HOUSE STAFF MANUAL

GENERAL INFORMATION

&
POLICIES AND PROCEDURES

2015-2016
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I. Welcome

A. Letters of Welcome

1. Chancellor

Dear Doctors:

Welcome to the challenging and rewarding world of residency training at LSU Health Sciences Center-Shreveport, or LSU Health Shreveport as we are commonly known.

Proud of our distinction as Louisiana’s first university teaching hospital, we are committed to providing high quality training programs that will prepare you well for your future medical practice. Under the guidance of the outstanding faculty of our School of Medicine, you will care for a diverse patient population in both inpatient and ambulatory settings.

We are fortunate to enjoy a rich, collaborative relationship with our communities and to have strong partnerships with community healthcare providers throughout the region. Patients from a wide area, who need both primary care and complex medical or surgical services, are referred to the talented physicians on our faculty.

Graduates of our residency programs are recognized for being highly trained physicians, able to manage complicated systems and disease. We believe this is a result of the rigorous clinical experiences that are a hallmark of our programs.

Please accept my congratulations and best wishes as you embark on this exciting phase of your career. We are happy to have you as part of the LSU family.

Sincerely,

Robert A. Barish M.D.
Robert A. Barish, MD MBA
Chancellor
Dear Residents:

Congratulations on your selection for residency training at LSU Health Sciences Center Shreveport. We are looking forward to educating and mentoring you during this exciting time.

During your residency, you will be under the supervision of our outstanding faculty members, who will inspire critical thinking, advance your technical skills and nurture your development as physicians. Over time, in an atmosphere of teamwork and support, you will progressively gain knowledge and responsibility. You will gain confidence in all aspects of your field of medicine.

Our faculty members are dedicated to producing physicians with the skills and knowledge to be excellent clinicians. We are committed to safe and compassionate patient care and to treating all patients and their families with respect and dignity.

If you are new to our area, you will find the Shreveport-Bossier area to be family-friendly with a congenial climate and many opportunities for outdoor recreation. We have great restaurants, festivals and cultural offerings. This is a close-knit and supportive community.

The mission of our health sciences center is threefold. We heal. We teach. We discover. Our hospital was opened in 1876 as a safety net hospital for the medically underserved, nearly a century before the School of Medicine was established in 1965. We are proud of our past, but our vision is firmly fixed on our future and the future of our students.

Sincerely,

[Signature]

John Marymont, MD, MBA
Interim Dean, School of Medicine
Welcome to the LSU Health Sciences Center-Shreveport and to the University Health Hospital. You are entering upon the second phase of your medical career, which promises to be both challenging and rewarding. Over the coming years you will have progressive responsibility for the care and treatment of large numbers of patients with simple and complex diseases, from different economic means, as well as varying degrees of education. Yet, they are all bound by one common thread—they are our patients who are entrusting their own or a family member’s life to your medical care. Using the proven standards of a good history and physical examination supplemented with appropriate laboratory and radiological tests, as well as exciting new technology, you will (with supervision of your staff) be able to return a significant number of these patients to full health, and improve the quality of life of others.

University Hospital excels in its service to patients and its training for residents. We can, however, always improve; and your thoughts, recommendations and suggestions are always welcome. All of us look forward to the coming years and challenges. We urge you to feel free to communicate your ideas to your staff and to the members of the Graduate Resident Medical Education Committee. Working together we can make a truly great Hospital even better.

Thank you for choosing LSU Health Sciences Center for your postgraduate medical training. We are honored to have a part in the furtherance of your career.

Sincerely,

Kevin Sittig, M.D.
Chief Medical Officer/ CMO
Senior Associate Dean for Clinical Affairs/DIO
Welcome to LSU Health Sciences Center. The Graduate Medical Education office provides support services to the residents and training programs at the Health Sciences Center. We look forward to serving your needs. Please feel free to stop by our office in the Medical School (Room 1-201) or call us at 5-5053 if we can be of any assistance to you. You may also view the Graduate Medical Education Website at http://www.lsuhscshreveport.edu/gme/gmehome.aspx for information.

Sincerely,

Kim J. Hunter
Director
khunte@lsuhsc.edu

Christine Cheney
Coordinator
cmarom@lsuhsc.edu
B. History

The first steps toward establishment of a state-maintained hospital in Shreveport were taken in 1876 when the Louisiana Legislature appropriated $10,000 to maintain a hospital that would care for the indigent in North Louisiana. Shreveport Charity Hospital was established in a group of log and frame buildings located in what is now downtown Shreveport. A five-man board was appointed to oversee operations of this new hospital. A Chief Surgeon, an Intern and a Physician staffed that early hospital. Six years later the Louisiana Legislature appropriated $20,000 to purchase a site for the hospital, and four acres on Texas Avenue were acquired. (This is the present location of Shreveport’s City Hall.)

The first Shreveport Charity Hospital built on the Texas Avenue site was erected in 1889 and was of frame construction. Dimensions of the two-story building were 215 feet by 38 feet. By 1904, there was need for a new hospital building and another was constructed at the same location for about $80,000. At this same time, the Charity Hospital School of Nursing, which is now defunct, was established.

Between 1916 and 1919, an outpatient clinic was begun so that medical needs of the indigent could be treated without having to admit the patients into the hospital. By the mid 1920's the bed capacity at the Shreveport Charity Hospital was 250. The bed capacity was nearly doubled by 1930; however, extensive renovation was done to repair damage the hospital suffered when a fire destroyed an entire wing in the late 1920's. Two hundred and eighteen patients had to be moved to safety from the fire, though none were injured.

The renovation program lasted for two years and, when completed, the hospital's bed capacity was 400. However, even this number of beds was considered to be insufficient to meet the patient load.

In 1930 the first cancer clinic in the State of Louisiana was organized at Shreveport Charity Hospital. About the same time, the hospital established a public outreach program through daily radio broadcasts of health programs narrated by local physicians. Airtime was provided free to the hospital, which had its own radio studio, by a member of the hospital's board, who also owned a radio station.

The hospital continued to grow, keeping stride with the advances in the health field. By the late 1940's plans were being completed for construction of another hospital building to be constructed on a site further south of downtown that would allow for future expansion.

In 1953 the new building was completed at the corner of Linwood Avenue and Kings Highway. Cost of construction of that building was 10 million dollars. Bed capacity was 800. This building, although modernized and renovated, still houses the hospital today. A three-story Outpatient Clinic building was opened in 1973 adjacent to the hospital as
the hospital continued to expand its role as provider of outpatient medical care to the indigent in North Louisiana.

Since 1953, there have been two name changes from Shreveport Charity Hospital to Confederate Memorial Medical Center. Shortly after the hospital marked its 102nd anniversary in 1978, the name again was changed. The name of the hospital today is Louisiana State University Hospital in Shreveport, a part of the Louisiana State University Health Sciences Center.

The change in name reflected the change of status that occurred in the hospital in 1976 when the Louisiana Legislature transferred ownership and control of the hospital from the Louisiana Health and Human Resources Department to the LSU Health Sciences Center.

Since the 1940's, the hospital has been engaged in postgraduate physician training, and with the opening of the LSU Health Sciences Center, School of Medicine in Shreveport in 1969, the hospital has become even more closely involved in the medical education not only of physicians but of other health professions as well.

The hospital was the primary teaching hospital for the School of Medicine, and with the opening of the School of Medicine buildings adjacent to the hospital in 1976, the affiliation became even closer. The heightened educational emphasis was matched by a rapid growth in institutional commitment to basic and applied research. Programs also grew in various allied health professions.

Since the mid 1970's, the hospital has embarked upon a program of renovation and construction designed to assure that LSU Hospital in Shreveport continues to keep pace with the most current medical advances in patient care and to affirm its obligation to the citizens of Louisiana through excellence of medical care as well as medical education and public service. In addition, LSU Hospital in Shreveport is recognized as a Burn Center, Bone Marrow Transplant Center, Level I Trauma Center, full-service surgery center, and also offers Centers of Excellence for Cancer and Rheumatology.

Today the LSU Hospital in Shreveport is a 459-bed licensed hospital providing tertiary care through its many specialty programs while maintaining its special mission for Louisiana’s indigent. The hospital’s outstanding programs increasingly attract a full-spectrum of patients from the region and beyond.
C. 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.

Louisiana State University School of Medicine
P. O. Box 33932
Shreveport, LA 71130
D. Code of Conduct

LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER – SHREVEPORT
COMPLIANCE PROGRAM
CODE OF CONDUCT

All employees and affiliated professionals of LSUHSC shall conduct all activities in a manner that will promote integrity and compliance while practicing sound, ethical, and professional judgment.

