published by the Information Security Director.
5. All physical relocation of Information Systems that store or process EPHI must be documented and available for review by the Compliance Officer.
6. University Health personnel must maintain a workspace that is clear of PHI or EPHI whenever that workspace is unattended.

Glossary

Electronic Protected Health Information ("EPHI")
1. Individually identifiable health information transmitted by electronic media or maintained in electronic media.
2. Health Information
3. Any information, whether oral or recorded in any form or medium, that is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or healthcare clearinghouse; and that is related to the past, present or future physical or mental health condition of an individual, the provision of health care of an individual, or the past, present or future payment for the provision of healthcare to an individual.
4. Individually Identifiable Health Information
5. Any health information, as defined above, that identifies an individual or where there is reasonable basis to believe that the information can be used to identify an individual.

Information Systems
1. Any electronic system that stores or processes information. An electronic system includes but is not limited to hardware components, software components and raw network data. Examples include:
2. Personal computers whether standalone or connected to a network
3. Servers whether standalone or connected to a network
4. Network devices such as routers and switches
5. Handheld computing devices such as PDAs and smart phones
6. Telephone equipment such as a VoIP system or facsimile machine
7. Operating systems such as Microsoft Windows, UNIX and/or Mac OS
8. Commercial, open-source or in-house developed applications
9. Commercial, open-source or in-house developed databases
10. Storage devices such as CD, DVD, USB drive or magnetic tape
11. Internet facing and private websites

Protected Health Information
Individually identifiable health information transmitted by electronic media, maintained in electronic media or transmitted or maintained in any other form or medium.

As defined by the Code of Federal Regulations, 45 C.F.R. 160.103. Definitions may be modified from their original form for the sake of clarity.
Purpose: To assure appropriate processing of a medical order for physician consultation.

Scope: All University Health Shreveport Facilities.

Responsibility: All staff and partners of University Health.

Procedure:
1. An order for a consultation shall be placed in the electronic health record (EHR). All consults must include the reason for consultation.

2. Physician (or designee) to physician (or designee) contact must be made by the consulting service to the consultant.
   a. Routine inpatient consults should be answered within 24 hours.
   b. Emergency or stat consultations shall be requested only when there is an emergency or urgent need for the consultation. Urgency must be communicated during the physician to physician contact.
   c. Emergency Department consults should be answered within ONE HOUR. Once the consult service writes orders or submits admission orders the patient becomes the responsibility of the consult service. The consult service should notify the ED physician of their plan BEFORE leaving the ED. In the event of a conflict as to which services is the most appropriate one for the patient, the Attending Physicians of the involved services should be contacted. If the Attending Physicians do not agree, the Medical Director or designee will determine the final disposition of the patient.
   d. Consults will not be placed on paper forms except during periods where the EHR is not functioning.

3. The consultation will be answered using the EHR.

4. A monthly listing of designated consultants for each clinical service is published and available at the Switchboard.

5. Problems obtaining consultations should be directed to the attention of Hospital Administration or Chief Medical Officer.

6. The consultant physician shall evaluate the patient and complete the consultation request in a timely manner. Consults determined to be inappropriate (patient’s medical condition not consistent with, or services needed not provided by, the consult service) are returned to the referring service with an explanation via the EHR.

7. The consultant shall make recommendations regarding testing, medications, and subsequent management.

8. The consultant should stipulate his plan of continued involvement and sign off the case when appropriate.

9. If additional input from the consultant is needed at a later date, a new consultation order should be initiated.
Purpose: All staff, partners, students and patients of University Health have the right to expect a safe and healthy environment.

Scope: All University Health Facilities.

Responsibility: All employees, consultants, partners, vendors, contractors, and students of University Health Shreveport.

Policy:
Possession of weapons, alcohol or drugs on grounds or into buildings of University Health or any other is prohibited by Louisiana Law. It is clear that weapons (firearms, explosives, knives with blades six or more inches in length, straight razors, etc.) constitute an unacceptable threat to the safety of employees, patients and visitors. The discovery of such unlawful items will be addressed by contacting University Police Department (UPD) immediately 675-6165.
Purpose: To establish a clear system for hospital-wide online reporting of information related to medical/health care not consistent with the standard routine operations of the hospital and its staff. To provide a confidential mechanism of identification, tracking, trending, and follow-up of all processes that poses an actual or potential safety risk to patients, families, visitors, and staff.

