TULANE UNIVERSITY SCHOOL OF MEDICINE

RESIDENT AND STAFF GRADUATE MEDICAL EDUCATION POLICIES AND PROCEDURES

2018-2019

All Graduate Students are bound by the University’s policies, which can be found at http://tulane.edu/administration/policies/
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PURPOSE OF GRADUATE MEDICAL EDUCATION

Welcome to Graduate Medical Education at the Tulane University School of Medicine, the 15th oldest medical school in the U.S. After nearly two centuries of medical education, Tulane remains dedicated to the development of residents in their progression to become exceptional physicians and scholars, encompassing excellence in each of the core competencies.

The GME office assumes stewardship in creating a supportive and safe clinical environment that facilitates residents’ professional, ethical, and personal development. The GME office ensures that each program, through curricula, evaluation, and resident supervision, ensures a residency training that enables safe and appropriate patient care.

Tulane’s participating hospitals have been chosen based upon their educational merits, permitting a diverse clinical exposure. Tulane’s faculty have been chosen based upon their educational, clinical and scientific prowess, enabling residents to advance their personal and professional careers. There are 32 ACGME-accredited training programs at Tulane University. The institution provides support for each training program, as well as the educational infrastructure necessary for training in each of these programs. Residents progressively advance in their clinical responsibilities based upon assessed competency, with close supervision by Tulane’s faculty at each stage of their development.

Dr. Jeff Wiese, the Associate Dean for Graduate Medical Education and Designated Institutional Official (DIO) oversees all GME activities. Each of the institution’s program directors answer directly to Dr. Wiese, and all major decisions regarding graduate medical education are brought before the Graduate Medical Education Committee (GMEC). In parallel to this committee is the Resident and Fellow Congress, composed of representatives from each program elected by their peers. The Congress in turn elects resident representatives to serve on the GMEC.

If I can assist you in any way during your years of training at Tulane please do not hesitate to contact me (504 388-7771) or anyone in the Graduate Medical Education Office (504-988-5464).

Jeff Wiese, MD, FACP, MHM
Associate Dean, Graduate Medical Education
jwiese@tulane.edu
SECTION 1:
Policies on Program Size and Complement
I. POLICY ON RESIDENT ELIGIBILITY AND SELECTION

Throughout the GME Policies and Procedures, the term “resident” collectively refers to both residents and fellows; “residency program” collectively refers to residency programs and fellowship programs.

A. Resident Eligibility. To be eligible for appointment to the Tulane University residency programs, applicants must meet one of the following qualifications:

1. Be a graduate in good standing from an allopathic medical school in the U.S. or Canada that is accredited by the Liaison Committee on Medical Education (LCME).
2. Be a graduate in good standing from an osteopathic medical school in the U.S. or Canada that is accredited by the American Osteopathic Association (AOA).
3. Be a graduate in good standing from a medical school outside of the U.S. or Canada who meets one of the following qualifications:
   a. Have received a currently valid J-1 Visa sponsored by the Educational Commission for Foreign Medical Graduates (ECFMG), or be a US Citizen, and have a Graduate Education Temporary Permit (GETP); or
   b. Have a full and unrestricted license to practice medicine in the state of Louisiana, as issued by the Louisiana State Medical Board, or
   c. Be a graduate in good standing from a medical school outside the U.S. who has completed a Fifth Pathway program provided by an LCME-accredited medical school.
4. Tulane University does not sponsor work visas (H1) for graduate medical education.