All employees and affiliated professionals of the HSC shall abide by regulations set forth by the state and federal healthcare programs and their appointed agents in conjunction with the policies and procedures established by the HSC.

HSC employees and affiliated professionals shall prepare complete and accurate medical records, financial information, and bills.

HSC employees and affiliated professionals shall report suspected non-compliant behavior that violates any statute, regulation, or guideline applicable to a state or Federal healthcare program or HSC policies. All reports are confidential. All employees have the right to remain anonymous. The HSC will not retaliate upon any employee that reports suspect behaviors in any form or fashion.

All employees shall attend and/or complete the mandated annual training requirements. All employees shall participate in any reviews, investigations, or audits whether conducted by an internal or external agency.

All employees shall refuse any type of illegal offers, remuneration, or payments to induce referrals or preferential treatment from a third party.

All employees shall disclose to the compliance officer any information received from the state or federal healthcare programs or their agents.

All employees shall adhere to the Code of Conduct as a condition of employment at LSUHSC. All employees and affiliated professionals can be suspended, terminated, or barred from further employment or affiliation with the HSC as a result of non-compliant behavior.
II. Graduate Medical Education Committee

The Graduate Medical Education Committee welcomes you as a new employee. LSUHSC-Shreveport employs more than 5,000 employees who have chosen to work in this large teaching hospital and who contribute by their services to the important task of patient care, teaching, research either directly or indirectly. The future development of this campus depends on each employee, their pride, and a continued development of productive effort. The Graduate Medical Education Committee (GMEC) recognizes that communication plays a vital role toward your development. Toward that goal, the following responsibilities have been outlined to communicate your responsibility in maintaining LSUHSC-Shreveport a center of excellence in providing patient care, teaching and learning. The following guidelines will be reviewed with you during orientation and may be re-emphasized by your assigned training program.

As a Resident of LSU Health Sciences Center-Shreveport you will have the responsibility to:

- Participate in safe, effective, and compassionate patient care under the appropriate level of supervision and at the level of advancement and responsibility assigned by your home training program. The level of required supervision is provided in your assigned training program’s goals and objectives. Further, the GMEC recommends that if a Resident does not understand what level of supervision is required in providing patient care that is his/her responsibility to seek appropriate clarification from the Program Director or Department Chairman.

- Comply and follow Hospital policies, EEO guidelines, mandated compliance programs, the Medical Staff rules, regulations and bylaws for the Medical Staff; also to comply with the Joint Commission on Accreditation for Healthcare Organizations standards emphasizing the appropriate documentation of patient care including compliance with timely chart completion, clinical pertinence, and etc.58

- Attend and participate on appointed institutional committees and councils whose actions affect future education and/or patient care.

- Report to assigned patient care areas in a timely and efficient manner, notifying the direct supervising physician.

- Provide an annual “confidential” evaluation of the educational experience of your assigned training program and of the faculty to the Program Director.

Attend and participate fully in Department or Institution specific educational and scholarly activities, which shall include the responsibility of teaching and supervising other students and residents in training. The requirements will vary from one resident to another but each resident is expected to meet compliance with the program’s requirements. Examples may include but are not limited to special case presentations, research, attendance at conferences and grand rounds, participation in lectures, teaching of other residents, students, written publications, etc.

- Follow and adhere to other policies and procedures of the institution, such as Safety, Infection Control, Medical Records, Confidentiality, Information Management, and the use of support services in a cost effective and useful manner.

- Comply with Federal laws and regulations, such as billing compliance, conditions of Medicare Participation, EMTALA/COBRA, etc. Maintain compliance with the ethics of the
institution in providing safe and efficient patient care in a protected environment to assure the well being of all patients.

Adhere to patient confidentiality and other institutional requirements for the security of patient information.

A. 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, the Chairman of the GMEC Committee, or the Senior Associate Dean for Clinical Affairs/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 Graduate Medical Education committee is appointed by the Dean/Chancellor of the Health Sciences Center or his/her designee. Voting members of the committee include representatives of the Program Directors, Resident representatives, Resident Association Residents, Hospital Administrator, Senior Associate Dean for Clinical Affairs/DIO. Additional members of the committee include the Associate Dean for Academic Affairs, who will serve as an Ad Hoc Member, and the Director of Medical Education.

The GMEC reports monthly to the Hospital Medical Executive Committee activities and updates regarding graduate medical education.

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

In the absence of the DIO, the Institution and DIO has designated the Executive Director of Medical Services the responsibilities of the DIO. Examples of responsibilities include, but are not limited to, signing of all program information forms, correspondence submitted to the ACGME or ACGME Residency Review Committees, etc.
B. 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:

- **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.

C. Roles and Responsibilities

- Establish and implement policies and procedures regarding the quality of education and the work environment for the Residents in all ACGME-accredited programs.
- Annually review and make recommendations to the Sponsoring Institution on Resident stipends, benefits, and funding for Resident positions to assure that these are reasonable and fair.
- Establish and maintain appropriate oversight of and liaison with program directors and assure that program directors establish and maintain proper oversight of and liaison with appropriate personnel of other institutions participating in the ACGME-accredited programs of the Sponsoring Institution.
• Establish and implement formal written policies and procedures governing Resident duty hours in compliance with the Institutional and Program Requirements. The GMEC must assure that the following requirements are met:
  1. Each ACGME-accredited program must establish formal written policies governing Resident duty hours that are consistent with the Institutional and Program Requirements. These formal policies must apply to all participating institutions used by the Residents and must address the following requirements:
     a. The educational goals of the program and learning objectives of Residents must not be compromised by excessive reliance on Residents to fulfill institutional service obligations. Duty-hours and call schedules must be monitored by both the Sponsoring Institution and programs and adjustments made as necessary to address excessive service demands and/or Resident fatigue. Duty hours, however, must reflect the fact that responsibilities for continuing patient care are not automatically discharged at specific times. ACGME-accredited programs must ensure that Residents are provided appropriate backup support when patient care responsibilities are especially difficult or prolonged; and
     b. Resident duty hours and on-call time periods must be in compliance with the Institutional and Program Requirements. The structuring of duty hours and on-call schedules must focus on the needs of the patient, continuity of care, and the educational needs of the Resident.
  2. The GMEC must develop and implement procedures to regularly monitor Resident duty hours for compliance with the Sponsoring Institution’s policies and the Institutional and Program Requirements.
  3. The GMEC must develop and implement written procedures to review and endorse requests from programs prior to submission to an RRC for exceptions in the weekly limit on duty hours up to 10 percent or up to a maximum of 88 hours. All exceptions requested must be based on a sound educational rationale. The procedures must outline the process for endorsing an exception in compliance with the ACGME policies and procedures for duty-hour exceptions. The procedures and their application, if the institution has utilized them, will be assessed during the institutional review.
• Assure that ACGME-accredited programs provide appropriate supervision for all Residents that are consistent with proper patient care, the educational needs of Residents, and the applicable Program Requirements. Supervision of Residents must address the following
  1. Residents must 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.
  2. On-call schedules for teaching staff must be structured to ensure that supervision is readily available to Residents on duty.
  3. The teaching staff must determine the level of responsibility accorded to each Resident.
• Assure that each program provides a curriculum and an evaluation system to ensure that Residents demonstrate achievement of the six general competencies listed in Section III.E and as defined in each set of Program Requirements.
• Establish and implement formal written institutional policies for the selection, evaluation, promotion, and dismissal of Residents in compliance with the Institutional and Program Requirements.

• Regularly review all ACGME program accreditation letters and monitor action plans for the correction of concerns and areas of noncompliance.

• Regularly review the Sponsoring Institution’s Letter of Report from the IRC and develop and monitor action plans for the correction of concerns and areas of noncompliance.

• Review and approve prior to submission to the ACGME
  1. All applications for ACGME accreditation of new program and subspecialties
  2. Changes in Resident complement
  3. Major changes in program structure or length of training
  4. Additions and deletions of participating institutions used in a program
  5. Appointments of new program directors
  6. Progress reports requested by any Review Committee
  7. Responses to all proposed adverse actions
  8. Requests for increases or any change in Resident duty hours
  9. Requests for “inactive status” or to reactivate a program
  10. Voluntary withdrawals of ACGME-accredited programs
  11. Requests for an appeal of an adverse action
  12. Appeal presentations to a Board of Appeal or the ACGME

• Conduct internal reviews of all ACGME-accredited programs including subspecialty programs to assess their compliance with the Institutional Requirements and the Program Requirements of the ACGME Residency Review Committees in accordance with the guidelines in Section V.

III. General Information

A. Office of Graduate Medical Education

The Office of Medical Education/Resident Administration 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.
B. 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.