Scope: All University Health Facilities.

Responsibility: All employees and partners of University Health.

Definitions:
Variances - defined as any event or circumstance not consistent with the standard routine operations of the hospital and its staff or the routine care of a patient/visitor.

Adverse Event – any event which is not consistent with routine patient care or the routine operation of the facility, and which adversely affects or has the potential to affect the health, life or comfort of the patient and is not caused by the patient’s underlying disease.

Disclosure – communication of information regarding the results of a diagnostic test, medical, surgical or other interventional treatment.

Unanticipated Outcome – a result that differs significantly from what was anticipated to be the result of a diagnostic test, medical treatment or surgical/invasive procedure. A known complication or side effect is not an unanticipated outcome, but information about such outcomes should also be disclosed to patients as a routine course of their treatment and care.

Medical Error – an act or omission with potential or actual negative consequences for a patient that, based on standards of care, is considered to be an incorrect course of action.

Near Miss - any process variation which did not affect the outcome but for which a recurrence carries a significant chance of a serious adverse outcome. Such a near miss falls within the scope of the definition of a sentinel event, but outside the scope of those sentinel events that are subject to review by the Joint Commission under its Sentinel Event Policy.

Sentinel Event - an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof to a patient, visitor, or an employee. Serious injury specifically includes loss of limb or function. The phrase, “or the risk thereof”, includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.
Procedure:
A. Variance
   2. The attending physician shall be notified immediately when the variance involves a patient.
   3. If a patient or visitor is injured in a common area (i.e. sidewalks, stairwell, elevator, waiting area, etc.) hospital security shall be responsible for completing a Variance/Sentinel Event Report.
   4. The employee identifying the Variance/Sentinel Event, or the employee to whom the Variance/Sentinel Event is first reported, shall be responsible for initiating the completion of the Variance Report Form prior to the end of their scheduled shift of duty.
   5. An unanticipated outcome, Near Miss, or Potential Sentinel Event shall be reported immediately upon recognition to the Hospital Administrator/Administrator on Call. The Administrator/designee shall contact the Chief Medical Officer and any other appropriate parties relative to the nature of the occurrence.
      a. The Chief Medical Officer is responsible to assure that the process of disclosure occurs in a timely and appropriate manner.
      b. The disclosure process shall not be initiated until the Chief Medical Officer and Administrator/designee has been contacted.

B. Disclosure Process
   1. The attending physician (faculty) responsible for the patient’s care or his designee appointed by the Chief Medical Officer shall serve as the primary communicator of an unanticipated outcome to the patient and/or family/legal guardian.
   2. The intent of disclosure is to provide necessary medical information, not to provide the basis for legal liability. The act/documentation of disclosure is not to place blame or discuss fault.
   3. Subjects to be communicated:
      a) Generally the physician managing the communications should presume that all information, which describes the specific event affecting a patient, can and should be disclosed, with the exception of identifying the specific staff members involved in the adverse event if unknown to the family.
b) During discussions, the following subjects may be discussed, although discussion of each item is not required nor is discussion limited to these topics:

i. That University Health and its staff regret and apologize that an unanticipated outcome has occurred
ii. The nature of the adverse event
iii. The time, place and circumstances of the occurrence
iv. The proximal cause, if known
v. The known, definite consequences for the patient and potential or anticipated consequences
vi. Actions taken to treat or ameliorate the consequences or outcome
vii. Who will manage ongoing care of the patient
viii. Planned analysis or review of the occurrence
ix. Who else has been informed of the occurrence (internal hospital departments, review agencies, etc)
x. Actions taken, if any, to identify system issues which may have contributed to the occurrence and to prevent the same or similar occurrences from occurring
xi. Who will manage ongoing communications with the family; names and phone numbers of individuals in the hospital to whom complaints or concerns may be addressed

6. Upon completion of the online Variance/Sentinel Event Report form:
   a. The appropriate director and administrator (including Medical Director) for the unit on which the event occurred are emailed the link to access the completed form. (Select the director’s name under the optional read-only space located above the “submit” box at the end of the Variance Report.)

7. The individual generating the report shall receive immediate notification via e-mail receipt that the Variance/Sentinel Event Report was received.