B. Resident Selection

1. Tulane University Graduate Medical Education Programs select from among eligible applicants on the basis of their preparedness and ability to benefit from the program to which they are appointed. Aptitude, academic credentials, personal characteristics, and ability to communicate are considered in the selection. These characteristics are accessed by the components of the ERAS application, or the equivalent, including the following: the applicant’s Dean’s letter of recommendation, the applicant’s letters of recommendation from faculty, the applicant’s medical school transcript and grades, the applicant’s NBME or COMLEX scores, the applicant’s scholarly and community service record, and the applicant’s evaluation from those who interview him or her on the date of his interview with the program. Tulane University has as its policy to consider all candidates for graduate medical education regardless of race, sex, creed, nationality, or sexual orientation. Performance in medical school, personal letters of recommendation, official letters of recommendation, achievements, humanistic qualities, and qualities thought important to the desired specialty will be used in the selection process.
2. All Tulane University Graduate Medical Education residency programs participate in the National Residency Matching Program (NRMP) in selecting residents with the exception of the Urology and Ophthalmology program, which selects residents through the San Francisco Matching Program, and the hematopathology, cytopathology, dermatopathology and preventive medicine fellowships, which have no nationally-organized match.
3. All programs must ensure that a sample copy of the resident’s contract is available to all applicants during the interview process, and all programs must make a sample contract available on their website.
   a. This contract should outline the terms, conditions, and benefits of appointment to the training program, either in effect at the time of the interview or that will be in effect at the time of his or her eventual appointment. (See Appendix C)
   b. Information that is provided must include: financial support; vacations; parental, sick, and other leaves of absence; and professional liability, hospitalization, health, disability and other insurance accessible to residents/fellows and their eligible dependents. (See Appendix C)
C. Recruiting residents outside of the match

1. Programs that participate in an organized match are bound by the conditions of the agreement with that entity. No applicant who is also a part of the organized match can be accepted into a residency program at Tulane outside of the terms of that match process.

2. Program directors who wish to add additional residents to their program during the time of the year when the match is not in effect (i.e., off-cycle) must send a formal request to the DIO, including the information outlined in Chapter III: Policy on Program Closure, Reduction, or Expansion.

3. No resident or fellow may be enrolled in a training program outside of the above noted match procedures without prior approval of the DIO. A resident or fellow enrolled outside of the match or without the prior approval of the DIO, will be the financial responsibility of the enrolling Department throughout the resident/fellow’s training, and may result in a reduction in the program’s match number for subsequent years.

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

D. Recruitment of residents between training programs at Tulane.

1. When a position in a training program is, or becomes, vacant, the program may advertise the vacancy and its intent to fill the position after receiving approval from the DIO.

2. A resident who is interested, but who is currently under contract in another Tulane training program, may apply for the open position.

3. The resident applicant must disclose to the recruiting program director any contractual obligation that currently exists to his or her current program. The resident must also disclose to his or her current program director the intention to pursue the open position.

4. The program director and faculty from the recruiting program must refrain from actively initiating, enticing or negotiating with the candidate until the resident’s current program director has given approval for this communication.

5. A letter of intent to release the resident from his or her contractual obligation and a letter of recommendation outlining his or her performance with respect to each of the core competencies must be obtained from the current program director before a contract can be offered to the resident by the recruiting program.

6. The start date for the resident in the new program must be approved by the resident’s current program director.

7. The DIO will serve as the mediator in any situation in which the two program directors cannot reach an amicable resolution to the resident wishing to switch programs.

8. Failure to abide by the rules set forth in this section may result in a reduction in the program’s complement for the following year.

E. Extension of Contracts

1. All residents who match to a GME position at Tulane will be sent a written contract outlining the terms and conditions of employment as a resident at Tulane. This contract will be mailed to the applicant within two weeks of the match results. Residents employed outside of the match or off-cycle will receive a similar contract within two weeks of extending the offer for employment.