<table>
<thead>
<tr>
<th>Benefits Office</th>
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<tbody>
<tr>
<td>Room 116</td>
</tr>
<tr>
<td>Administration Building</td>
</tr>
<tr>
<td>318-675-5632</td>
</tr>
<tr>
<td>318-675-7990 (fax)</td>
</tr>
<tr>
<td><a href="mailto:shvbenefits@lsuhsc.edu">shvbenefits@lsuhsc.edu</a></td>
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<thead>
<tr>
<th>Hours of Operation</th>
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<tbody>
<tr>
<td>Monday – Friday 7:30am – 4:30pm</td>
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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.lsuhsctcreveport.edu/hr/fmla.php](http://myhsc.lsuhsctcreveport.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.
IV. Employment

A. 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.
B. 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.
V. Resident Application and Eligibility

A. 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.

B. 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.

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 COMLEX 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.

C. 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

D. 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.

E. Resident Appointment (GME 1.1.b)

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, Hospital Administrator, and the Senior Associate Dean for Clinical Affairs/Chief Medical Officer and the original agreements must be maintained as part of the Hospital’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, and the Senior Associate Dean for Clinical Affairs/Chief Medical Officer.
- 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.

F. Residency Closure/Reduction (GME 10.1)

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

The Sponsoring Institution must either allow residents already in the program(s) to complete their education or assist the residents in enrolling in an 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.

VI. Resident Responsibilities and Policies

A. 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.
B. 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 Hospital orientation. After their first year of employment, 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.

C. 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.

D. Licenses and Certifications

1. Louisiana State Medical License

   Intern (PGY I) Registration

U.S. Medical School graduates who are first year Residents 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.

Once you have received your medical license, registration in the Clerk of Court for the parish (es) in which you will practice needs to be filed. There is a $10 fee. The registration form will be in the LSBME packet. Your ORIGINAL medical license will need to accompany the form. The Medical Education Office will assist you in the filing of your license and will notify you when your license is returned from the Clerk of Court. A copy of your license will remain on file in the Medical Education Office.

**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)**

Obtaining an individual DEA NUMBER for prescribing controlled substances for outpatients’ prescriptions is a three step procedure:

1. FULL Louisiana Medical License
2. LOUISIANA STATE NARCOTIC NUMBER – This application is obtainable once you have a current Louisiana Medical License.
3. FEDERAL DEA NUMBER – Can be obtained once you have fulfilled requirements 1 and 2 above. Applications for your Louisiana State Narcotic number and federal DEA number are available in the Medical Education Office.

Prescription orders for controlled substances may be issued by physicians, dentists, and veterinarians who are authorized to prescribe controlled substances by the jurisdiction in which they are licensed to practice their profession and either are registered with the DEA under the Controlled Substances Act for the appropriate schedules or are exempt from registration.

House Officers are issued a temporary DEA number which can be used only until the resident is eligible for his/her own Federal DEA number. You will be responsible for securing the appropriate narcotic licenses and maintaining those permits. Residents and internationally trained physicians may dispense, administer, and prescribe controlled substances under the registration of LSUHSC in Shreveport in lieu of being registered themselves provided that the following conditions exist:

- The dispensing, administering, or prescribing is in the usual course of professional practice;
- The individuals are authorized or permitted to dispense, administer, and prescribe by the Louisiana State Board of Medical Examiners.
- LSUHSC-S has verified that the individual has never had a DEA registration application denied or revoked.
- The practitioners are acting only within the scope of their employment at LSUHSC-S;
- LSUHSC-S authorizes individual practitioners to dispense or prescribe under the hospital’s registration and designates a special code number for each individual. The temporary number is issued initially to all first year Residents for their use at LSUHSC-S only until they receive their own DEA numbers. Issuance and monitoring of the number shall be through the Medical Education Office in conjunction with the Chief Pharmacist.
- Resident I’s and other upper level Residents who do not have a full Louisiana license are issued a temporary DEA number which can be used during the PGY 1* year and will expire at the end of the last day of the current fiscal year (June 30th).
  *includes Residents who do not have a full license or may have the GETP.
- Residents who have a full Louisiana license are required to obtain a DEA number which can be used during their residency at LSUHSC. There is not a cost to the resident while in training. (www.deadiversion.usdoj.gov)
- A current list of internal codes assigned to practitioners is kept and is made available to other registrants and law enforcement agencies upon request to verify the authority of the prescribing individual practitioner. The Medical Education Office keeps the current list of numbers and signatures with Pharmacy receiving a copy.

HOUSE OFFICERS WILL BE REQUIRED TO PURSUE DEA REGISTRATION UPON RECEIPT OF THEIR MEDICAL LICENSE UNLESS THEIR TRAINING SPECIALTY DOES NOT ROUTINELY REQUIRE PRESCRIPTION ORDERS.
3. 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.

4. 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.

E. 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.

F. 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.
G. 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.

H. House Officer Leave Policy (GME 5.1)

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.

1. Annual Leave: First-year house staff are allowed three weeks (21 days) vacation with pay and second through seventh year house staff are allowed four weeks (28 days) vacations with pay, except where prohibited by specialty ACGME Residency Review Committee regulations and all requests for annual leave and/or sick must be approved by the respected Program Director. It is strongly recommended that first year vacation requests be submitted before August 1 of the intern year. Vacation requests should be in increments of one week (five working days plus two weekend days). Any vacation request that surrounds a holiday will automatically count the holiday as a vacation day. Any vacation request for a single Monday or a Friday will automatically include the
adjoining weekend as vacation unless the weekend is worked. 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. You are encouraged to take your vacation in increments of at least one week (7 days). If a house officer applies for one week of vacation (Monday-Friday) it is expected that the house officer will also be free of duty for one of the adjoining weekends. Vacation is non-cumulative – it must be used during the year earned and cannot be carried forward.

2. Sick Leave: All House Officers are allowed two weeks (14 days) for sick leave each year. Sick leave may not be used as vacation time. Sick leave includes personal doctor’s appointments i.e. medical, optical, and dental.

3. 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.

I. Call in 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 Resident 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.

J. 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 will be responsible for bearing its replacement cost of $125.00.

   • 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:
1. All pages shall be answered within ten minutes of being received. If a page is not answered within this prescribed time frame, the individual initiating the page 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 when response is not within the ten-minute time frame.
2. The pager system is owned and operated by LSU Health Sciences Center and is solely for the use of its staff. It provides a mechanism that allows for immediate access to staff facilitated by the Hospital Switchboard.
3. The Hospital Switchboard is responsible for the procurement and distribution of beepers.
   a. Local pagers – (32 mile radius) – requesting department submits an Internal Transaction (SN 1247) to the Hospital Switchboard.
   b. Long Range pagers – requesting department submits a memo indicating the type of pager requested and name of employee who will utilize it to Telecommunications Office G-112.
4. Funding for pagers and any repairs is the responsibility of the user department. There is no monthly expense to the departments for service.
5. The Hospital Switchboard is responsible for facilitating the repair of local pagers.
6. To access the LSU pager system, dial 675-7007 and follow operator’s instructions. A current (updated every six months) pager list is maintained by the Switchboard.
7. Staff who has obtained pagers outside the institution is responsible for notifying the Switchboard of their pager number.

5. 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.

6. 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.

K. Duty Hours (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. Duty 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 duty hours and on-call assignment periods must not be excessive. Duty hours are defined by the ACGME as “all clinical and academic activities related to the residency program, i.e., patient care (both inpatient and outpatient), the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences.” All training programs must adhere to the following guidelines governing duty hours as set forth by the ACGME.

Maximum Hours of Work per Week
• Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting.

Moonlighting
• Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program.
• 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.

Mandatory Time Free of Duty
• Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.

Maximum Duty Period Length
• Duty periods of PGY-1 residents must not exceed 16 hours in duration. Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.
• It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.
• Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.
• In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.
  o Under those circumstances, the resident must:
    appropriately hand over the care of all other patients to the team responsible for their continuing care; and,

    document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.

Minimum Time Off Between Scheduled Duty Periods
• Adequate time for rest and personal activities must be provided. PGY-1 residents should have 10-hours, and must have eight hours, free of duty between scheduled duty periods.

• Intermediate-level residents (as defined by the RRC) should have 10 hours duty free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.

• Residents in the final years of education (as defined by the Review Committee) must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.
  o This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in-seven standards. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances [as defined by the Review Committee] when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty.
  o Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education must be monitored by the program director.

Maximum Frequency of In-House Night Float

• Residents must not be scheduled for more than six consecutive nights of night float. (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

• PGY-2 residents and above 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 in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour 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 duty, when averaged over four weeks.
  o 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 care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period”.