8. The Quality Management staff screens all variances and assigns a Harm Score Distribution based on a six-point classification scale.

9. The Quality Management Department also summarizes each variance and refers them to the department(s) involved for investigation and resolution as needed. A resolution / corrective action related to conducting proactive risk reduction activities and the patient outcome shall be forwarded to the Quality Management Department for reporting to the Senior Leadership Team within fourteen (14) days.
10. A Sentinel Event Root-Cause Analysis shall be initiated when an occurrence meets any of the following criteria:
   a. Event that resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient’s illness or underlying condition
   b. Suicide of any individual receiving care, treatment, or services in a staffed around-the-clock care setting, or within 72 hours of discharge
   c. Unanticipated death of a full-term infant
   d. Abduction of any individual receiving care, treatment, or services
   e. Discharge of an infant to the wrong family
   f. Rape/assault or homicide of any patient, staff member, visitor, vendor, or practitioner
   g. Hemolytic transfusion reaction involving administration of blood or blood products having major group incompatibilities (ABO, Rh, other blood groups)
   h. Invasive procedure on wrong individual, wrong site, or that is wrong procedure
   i. Unintended retention of a foreign object in an individual after a surgery or other procedure
   j. Severe neonatal hyperbilirubinemia (bilirubin greater than 30 milligrams/deciliter)
   k. Prolonged fluoroscopy with cumulative doses greater than 1,500 rads to a single field, or any delivery of radiotherapy to the wrong body region or 25% above the planned radiotherapy dose
   l. Any elopement of a patient from a staffed around-the-clock care setting (including ED), leading to death, permanent harm, or severe temporary harm to the patient
   m. Or as deemed by administration

11. Occurrences that potentially meet the above criteria shall be forwarded to the VP of Quality and the Administrator (including Chief Medical Officer) for advisement and approval for a Root-Cause Analysis to be completed. The Administrator shall direct the reporting of this occurrence to The Joint Commission and/or Centers for Medicare and Medicaid (CMS).
12. Quality Management shall coordinate the completion of a credible Root-Cause Analysis in conjunction with the assistance of Administration, Department Directors(s), Physicians, House Officers and staff of the involved area(s). The Department Directors will also provide support, as appropriate, for staff who are directly involved in a sentinel event.

13. A thorough written summary of the Root-Cause Analysis of a Sentinel Event shall focus primarily on organizational systems and processes. The Root-Cause Analysis must include:
   a. Determination of the direct or “proximate” cause of the Sentinel Event and the processes and systems related to its occurrence.
   b. Analysis of the related systems and processes.
   c. Analysis of special causes in clinical processes and common causes in organization processes.
   d. Determination of appropriate risk reduction activities in order to minimize the likelihood of such risks in the future, or a determination that no such improvement opportunities exist.
   e. Establishment of a plan to address identified opportunities for improvement or formulation of a rationale for not undertaking such changes.
   f. Identification of who is responsible for implementation and how the effectiveness of the actions shall be evaluated.
   g. The completed RCA shall be presented to Administration.

14. Variances are monitored on a regular basis. Reporting of all variances with risk score are presented to the Interdisciplinary Quality Council. Ones (1) and twos (2) are presented to ensure resolution is appropriate, no further gaps present. Three’s (3) and fours (4) are presented to ensure no gaps present after RCA complete. Variance reporting is also presented to the Quality Subcommittee of the Governing Board.

15. Quality Management shall forward Variance/Sentinel Reports received to the appropriate areas by Variance type:
   a. Environmental Variances involving falls or injuries on the grounds or damaged/lost patient property shall be forwarded to the Safety Department, equipment malfunctions shall be forwarded to BioMed, utility outages and pest control issues shall be forwarded to Physical Plant, bed/rooms not ready shall be forwarded to Environmental Services for investigation. Falls or injuries in the clinical areas shall be forwarded to the nurse manager responsible for the specified department.

   b. The Safety Department or nurse manager responsible shall investigate patient falls/injuries and provide identification of changes that will lead to improved patient safety. A description of Environmental Variances shall be forwarded to the Senior Leadership Team monthly.

   c. A Clinical Quality Performance Report shall also be compiled by the Quality Management Department for the Senior Leadership Team on a quarterly basis. The report shall identify the occurrence of medical/health care errors and actions taken to improve patient safety in response to actual occurrences and proactively.