2. The contract must comply with the institutional requirements for employment. A listing of the core components of the Tulane University standard GME contract is provided below. With the exception of the start and finish date, the standard institutional GME contract cannot be modified without the express permission of the DIO. The contract shall contain or provide a direct link to:
   a. Residents’ responsibilities
   b. Duration of appointment
c. Financial support  
d. Conditions for reappointment, including criteria for non-renewal and non-promotion  
e. Grievance procedures and due process  
f. Professional liability insurance  
g. Health and disability insurance  
h. Vacation, parental, sick, and other leave(s), including the effect of leave on the ability of residents to satisfy requirements for program completion  
i. Duty Hours policies  
j. Moonlighting policies  
k. Access to counseling services  
l. Physician impairment policies  
m. Harassment policies  
n. Accommodation for disabilities  
o. Access to information related to eligibility for specialty board examinations

3. Each resident contract requires the signature of the resident, the program director, the departmental chair, and the DIO. Payroll will not authorize salary payment unless the DIO has approved the contract by signature.  
4. Contracts for all residents are extended on a yearly basis. A contract must be initiated each year.  
5. Neither the Sponsoring Institution nor any of its ACGME-accredited programs will require a resident/fellow to sign a non-competition guarantee or restrictive covenant.  
6. A sample contract is included in Appendix C  
7. The PGY status listed in the contract is to be assigned based upon the PGY level routinely held for that position in the program (i.e., a first year resident will be paid as a PGY-1 status; a first year cardiology fellow will be paid as a PGY-4 status) regardless of the resident’s years of past training.

F. Policy on Completion of USMLE Step Examinations
1. The United States Medical Licensing Exam (USMLE) STEP II CK and CS must be passed prior to matriculation into any Tulane training program.  
2. An applicant who has failed Step II or Step III of the USMLE more than three times, even if the examination is subsequently passed, is ineligible for enrollment in a Tulane University residency training program.  
3. The United States Medical Licensing Exam (USMLE) STEP III must be taken within the PGY1 year of residency training. This requirement also applies to residents transferring into Tulane University programs during the PGY-2 year of training; these residents must have taken Step III in order to be eligible for enrollment.  
4. Any resident who fails to take STEP III by June 30th of the PGY1 year of training will be placed on immediate probation, for which the remediation will require a non-paid leave of absence (LOA) as outlined within Chapter XIV. Such Leave of Absence will remain in effect until STEP III has been taken and supporting documentation is obtained. The Departmental Chair and/or the Program Director will determine the maximal duration for which the LOA will be permitted; after that point, the resident is then in violation of his or her probation and immediate termination will be enacted.  
5. STEP III must be passed by December 31st of the PGY2 year of residency training. Failure to pass STEP III by December 31st may result in a formal letter of non-renewal of contract for the upcoming academic year.
6. All residents must have passed STEP III prior to matriculation into the PGY-3 year of training.

G. Residents Transferring to Another Program Outside of Tulane University.
In the event that a resident enrolled in a Tulane training program transfers to another training program outside of Tulane University, the Tulane program director must provide to the accepting training program timely verification of the resident’s education while at Tulane, and a summative performance evaluation of the resident in each of the six core competencies, as outlined in *Chapter XIV. Policy on Evaluation of Residents*.

H. Residents Rotating to Another Program Outside of Tulane University and Tulane University’s affiliated institutions.
1. To fulfill or expand curricular requirements, Tulane residents may on occasion be allowed to rotate to external training locations.
2. All external rotations must be approved by the resident’s program director.
3. To maintain training credit, the location must be an ACGME-approved training location, and the rotation must be under the supervision of an ACGME-accredited training program.
4. Because Tulane resident salaries and benefits (including malpractice insurance) are paid by the hospital at which he or she rotates, salary and benefits are not transferrable for rotations outside of Tulane University’s affiliated institutions.
5. Residents seeking to do rotations at external training locations must be responsible for ensuring that their salary and benefits, including malpractice insurance, are paid by the receiving training location or another external source for the time they are rotating away from Tulane University. Residents may choose to forgo salary/benefits during this time, or use vacation time to support this rotation, but they are still responsible for ensuring malpractice insurance is covered in order that they may participate clinically at the external rotation.
6. Tulane University will not authorize the transfer of CMS caps to support external rotations.