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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 duty 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 duty hours and the working environment. The policies and procedures must be distributed to all Residents and faculty. Frequent monitoring of duty 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 duty hours will also help identify any vulnerabilities of resident/fellow fatigue. Indicators of duty 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 Medical Education Department shall monitor duty hours on an on-going basis and report non-compliance to the GMEC and the Program Director. All programs must adhere to the MyEvaluations Duty Hour Data Entry Policy regarding the recording and reporting of duty hours electronically.

L. Moonlighting (GME 8.1.a)

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. Internal moonlighting is defined by the ACGME as moonlighting at the sponsoring institution or the non-hospital sponsor’s primary clinical site.

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.
- 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.

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

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

M. 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.

### N. Resident Quality Improvement

All Residents receive instruction in quality-assurance/performance improvement at the Annual House Officer Orientation. Residents are required to participate in the University’s Quality Improvement Program. Each Clinical Department is charged with including House Officers in the discussion of the QI events of their department.

As part of the educational program, it is important that autopsies are performed whenever possible and appropriate. The Autopsy Review is automatically included in the QI monitors for the clinical departments. The institution encourages the House Officers to request an autopsy when appropriate in order to provide not only an adequate educational experience but to enhance the quality of patient care.

### O. Changing Graduate Education Programs

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 Clinical Department Head in which he is presently serving at least 90 days before the end of his contract period.

Before accepting a House Officer 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.

A program director must provide timely verification of residency/fellowship education and summative performance evaluations for Residents who leave the program prior to completion.

Chairman who are discussing appointments to their Department should require the House Officer to obtain a release from the Chairman of his present department before making an offer to accept that House Officer in his program.
P. Evaluations

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.
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.

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.

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.

The program director must maintain the summative evaluation in each Resident’s permanent record.

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.

Q. Probation

Probation is the formal notification to the house officer that the house officer’s performance is not satisfactory. 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 house officer 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.

R. Promotion/Advancement (GME 2.1)

The promotion/advancement of a house officer 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 house officer 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.

S. Dismissal/Non-Renewal of Contract (GME 2.1.a)

In all cases in which revocation of a Resident’s appointment has been recommended by the program director of a clinical department, the Resident and the Designated Institutional Official (DIO) shall be notified in writing by the director. An opportunity for the Resident concerned to have a hearing shall be afforded as provided in these policies. If the Resident 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.
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 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. 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 House Officer Manual.

T. Completion of Training

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 $15 per certificate.

U. Due Process (GME 3.1)

The LSU Health Sciences Center-Shreveport is committed to the principal 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.
2. The Departmental Chair is the final appeal for all disciplinary matters of oral counseling, written counseling, probation, 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, appeals may be made to senior university authorities, 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.

3. In disciplinary/adverse action(s) involving thirty (30) or more days suspension 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 and the relief desired.

4. The Department Chair shall have five (5) working days from the receipt of the written request to render a decision in writing.

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 (BRF, Room F-1-32B) 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. 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 24 working hours after the receipt of the request, the hearing appeals date shall be within 30 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 participate in the Committee’s deliberations/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. Both the House Staff and the Department Chairman shall submit the names of the members that they name to serve on the committee to the office of Legal Affairs within **five (5) working days** from the receipt of the date for the appeal hearing.

8. Not later than **five (5) working days** prior to the hearing, both sides (House Staff and department) shall submit the office of Legal Affairs, any documents that they wish 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 10-15 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 20-30 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 five 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 submit a brief written summary within 2 working days of the close 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 decision of the Committee whether or not to uphold the action of the Department Chairman. The written decision concludes the administrative appeal process.

   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.
<table>
<thead>
<tr>
<th>Event</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident/Fellow Receives Disciplinary Action</td>
<td>resident/fellow contests action (within 5 working days)</td>
</tr>
</tbody>
</table>
| 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: appeals made to senior university authorities |
| Decison 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 official 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) |
| Appeals Review Panel                       | resident/fellow selected member; departmental chair selected member; dean of the medical school selected member; legal affairs attorney (non voting/deliberating member)  
both resident/fellow and 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 |
**V. 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
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, located in the BRF, Room F-1-32B. 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.

**VII. Services and Programs**

**A. 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.

<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>
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</tbody>
</table>

The ID badge is used as the meal card, and the meal card may be activated in the Hospital Cafeteria, Monday - Friday, 7am - 4pm. It is the responsibility of the cardholder to take care of ID Badge/Meal Card.

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 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 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.**

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>
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<tr>
<td>Monday – Friday</td>
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<tr>
<td>Monday – Friday</td>
</tr>
<tr>
<td>Weekends &amp; Holidays</td>
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</tbody>
</table>

   Menus are available online at [http://www.sh.lsuhsc.edu/nutrition/index.html](http://www.sh.lsuhsc.edu/nutrition/index.html)

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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</thead>
<tbody>
<tr>
<td>Monday-Friday</td>
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</table>

   Menus are available online at [http://www.sh.lsuhsc.edu/nutrition/index.html](http://www.sh.lsuhsc.edu/nutrition/index.html)
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.

<table>
<thead>
<tr>
<th>ACC Deli Hours of Operation</th>
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<tbody>
<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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</table>

B. 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.

<table>
<thead>
<tr>
<th>Library Hours</th>
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<tbody>
<tr>
<td>Monday – Friday</td>
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<tr>
<td>Saturday</td>
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<tr>
<td>Sunday</td>
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</table>

For more information and services about the Medical Library please visit http://lib.sh.lsuhsc.edu/

C. 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.

D. 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 carriers, medical boards, etc. Dr Mary Fitz-Gerald, Department of Psychiatry is a member of the Board of Trustees for the PGFL.

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. Fitz-Gerald or another psychiatry faculty member in writing. This request will also list specific information as to why the evaluation is warranted. Dr. Fitz-Gerald 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. Jo Fitz-Gerald or a psychiatry faculty member. Dr. Fitz-Gerald 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.

**E. 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.lsuhscshreveport.edu/Payroll/payrollhome.aspx

F. 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.

G. 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: srober1@lsuhsc.edu
H. 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.

VIII. GMEC Policies

A. Resident Supervision (GME 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
o 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.

o With direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but it 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.

B. **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.
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.

C. 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)) The program director must ensure that residents are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs. (CPR VI.A.3.)

Procedure
- Residents/Fellows participate in the Hospital Wide Performance Improvement and Patient Safety Plan 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. (Hospital Wide Performance Improvement and Patient Safety Plan)
- 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.

D. 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.

E. 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.

F. My Evaluations 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
   o Program Coordinators will receive proper training on entering demographic information in MyEvaluations.
   o Program Directors, Coordinators, or program designee will enter demographic information for each resident/fellow ensuring accuracy of the information being entered.

Duty Hour Data Entry:
All House Staff are responsible for accurately and honestly reporting all duty hours. All training programs must adhere to the guidelines governing duty hours as set forth by the ACGME. To ensure proper reporting of Duty Hours, the Sponsoring Institution has made it mandatory that all programs utilize MyEvaluations when recording Duty Hours. The Program Director must monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements. The Sponsoring Institution has made the program MyEvaluations available to all programs as a tool for data entry and healthcare workflow. (IR III B.S.a-III.B.S.a). This allows the GME office the ability to review programs’ duty hours for reporting purposes.

Procedure
   o Programs must educate their Residents/Fellows on how to properly enter and submit duty hours into MyEvaluations.
   o Program Directors, Program Coordinators, or Program designee must confirm duty hours submitted in MyEvaluations by the 14th of each month.
   o The GME office will run a monthly Duty Hour report for all programs. The report will then be presented at the monthly GMEC meeting for compliance.
   o Any Duty Hour violations will be discussed during the GMEC meeting.
   o Programs that do not submit duty hours by the deadline will receive a violation of “No Duty Hours Reported.”

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
   o 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.
   o 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 12th 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 every 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.

**G. 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 Associate Dean for Clinical Affairs. The Associate Dean shall notify the appropriate regulatory bodies, department chairman or others as deemed appropriate or mandated by law.

• The Associate Dean, 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:

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 15 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 Dr. Kevin Sittig before being able to return to work.
H. Social Media (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. This 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, 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.

Procedure
House Officers must adhere to the following:

- House Officers should use discretion when accepting or requesting “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 University Health 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 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 should maintain appropriate professional boundaries and should separate personal and professional content online.

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.

I. 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.
IX. LSU Health Sciences Center Policies

A. Frequently Referenced Administrative Directives

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.
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 workers.
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 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 or 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.

Management Team Signature ___________________________ Date __________

Directors/Administrators Signature ___________________________ Date __________
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 himself 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 the 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 locations 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 unreasonably 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.
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.)