   d. Medication Usage Variances (Adverse Drug Reactions, Medication Errors, and Controlled Substance/Narcotic Discrepancy) shall be forwarded to the appropriate department manager for investigation. Cases shall be referred to the Pharmacy and Therapeutics (P&T) Committee as appropriate. Results shall be tracked and trended by the Pharmacy Department and reported to the P&T Committee at least quarterly. The P&T Committee shall proactively review how errors occur and make recommendations to reduce patient risk.
e. **Clinical and Department Specific Variances** shall be reviewed and investigated by Quality Management for possible input into the Medical Staff and Resident Peer Review Profiles and/or other areas as appropriate to proactively identify how errors occur and reduce risks relevant to the management of the patient’s condition. The data is utilized to generate a monthly and quarterly Patient Safety Report for the Senior Leadership Team and the Medical Executive Committee (MEC).

f. **Disruptive Behavior Variances** shall be investigated and action taken when indicated by the appropriate department manager and Hospital Administrator variances involving members of the medical staff, residents or fellows shall be forwarded to the appropriate Department Clinical Service Chief and the Chief Medical Officer for review and action.

g. **Variance involving House Officers** shall be sent to the House Officer, Attending of record, and Program Director for comments and follow-up. A summary of House Officer and Fellow variances shall be sent to the DIO monthly.

h. **Variance involving Attending’s** shall be sent to the Attending and Department Chair for comments and follow-up.

16. The Quality Management Department shall maintain the information of all Variance/Sentinel Event Reports received in the department’s database management program. In addition to the above reports, ad hoc reports for other appropriate departments, committees or management are generated as needed.

C. **Documentation**

1. The person designated as the primary communicator with the patient/family shall document in the progress notes of the patient’s medical record what was communicated to the patient/family and any response or other discussion.

2. Confidentiality of peer processes shall be maintained. Patients/families shall not be given official reports of those processes.

3. The Hospital Administrator shall be responsible for completion and filing of any mandatory reports to outside regulatory agencies.
Other Offsite Rotation Policies

House Officers rotating to any participating site must abide by the policies and procedures of that participating site while on that rotation. House Officers should familiarize themselves with each site’s policies and where the policies can be found for each site.

Willis Knighton

Prior to beginning a rotation at any Willis-Knighton facility ALL residents are required to contact the Medical Staff Services Department (318) 212-4665 to schedule an appointment time, Monday – Friday 8:30 AM to 4:00 PM, 2551 Greenwood Road, Medical Arts Bldg. Suite 330, Shreveport, LA 71103. Residents will need to bring their completed application along with the following required information:

- Proof of Current TB test
- Proof of Current Flu shot
- Copy of background check
- Driver’s License
- LSUHSC badge

When arriving at scheduled appointment, the completed application will be reviewed, photo taken for WK badge and a brief orientation will be completed. During the orientation policy and procedures will be addressed and any questions will be answered. While residents are circulating at WK any questions regarding processes or policies should be directed to their supervising physician. Residents can also access WK policies via the WKNET (intranet) on any WK hospital PC.

Any questions about the WK process can be directed to Donnie Aultman, M.D., WK Residency Director or the Medical Staff Services Department at (318) 212-4665.
Willis-Knighton Health System Resident Policy

APPENDIX B

Purpose:
The purpose of this policy is for the coordination of appropriate, timely and compassionate care for the patients, as well as a meaningful learning experience for the resident in training.

Definition:
Residents are medical graduates performing temporary attendance at the health system in a training capacity under the supervision of faculty members of a Residency Program and/or private attending physician(s) in good standing with relevant clinical privileges in the health system. Residents must be licensed as a physician by the Louisiana State Board of Medical Examiners except for PG1 and PG2 residents who are active residents at LSUHSC.