At a minimum, 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 indicating 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 property 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 absences 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.
Louisiana State University
Health Sciences Center - Shreveport

Administrative Directive

2.8.5 Substance and Alcohol Abuse Policy

A. Purpose

Louisiana State Health Sciences Center Health Sciences Center - Shreveport 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 dangerous 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 M93-38. This policy is specifically directed at illegal actions 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, dispensing, possession, or use of a controlled substance in accordance with the requirements of the Federal Drug Free Workplace Act of 1988.

"Controlled Substance" means a controlled substance in schedules I through V of section 202 of the Controlled Substances Act (21 U.S.C. 812).

"Criminal drug statute" means a criminal statute involving manufacture, distribution, dispensing, 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 no contest) 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 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, dispensing, 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 slowness
   - Unexplained work/school related accidents or injuries
   - Illegible or erratic 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 LSUHS-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, LSUHS-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 LSUHSC-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, LSUHSC-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 LSUHSC-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 statute 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 LSUHSC-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 LSUHSC-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 LSUHSC-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 V 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 $10,000.
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 MUF 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 MUF 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. MUF 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.
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.
This Administrative Directive is effective June 1, 2005
Revision effective January 1, 2013

Date: 11/7/2013

Signed: Dr. Robert A. Barish, Chancellor
X. Frequently Referenced Chancellor Memoranda

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.

Robert A. Barish, MD, MBA, Chancellor
July 13, 2010
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.lsuhsscshreveport.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

DELINQUENT 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 6:00 am each day Medical Records will determine which operative reports have not been dictated from the preceding day. Physicians who have un-dicted 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 fail 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, 2003.

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 leadership will be using 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 Deans or their delegates. They may use distribution channels like the Dean’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_
XI. Frequently referenced University Health Policies

**BRFHH**

**POLICY #: 6.2**

**SUBJECT: Security, Confidentiality and Integrity of Information**

**Effective: 10/01/13**

**APPROVED BY: Governing Board**

**Page 1 of 7**

**Definitions:**

1. **AIC:** Availability, Integrity and Confidentiality

2. **Security:** The protection of information to insure availability, integrity and confidentiality (AIC).

3. **Information Resources:** Includes, but is not limited to, computers, faxes, telecommunication hardware, software, storage media, computer sign on codes, medical records documentation, and information stored, printed and/or processed by a computer system.

4. **Storage Media:** Includes, but is not limited to, paper, magnetic media, optical disk, film and other methods of retaining information.

5. **Integrity:** Protecting information from accidental or unauthorized intentional change.

6. **Information Browsing:** Viewing of information by unauthorized or legitimate user.

7. **BRFHH Confidentiality Statement:** A signed statement that verifies the individuals understanding of the information security standards and implications for inappropriate access or disclosure of information.

8. **Access:** Permissions, rights and privileges to perform a set of functions.

9. **User ID/Password:** Personal identification key that authorizes a specific user to access information resources and establishes accountability for transactions.

10. **Accountability:** Responsibility is assumed for actions performed when interpreting, handling, and transmitting, transcribing or reporting information.

11. **Audit or Activity Logs:** Detailed documentation of events (read, write, etc.)

12. **Protected Health Information (PHI):** Individually identifiable health information that relates to the past, present, or future healthcare services provided to an individual.

13. **HIPAA:** The Health Insurance Portability and Accountability Act of 1996 and the regulations issued pursuant to the law – Public Law 104.191:45 C.F.R. 160 and 164.

14. **Protected Health Information (PHI):** Individually identifiable health information that relates to the past, present, or future healthcare services provided to an individual as described by HIPAA rules.

15. **ePHI:** Electronic PHI (Protected Health Information) or information transmitted or viewed electronically such as faxing or displaying on computer screens.
16. ITSP: Information Technology Security Plan outlines plans for implementing information technology security “best practices” to address procedures and plans of healthcare and educationally related information security needs. It insures AIC of all information assets associated with BRFHH.

1. Administrative Responsibilities
   a. BRFHH Human Resource Management
      1) Newly appointed faculty, staff and volunteers or other personnel authorized to access BRFHH information assets shall receive information regarding the facilities’ standards regarding the AIC of information and use of information resources.
      2) Newly appointed faculty, staff and volunteers or other personnel authorized to access BRFHH information assets shall be presented with the BRFHH Confidentiality Statement for signature. (See Appendix A – BRFHH Confidentiality Statement.)
      3) A copy of the Confidentiality Statement shall be filed in the permanent record in Human Resource Management and a copy shall be given to the individual.
   b. BRFHH Department Manager/Supervisor/Head
      1) Faculty, staff and volunteers or other personnel authorized to access BRFHH information assets shall receive “hospital-wide” and “department specific” orientation and periodic review of access to BRFHH information assets, security and appropriate processing of information relative to their job function and role that should include, but not be limited to:
         a) log in and sign off procedures
         b) lawful or legitimate information browsing
         c) release of information
         d) access rights
         e) processing and handling of information resources and storage media
         f) accountability and audit logs
         g) Viewing the online videos – Computer Access Training for New Employees and Protecting Electronic Health Information (ePHI)
      2) All non-compensated observers, students, vendors, or other persons conducting business with BRFHH shall receive specific instructions on the principles of appropriately processing information received or observed within the facility.
      3) Affiliations agreements shall require that all persons associated with the agreement be informed, understand, and comply with the standards of AIC prior to entry into the facility.
      4) Departments who acquire and are responsible for maintenance of information systems shall establish policies and procedures consistent with facility standards and recommended guidelines.

2. Access
   a. System administrators (database, hardware, security, etc.) shall:
      1) Define system and network access policies, procedures and controls to ensure the AIC of BRFHH information assets.
      2) Provide guidance and expertise to application administrators for operation of their application.
   b. Application administrators (generally departmental resources assigned management tasks associated with an application) shall:
      1) Define application access policies and procedures, including assignment of user ID and password, for any system containing restricted, confidential or personal information.
      2) Define policies and procedures to ensure the AIC of the information within their applications and in accordance with facility standards.
      3) Provide mechanisms for audit purposes in accordance with facility standards.
      4) Define password expiration policies and procedures in accordance with facility standards.
      5) Shall comply with all applicable facility policies, administrative directives or memorandums that address server based systems, networks, security and integrity of data, and maintenance of systems.
Provisional access

1) Computer Services shall:
   a) Coordinate department requests for application access approval with designated
      application data owners and ensure approved access results in appropriate permissions
      for access.
   b) Coordinate department requests for updating application access upon user transfer
      according to current business need.
   c) Remove user access upon termination or dismissal.

2) Department administrative personnel responsible for the supervision of individual users
   must submit:
   a) A detailed request in writing (memo, approved access form, email) specifying specific
      access requirements, suitable to the employees job role (read, write, amend, etc.), to
      the appropriate owner.
   b) The Louisiana Revised Statute 14.73.1 et seq. dictates access to information or
      systems without the consent of appropriate authorities constitutes illegal activity and the
      person(s) involved are subject to enforceable penalties that may include fine and
      imprisonment.
   c) Review access rights periodically to ensure that the rights granted are relevant to the
      assigned responsibilities for that individual.
   d) Notify Computer Services and data owners as soon as possible:
      - of termination or resignation of personnel.
      - of transfer of personnel to another area, unit or department.

3) Data owners are responsible for approving or denying application access based on valid
   business need for access. Only the minimum necessary access may be approved.

4. The electronic health record provides the following options to comply with legal mandates,
   hospital policy and the patient's wishes:
   - Break the Glass (BTG) – designed to allow user’s access to a restricted patient’s
     information. An audit trail stores details of the events when a user chooses to break the
     glass.
   - Confidential names (alias names)
   - Confidential patient types
     - Anonymous
     - Confidential (VIP)
     - Employee
     - Prisoner
     - Employee’s Family
   - Confidential Departments
     - Psychiatry Unit
     - Psychiatry Clinic
     - CARA Center
     - Viral Disease Clinic
     - PSY Faculty Clinic

5. All authorized users shall be accountable for:
   1) Properly safeguarding data under their control and/or direction according to its level of
      sensitivity.
   2) Maintaining the integrity of data.
   3) Accessing only the data and automated functions for which s/he is authorized, in the course
      of normal business activity
   4) Password control (in accordance with ITSP): a) password not easily guessed
      b) inadvertent disclosure
      c) immediate change if suspected disclosure
      d) report of any suspected misuse by another individual
   5) Appropriate log-off from the application(s).
   6) Safeguarding information, including ePHI, and resources available in the course of their job
      duties

Refer to:
security issues and policies.
3. User termination or transfer
   a. Department administrative personnel must insure that:
      1) Personnel who separate from the facility complete the Employee Clearance process.
      2) Appropriate system administrators receive notification of separation or termination of individuals who do not complete the Employee Clearance process or who involuntarily separate from the department. This notification shall be made as soon as possible.
      3) Appropriate system administrators receive notification when employees transfer to another unit, area or department.
      4) Timely review of staff’s access to systems is performed when job duties or assigned role is modified within the department.
   b. Application administrators shall:
      1) Disable access as soon as possible after receiving notification of separation or termination or notice of transfer.
      2) Shall comply with all applicable facility policies, administrative directives or memorandums that address server based systems, networks, security and integrity of data, and maintenance of systems.

4. Securing Information
   a. Storage Media
      1) Used to access, retrieve, and communicate confidential or sensitive information shall be maintained in accordance with facility standards. (See appropriate Chancellor Memorandums and or Administrative Directives).
      2) Are safeguarded against theft, tampering, and unauthorized access.
      3) Identified as confidential or sensitive information shall be labeled as “CONFIDENTIAL” and stored in areas that are restricted only to authorized personnel. Prior to discarding any CONFIDENTIAL storage media, the information shall be rendered unusable.
      4) Maintained to comply with all applicable facility polices administrative directives or memorandums.
   b. Request for Information/Records
      1) Requests for health record information shall be made available only to those employees, medical staff members, support staff, students, and etc., with a need to know, after displaying their identification badges.
      2) All requisitions for the retrieval of medical records shall contain the patient’s name, medical record number, current date/time and requesting party’s name. The requesting party’s telephone number and room number are also required for records requested for administrative purposes.
      3) Telephone request for patient-identifiable information are discouraged and limited to emergency situations (emergency requests are usually generated by physicians or other ‘key’ hospital/physician office staff). Telephone request shall be handled using a ‘call-back’ procedure to verify the identity of the requesting party.
      4) Release or disclosure of protected health information from external parties should be referred to the HIM department for disposition. Guidelines for disclosure are outlined in Hospital Policy #6.3 and BRFHH HIPAA Policies.
      5) Facsimile transmission of patient information is addressed in Hospital Policy 6.3.1
      6) Voice messages containing confidential information should not be left on answering machines.
      7) Shall comply with all applicable facility policies, administrative directives or memorandums.
   c. Patient Medical Records
      1) The “Lite Chart” (paper record) displays two warnings reminding of the obligation to maintain confidentiality and security of information: “Confidential Health Information” and “This folder may not be removed from the hospital premises”.
      2) The “Lite Charts” are transported to patient care areas and administrative offices via the pneumatic tubes, dumbwaiter, carts and/or courier staff. All staff transporting paper medical records must ensure the privacy of patient-identifiable information during the transport process. Medical records and/or carts loaded with medical records shall not be left unattended during the transport process. “Lite Charts” shall not be left unattended during the transport process.
      3) The “Lite Charts” are to be maintained in the patient care areas in locations that are not accessible by unauthorized individuals.
      4) Protected health information, paper or electronic, shall not be removed from the hospital premises except upon receipt of subpoena duces tecum, court order or state statute.
      5) Shall comply with all applicable facility policies, administrative directives or memorandums.
d. Disposing/Discarding Patient Identifiable Information
   1) PHI must be shredded or placed in a secured shredding container to ensure confidentiality.
   2) Labels containing patient identifiable information must be rendered illegible when discarded.
   3) Shall comply with all applicable facility policies, administrative directives or memorandums.

e. Hardware and System Access
   1) Personnel who are the primary user of a personal computer must maintain an approved anti-virus software package. Failure to do so will result in loss of ability to connect to the campus network.
   2) Remote access to systems shall be governed in accordance with facility standards.
   3) Screen savers, auto logoff, screen shields, or other means must be utilized to prevent unauthorized view of computer systems that contain sensitive or confidential data.
   4) Information Technology production areas shall be accessible only through a secured entrance by authorized personnel; unauthorized personnel must be accompanied by authorized personnel.
   5) Shall comply with all applicable facility policies, administrative directives or memorandums.

5. Security and Privacy Violations
   a. Security and Privacy violations are described in BRFHH Confidentiality Statement, BRFHH HIPAA policies and other applicable hospital policy resources.
   b. Reported variances/ incidents:
      1) Will be investigated by administrative staff to determine if the events were intentional due to an individual’s negligence, accidental mistake, improper training, or misunderstanding of the information resource and or policy.
      2) May result in suspension of an individual’s access.
      3) May result in disciplinary action up to and including termination. Violations, also, may constitute a criminal offense, Louisiana Revised Statutes 14.73.1 et seq.
      4) Shall comply with all applicable facility policies, administrative directives or memorandums.
   c. Unauthorized or improper disclosure, modification, or intentional destruction of health information violates state and federal laws, and may result in disciplinary action and/or civil and criminal penalties.
BRFHH CONFIDENTIALITY AGREEMENT

BRFHH has a legal and ethical responsibility to safeguard the privacy of all patients and protect information that is defined as confidential. Confidential information includes oral communication, information contained in manual documentation as well as information stored in the facilities computer systems. Patient, personnel, financial and other business records contain confidential information.

I understand that information regarded as confidential must be maintained in the strictest of confidence. As a condition of my affiliation with BRFHH, I hereby agree that I will not at any time during or after my affiliation with BRFHH, disclose any confidential information to any person, other than as necessary in the course of my affiliation with BRFHH, and when accompanied by the appropriate, authorized personnel. I understand that I am directly responsible for the accuracy and completeness of data entries which are entered into the facilities storage media.

Information in the facilities storage media may be accessed only by authorization from the Assistant Dean for Information Technology; computer system access is granted only to persons who have submitted a written application, and have been issued user identification codes. I understand that all user identification codes and passwords are confidential, and may not be shared or disclosed to any other person.

It is a crime punishable by fine and or imprisonment to reveal user identification codes or passwords (La. R.S. 14.73.1 et seq.). Using another employee’s user identification code/password or giving your user identification code/password to another person may result in disciplinary action, which may include suspension and/or termination.

I understand that it constitutes a security violation to fail to sign off when leaving the computer unattended; accessing any medical or employment record without appropriate need or approval; requesting another employee to access my employment or medical record; allowing another employee to utilize my password; accessing medical or employment records without having a legitimate reason; using another employee’s access code, revealing confidential information of patients, employees or business/financial details, etc. All security violations will be reported to and investigated by the appropriate authorities.

My signature below indicates I have read the Security, Confidentiality and Integrity of Information Policy and have been given the opportunity to have any questions regarding this statement explained to me, and the failure to abide by this agreement may result in disciplinary action, including dismissal from employment.
The introduction of weapons, alcohol or drugs on grounds or into buildings of BRFHH 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. Accordingly, it is the policy of the BRFHH that discovery of such unlawful items will be addressed as follows:

1. Contact the University Police Department (UPD) immediately upon discovery.

2. UPD shall:
   a. Confiscate the weapon, alcohol or drugs;
   b. UPD will act according to R.S. Codes or Federal Statutes as appropriate;
   c. Report the incident to the Hospital Administrator/Administrator on Call and Director of Human Resources (if employee involved). If faculty is involved, the Medical Director or Associate Dean for Academic Affairs shall be notified. Based on the UPD report, the appropriate disciplinary action, up to and including termination, may be taken.

Introduction or possession of such contraband is chargeable as “Deliberately or carelessly endangering the safety of, or causing injury to personnel or patients” for which the penalty is dismissal.
1. All medical record entries, including handwritten and electronic (EHR), must be legible, complete, dated, timed and authenticated by the person responsible for providing or evaluating the services provided, consistent with hospital policies and procedures.