Policy Issues for Residents:
1. Medical staff privileges may not be granted to a resident. According to the medical staff bylaws Section 2-F – Residents in training shall be under the supervision of an attending physician on staff at Willis-Knighton Health System (WKHS). The residents shall have no hospital privileges as such but shall be able to care for patients in the Medical Center under the supervision and responsibility of their attending physician. The general rules and regulations of each clinical department and general bylaws of the medical staff will govern the care they extend. The practice of care shall be limited by the scope of privileges of their attending physician and scope of practice for their level of residency. Any concerns or problems that arise in the resident’s performance should be directed to him/her and the director or designee of the training program to solve or clarify the problem. A copy of any concern or complaint will be forwarded to the Medical Staff Services Department.
   A. Residents may write orders for the care of patients under the supervision of the attending physician.
   B. Residents may consent patients for surgery provided that a history and physical exam with provisional diagnosis and projected surgical procedure has been done and approved by the supervising physician. A co-signature on the permit by their supervising physician must be obtained prior to the procedure but may be done in the OR.
   C. All records of resident cases must document involvement of the attending physician in the supervision of the patient’s care to include co-signature of the history and physical, operative report and discharge summary.
   D. All admissions will be co-designated in name and responsibility to include an attending physician and must be seen by the attending physician or faculty member upon admission, or within a reasonable period of time.

2. The resident is a guest of WKHS and is in no way to interfere with patient care or the professional responsibilities of the hospital staff.

3. The Administration of WKHS must approve all resident physician programs by contract with LSUHSC.

4. LSUHSC must provide professional liability coverage for the residents.

5. No resident may use his/her supervising physician’s identification number or computer access code(s) at any time.
6. Residents while on duty at WKHS must have and display their WKHS and LSUHSC picture ID.

7. Prior to patient contact at WKHS the resident must present to the Medical Staff Services office for registration and completion of the Resident Form. All additional information requested must be supplied to the Medical Staff Services office for consideration and approval prior to working in the hospital.

8. The clinical privileges for each resident will correspond to those of the physician preceptor when under the direct supervision of this staff physician who is physically present. Services which may be rendered when the preceptor is physically absent will be limited by the scope of service for that specific resident’s specialty and year of training. This scope of service will be posted on the Meditech system and thus available to medical and nursing staff members. Each resident will be provided with a copy of his or her applicable scope of service when initially registering with the Medical Staff Services Office.

**Policy for Supervisory Physicians:**

1. Any member of the medical staff who is responsible for supervising participation in patient care by house officers in training shall be a medical staff member in good standing. With relevant clinical privileges at WKHS.

2. No medical staff member, whether or not he/she is a member of the teaching faculty, shall leave patients in the charge of residents in training without supervisory coverage.

3. In the case of clinical consultation, any medical staff members called to consult shall have primary responsibility for the consultation even if the patient is seen by the house officer in training.

4. The extent of participation of house officers in training in the care of patient(s) (if any) shall be disclosed and clarified to the patient and/or family members by the attending.

5. Admitting/attending physicians without teaching responsibilities who do not wish to participate in the teaching programs will not be required to supervise residents. In that case, residents will not be expected to participate in the care of this physician’s patients in any way, except as any physician would respond in the event of a life-threatening emergency.

6. The supervising physician shall submit written individual competencies/evaluations to the Medical Staff Services Office semi-annually or at the end of the resident’s rotation if less than 6 months.

Approved by WKMC/WKS/WKP Executive Committee: 02/24/03
Approved by Board of Trustees: 03/25/03
Revised: 01/12
Overton Brooks VA Medical Center
House Officers rotating to the Overton Brooks VA Medical Center will attend VA orientation prior to their start date. The orientation will familiarize house officers with policies and procedures of the medical center. House officers are required to complete a mandatory training for trainees prior to in-processing. House Officers will also receive a resident handbook at orientation. Residents will be responsible for familiarize themselves with the contents of the Resident Handbook

Helpful Links
- Graduate Medical Education Homepage: http://lsuhscshreveport.edu/Education/gme/index
- ACGME: http://www.acgme.org/
- ACGME Glossary of Terms: http://www.acgme.org/acgmeweb/Portals/0/PFAssets/ProgramRequirements/ab_ACGMEglossary.pdf
- LSUHSC Human Resources: http://myhsc.lsuhschoolshreveport.edu/HResources/HRHome.aspx
- University Health Hospital Policies: https://uhsharepoint.uhsystem.org/sites/PoliciesProcedures/default.aspx
- ECFMG (for J-1 Visa Sponsored HOs): http://www.ecfmg.org/
- Louisiana State Board of Medical Examiners: http://www.lsmbme.la.gov/
- My Evaluations Mobile Link: mobile.myevaluations.com