2. Content of the Medical Record
   a. The content of the medical record, which includes written and electronic documentation, must enable:
      1) 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;
      2) a consultant to render an opinion after a patient examination and review of the medical record;
      3) another practitioner to assume patient care at any time;
      4) and the review of information required for case management, utilization review, quality review, transfer recommendations, etc.
   b. The medical record contains the following demographic information:
      1) The patient’s name, address, date of birth, and the name of any legally authorized representative;
      2) The patient’s sex
      3) The patient’s race and ethnicity
      4) The legal status of any patient receiving behavioral health care services
      5) The patient’s language and communication needs, including the preferred language for discussing health care issues.
   c. The medical record contains the following clinical information:
      1) The reason(s) for admission for care, treatment and services
      2) The patient’s initial diagnosis, diagnostic impression(s) or condition(s)
      3) Any findings of assessments and reassessments
      4) Any allergies to food or latex
      5) Any allergies to medication
      6) Any conclusions or impressions drawn from the patient’s medical history and physical examination
      7) Any diagnoses or conditions established during the patient’s course of care, treatment, and services
      8) Any consultations reports
      9) Any observations relevant to care, treatment and services
      10) The patient’s response to care, treatment and services
      11) Any emergency care, treatment and services provided to the patient before his or her arrival
      12) Any progress notes
      13) All orders
      14) Any medications ordered or prescribed
      15) Any medications administered, including the strength, dose, frequency and route
      16) Any access site for medication, administration devices used and rate of administration
17) Any adverse drug reactions
18) Treatment goals, plan of care, and revisions to the plan of care
19) Results of diagnostic and therapeutic tests and procedures
20) Any medications dispensed or prescribed on discharge
21) Discharge diagnosis
22) Discharge plan and discharge planning evaluation

d. The medical record contains the following information as needed to provide care, treatment and services:
   1) Any advance directives
   2) Any informed consent, when required by hospital policy
   3) Any records of communication with the patient, such as telephone calls or email
   4) Any patient-generated information

e. The medical record of a patient who receives urgent or immediate care, treatment and services contains all of the following:
   1) The time and means of arrival
   2) Indication that the patient left against medical advice, when applicable
   3) Conclusions reached at the termination of care, treatment and services, including the patient's final disposition, condition and instructions given for follow-up care, treatment and services
   4) A copy of any information made available to the practitioner or medical organization providing follow-up care, treatment or services.

f. A summary list (Snapshot) is initiated for the patient by his or her third visit. The patient’s summary list contains the following information:
   1) Any significant medical diagnoses and conditions
   2) Any significant operative and invasive procedures
   3) Any adverse or allergic drug reaction
   4) Any current medications, over-the-counter medications and herbal preparations

The patient’s summary list is updated whenever there is a change in diagnoses, medications or allergies to medications and whenever a procedure is performed.

The summary list is readily available to practitioners who need access to the information of patients who receive continuing ambulatory care services in order to provide care, treatment and services.

3. Chart Rules and Regulations
   a. History and Physical Examination
      1) A complete history and physical examination shall be documented and filed on the patient's medical record within the first 24 hours after admission for any procedure requiring consent or involving or requiring anesthesia services.
      2) If a history and physical examination has been completed within thirty (30) days prior to admission or performing a procedure requiring consent, a signed, durable, legible copy of this report may be used in the patient's medical record provided there has been no subsequent changes. An updated entry must be documented within 24 hours after admission for any procedure requiring consent or anesthesia services, documenting any changes in the patient's condition when the medical history and physical examination are completed within 30 days before admission. Upon admission, the patient shall be examined and the following entered into the EHR – patient examined, H & P reviewed and no changes noted or pertinent change includes the following.
      3) In the case of an emergency a preoperative note is recorded prior to the surgery/invasive procedure. In addition, the preoperative diagnosis & indicated diagnostic tests are completed and recorded in the patient's medical record before surgery/invasive procedure.
4) The history should include the following:
   a) Chief complaint
   b) Present illness
   c) Relevant past, family, and social histories, appropriate for age (including tobacco, alcohol and other substance use)
   d) Inventory 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.
   e) Evaluation of patient's developmental age (pediatric/adolescent records only)
   f) Consideration of educational needs and daily activities (Pediatric/adolescent records only)
   g) Immunization status (Pediatric/adolescent records only) and for the adult patient with a preliminary diagnosis of Heart Failure or Pneumonia, the vaccine history related to pneumococcal and influenza shall be documented
   h) Family and/or guardian's expectation for and involvement in, the assessment, treatment, and continuous care of the patient (Pediatric/adolescent records only)
   i) Head circumference until fontanel close (pediatric) as appropriate to patient's age & needs
   j) Length/weight within the past 7 days (pediatric/adolescent)

5) 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)

6) The recorded history and physical examination must be authenticated by a practitioner privileged to do so.

7) 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.

b. History and Physical Examination (Outpatient Surgery)
1) The history and physical information for outpatient surgery may be completed by a qualified physician or oral surgeon, but the individual performing the procedure MUST enter the following into the EHR (at minimum):
   a) An evaluation note regarding the patient's overall condition and
   b) Information regarding the operative/procedure site

2) The outpatient history must include the following for outpatient surgery:
   a) Indications/symptoms for surgical procedure;
   b) Current medications (dosages/frequency)
   c) Any known allergies, including medication reactions
   d) Existing co-morbid conditions, if any.

3) 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:
      - Vital signs
      - Assessment of mental status; and
      - An examination specific to the procedure proposed to be performed and any co-morbid conditions.
   b) Procedural Sedation:
      - Vital signs
      - Assessment of mental status
      - An examination specific to the procedure proposed to be performed and any co-morbid conditions.
      - Examination of heart and of lungs by auscultation.
      - Allergies
      - Family history of anesthesia problems
      - Medication history
      - Abnormal lab results
c. Deep Sedation, General, Spinal or Epidural Anesthesia:

Complete Physical Examination

Note: Anesthesia combinations require a physical relevant to the highest level of anesthesia provided.

d. The medical record contains the following 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.

e. 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 must reflect the involvement of the attending physician in the patient’s care.
5) All progress notes must be signed, dated and timed.

f. Consultations

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.

1) 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.

2) 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.

3) 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.

4) Professional Consulting Services (i.e. Nutritional Services, PT/OT, WOCN) may Pend orders for physicians to review and release once a consult is complete. The service will Pend orders that are within their scope of practice. All other recommendations that require orders shall be placed in the Physician Sticky Note.

5) To Pend an order the end users chooses “Pend” rather than “Sign” and must designate a reason for Pending. The MD then may view “Pended Orders”, open and either delete or release as appropriate.
g. Informed Consent
Informed consent must be obtained by a physician prior to any invasive and/or operative
procedure from each patient or the patient’s legally authorized representative. Informed
consent implies that the patient has been informed of the procedure to be performed, the risks
involved, any alternative procedures and the intended outcome. Informed consent is
documented by making:
1) appropriate progress notes in the patient's medical record and
2) by obtaining the signature of the patient or his/her legal representative on the approved
consent form. The progress notes should reflect the content of the discussion with the
patient and the physician's evaluation of the patient's understanding and response to the
information provided.

h. Operative Reports
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. 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) The name of the procedure performed
c) A description of the procedure
d) Findings of the procedure
e) Any estimated blood loss
f) Any specimens removed
g) The Postoperative diagnosis
2) The surgeon must authenticate the completed operative report as soon as possible
   following surgery.

i. Pre and Post Sedation/Anesthesia Assessment
There must be a pre-sedation or pre-anesthesia assessment documented in the patient’s
medical record before initiating operative or other high-risk procedures, including those that
require the administration of deep sedation or anesthesia. The pre-anesthesia/pre-sedation
assessment is entered by an individual qualified to administer anesthesia within 48 hours prior
to surgery or a procedure requiring anesthesia services.
1) The medical record contains the following postoperative information:
   1) The patient’s vital signs and level of consciousness
   2) The patient’s vital signs and level of consciousness
   3) Any medications, including intravenous fluids and any administered blood, blood products
      and blood components
   4) Any unanticipated events or complications and the management of those events.

j. Diagnostic and Therapeutic Orders (Verbal and Telephone Orders)
1) All orders for medications and treatment shall be entered by members of the medical staff
   and other practitioners involved in the care of the patient who may have been authorized to
do so by the granting of privileges.
2) Verbal orders shall be minimized. Verbal and telephone orders shall be accepted by the
   following healthcare professionals – registered nurses, registered pharmacist licensed
   respiratory therapists, certified/registered EEG technologists, physical/occupational
   therapists, licensed dietitians, medical technologists/ technicians, radiology technologists,
   nuclear medicine technologists, radiation therapists, and physician assistants. The
   healthcare professional accepting the verbal order must read the order back to the
   prescribing physician and enter the ‘read back’ into the EHR.
3) Physician extenders (physician assistants, advance practice nurses, etc.) may accept
   verbal orders from their supervising physician; the supervising physician shall authenticate
   these verbal orders (paper or electronically) within 24 hours for inpatients and hospital
   emergency departments and 72 hours in all other cases.
k. Do Not Resuscitate (DNR)
   DNR orders must be authenticated by an attending physician.

l. Transfers
   When a patient is transferred within BRFHH, 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.

m. Discharge Summary
   1) The discharge summary should be completed before or shortly after the time of inpatient discharge from the facility and should follow the following approved format:
      a) Patient Name
      b) Medical Record Number
      c) Hospital Service
      d) Attending/Resident Physician
      e) Referring Physician or Clinic
      f) Admission/Discharge Date
      g) Discharge Diagnosis (documented without the use of abbreviations or symbols):
      h) Reason for Hospitalization
      i) Significant Findings (physical and laboratory)
      j) Hospital Course
      k) Procedures performed and care, treatment and services provided
      l) 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.)
      m) Information provided to the patient and family (i.e., diet, medication, activity and follow-up, other discharge instructions)

   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 Advice” (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.

n. Countersignatures
   All written or electronic entries by physician extenders (physician assistants, advance practice nurses, etc.) shall be reviewed, and authenticated by the supervising physician within 24 hours for inpatients and within 72 hours for clinic and other practice settings. 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
1. A complete, legible and accurate paper and/or electronic medical record (EHR) will be maintained for every individual who is evaluated or treated as an inpatient, outpatient, or emergency patient at BRFHH.

2. Medical record entries must be completed in a timely manner. Records not completed within 30 days of discharge are considered delinquent.

3. The following time frames shall be followed when documenting the patient's medical record:

<table>
<thead>
<tr>
<th>Table Header</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>History and Physical Examination</td>
<td>H &amp; P must be completed and documented within 24 hrs following admission of the patient but prior to surgery or a procedure requiring anesthesia. An H&amp;P performed within 30 days prior to admission may be used if the following requirements are met—the physician enters an update; indicates that the patient was examined; and notes no changes or documents changes that have occurred.</td>
</tr>
<tr>
<td>Progress Notes</td>
<td>A daily progress note shall be entered into the electronic health record to provide a chronological record of the patient's encounter.</td>
</tr>
<tr>
<td>Verbal Orders</td>
<td>Verbal Orders shall be minimized and authenticated within 5 days of the date authorized. It is not prohibited for physicians and other practitioners to text orders for patients.</td>
</tr>
<tr>
<td>Operative report or other high-risk procedure</td>
<td>Operative or other high-risk procedure report is entered into the electronic medical record or dictated upon completion of the operative or other high-risk procedure before the patient is transferred to the next level of care. When the full report cannot be entered immediately a brief progress note is entered, including the following—names of the primary surgeon, any assistants, procedure performed and a description of each procedure, finding, estimated blood loss, specimen removed and postoperative diagnosis.</td>
</tr>
<tr>
<td>Discharge Summary</td>
<td>A concise discharge summary shall be documented within 10 days post discharge, including the following—reason for hospitalization, procedures performed; the care, treatment, and services provided; the patient's condition and disposition at discharge. Information provided to the patient and family and provisions for follow-up care. When a patient is seen for minor problems, a final progress note may be substituted for the discharge summary provided the note contains the outcome of hospitalization, disposition of the case and provisions for follow-up care.</td>
</tr>
</tbody>
</table>
4. The copy functionality in the electronic health record includes cut and paste, copy forward, cloning and any other intent to move documentation within or between records. This functionality can efficiently enter data and findings, however, inappropriate use may impact the accuracy of the data by adding unnecessary, irrelevant or inaccurate information to the record. The copy functionality must be used with caution.

Physician documentation must support medical necessity and the appropriateness of services provided. The copy functionality can assist in documentation if care is taken to edit records accurately to reflect the patient’s condition at each encounter. In addition to protecting the integrity of the health record and the provision of quality care, this quality documentation reduces organizational risk and the risk of payer’s denials.

5. Abbreviations listed on the Prohibited Abbreviations List may not be used in the paper or electronic health record:

<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>Misused as zero, four, or cc</td>
<td>Write unit</td>
</tr>
<tr>
<td>IU (International unit)</td>
<td>Misused as IV or 10</td>
<td>Write international unit</td>
</tr>
<tr>
<td>QD, Q.D., q.d., Q.D., q.d., qod (Latin abbreviation for once daily and every other day)</td>
<td>Misused for each other. The period after the Q can be mistaken for an “I” and the “O” can be mistaken for “I”</td>
<td>Write daily and every other day.</td>
</tr>
<tr>
<td>X.O - trailing zero</td>
<td>Decimal point missing</td>
<td>Never write zero by itself after a decimal and always use a zero before a decimal point.</td>
</tr>
<tr>
<td>.X mg - leading zero</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>

6. The EHR contains a summary list (snapshot) for each patient who receives continuing ambulatory care services.

7. A patient’s record is complete when the following criteria are met:
   - A medical history and physical examination
   - Admitting diagnosis
   - Results of all consultative evaluations
   - Documentation of complications
   - Property executed informed consent forms
   - Practitioners’ orders, nursing notes, reports of treatment, medication records, radiology and laboratory reports and vital signs and other information necessary to monitor the patient’s condition
   - Discharge summary with outcome of hospitalization, disposition of case and provisions for follow-up care
   - Final diagnosis

8. A weekly count of all incomplete and delinquent charts is generated by the electronic health record system on Sunday of each week. The report includes account of the number of total deficiencies, the total unique records, the total delinquent deficiencies and the total delinquent records. The report is distributed electronically to Hospital Administration, the Clinical Department Heads, Section Chiefs, residency coordinators and HIM management. Individual physicians receive notification electronically via their Pelican in-baskets of specific deficiencies requiring their attention.
9. Entries in the electronic health record may be corrected only by the ‘user’ (the individual who documented incorrectly). Specific detail instructions are available in the Chart Correction Guide available at http://pelican.lsuhealthsystem.org/golive/wp-content/uploads/2012/09/Chart-Correction-Guide.xls

10. Medical records entries shall be entered into the electronic health record at or near the time services are provided, except when the system is unavailable.

11. During downtime, the electronic health record downtime procedures shall be followed along with these record keeping practices:
   - All medical record entries must be legible, dated, timed and signed
   - Black or blue ink is recommended
   - Signatures shall include the first name, last name, licensure status and pager number.
   - Errors shall be corrected by drawing a single, thin line through each line of incorrect information; dating and initializing the error and entering the corrected information in chronological order indicating which entry the correction is replacing.
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 Hospital Clinical Board has adopted the following abbreviations as prohibited abbreviations (applies to all medical record entries – paper and electronic) –

<table>
<thead>
<tr>
<th>A. Prohibited Abbreviations</th>
<th>Potential Problem</th>
<th>Preferred Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>U, u (unit)</td>
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<tr>
<td>QD, Q.D., qd, 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 “I” and the “O” can be mistaken for “O”</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>A trailing zero may be used only when required to demonstrate the level of precision of the value being reported. However, a trailing zero may not be used for medication orders or medication-related documentation. - Always use a zero before a decimal point</td>
</tr>
<tr>
<td>MS, MSO₄</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.

5. The ‘Do Not Use’ Abbreviations List is posted on the facility’s web [http://www.sh.lsuhs.edu/policies/policy_manuals via ms word/prohibited_abbreviations.pdf](http://www.sh.lsuhs.edu/policies/policy_manuals via ms word/prohibited_abbreviations.pdf).

6. The use of prohibited abbreviations shall be monitored and reported through ongoing record review functions.
XII. Helpful Links

- Graduate Medical Education Homepage: [http://www.lsuhscshreveport.edu/gme/gmehome.aspx](http://www.lsuhscshreveport.edu/gme/gmehome.aspx)
- ACGME Glossary of Terms: [http://www.acgme.org/acgmeweb/Portals/0/PFAssets/ProgramRequirements/ab_ACGMEglossary.pdf](http://www.acgme.org/acgmeweb/Portals/0/PFAssets/ProgramRequirements/ab_ACGMEglossary.pdf)
- LSUHSC Human Resources: [http://myhsc.lsuhscshreveport.edu/HResources/HRHome.aspx](http://myhsc.lsuhscshreveport.edu/HResources/HRHome.aspx)
- University Health Hospital Policies: [http://team.uhsystem.com/BRFHHIntranet/TeamUHSPolicies-Hospital.aspx](http://team.uhsystem.com/BRFHHIntranet/TeamUHSPolicies-Hospital.aspx)
- Louisiana State Board of Medical Examiners: [http://www.lsbme.la.gov/](http://www.lsbme.la.gov/)
- My Evaluations Mobile Link: [mobile.myevaluations.com](http://mobile.myevaluations.com)
I acknowledge receipt of a copy of the Louisiana State University Health Sciences Center-Shreveport House Officer Manual. I understand that it is my responsibility to read and understand its contents. Any questions I may have about its contents should be directed to my program director. I understand that the information in the House Officer Manual is not all-inclusive and that the Medical Center or an individual department may establish additional policies and procedures necessary for the orderly fulfillment of its responsibilities. I understand that it is also my responsibility to learn and follow the policies and procedures established by my department that are not included in the House Officer Manual.

I recognize the Medical Center may, at its discretion, amend, add or eliminate policies when circumstances so require, and that I have a responsibility to do my best to keep apprised of any changes as they occur.

I agree to follow the Medical Center’s policies and I am aware that failure to do so may result in disciplinary action up to and including termination.

________________________________________
Resident Name (PRINT)

________________________________________
Resident Signature

________________________________________
Date Received

THIS DOCUMENT SHOULD BE PLACED IN THE MEDICAL EDUCATION FILE
PLEASE RETURN TO ROOM 1-201