I. Auxiliary Learners
1. The presence of other learners (including, but not limited to, residents from other specialties, subspecialty fellows, PhD students, pharmacology students and nurse practitioners) must not interfere with the appointed residents’ education.
2. The program director must approve the presence of all auxiliary learners. If, in the program director’s discretion, the presence of auxiliary learners dilutes or impairs the training of the Tulane residents, the program director is authorized to remove and prohibit said auxiliary learners from the training environment.

J. External Resident and Fellow Rotators
1. External Rotators are defined as trainees currently enrolled in an ACGME-accredited residency training program who are not enrolled in Tulane University’s training programs.
2. The receiving program director must first approve the external rotation to ensure that it does not disrupt or diminish the educational experience of the Tulane University residents.
3. Upon receipt of the program director’s approval, the DIO must then approve the rotation.
4. Financial support of external rotators.
   a. The external rotator’s sponsoring institution must agree to financially support the external rotator, including salary, benefits and malpractice insurance.
   b. If the external rotator’s sponsoring institution is seeking CMS reimbursement for the external rotator, the respective GME Office must arrange a CMS cap transfer with the hospital at which the rotator will spend his/her time. This arrangement is between the external rotator’s sponsoring institution and the hospital; the financial funds flow will be between the hospital and the external rotator’s sponsoring institution. The role of the
Tulane University GME Office is to approve the rotation, but not to facilitate the contract between the rotator’s sponsoring institution and the hospital. 
c. If the external rotator’s sponsoring institution is not seeking CMS reimbursement for the external rotator, the external rotator’s sponsoring institution must assume all financial responsibility for the rotator, including salary, benefits and malpractice insurance.

5. The procedure for an external rotator is as follows
   a. The receiving program director must approve the rotation, as outlined above.
   b. The DIO must be informed of how the external rotator will be funded.
   c. The DIO must then approve the rotation, as outlined above.
   d. The receiving program coordinator will be responsible for the appropriate credentialing of the rotator for the respective rotation(s). This will include:
      i. Verification of approval from the rotator’s sponsoring institution
      ii. Verification of malpractice insurance
      iii. Assuring the appropriate orientation for the hospital/clinic rotations at which he/she will rotate.
      iv. Completing appropriate forms (TB testing, etc.) as required by the hospital at which he/she will rotate
      v. Obtaining a hospital ID card
      vi. Arranging for parking/beeper and other required amenities
      vii. Ensuring the rotator has been trained in all applicable Tulane University, and affiliated hospital policies, including, but not limited to, HIPPA training and compliance, and has received appropriate EMR training for the rotation at which he or she will attend.
      viii. Ensuring appropriate evaluation forms are returned to his/her sponsoring institution.
      ix. Communicating with the hospital at which the rotator will attend that the rotator has will temporarily be a part of the Tulane residency program during this rotation, and ensuring that the hospital has all necessary forms/credentials as noted above.
   e. Once the above procedure has been fulfilled, for the purposes of hospital credentialing, the external rotator will be considered a part of the Tulane training program during the time that he/she rotates at Tulane affiliated hospitals. All policies and procedures applying to Tulane residents including, but not limited to, grievance and supervision policies, will apply to the rotator during his/her time at Tulane.
   f. The Tulane GME Office will not be responsible for the credentialing process of the rotator as outlined above; the receiving program coordinator and director must assume this responsibility.

K. Residents not in ACGME-accredited programs
   1. Non-accredited trainees are defined as trainees who have completed their residency in an ACGME-accredited program who are now seeking to engage in additional clinical training for which there is no ACGME-accredited program (e.g., fellows seeking additional clinical training outside of ACGME-accredited training programs).
   2. Non-accredited training may be extended to trainees with the following provisions:
      a. The approval of the respective program director must be obtained prior to the non-accredited trainee’s presence on the teaching service. The program director is responsible for ensuring that the non-accredited trainee’s presence does not disrupt or diminish the educational experience of the residents in the training program.
      b. The approval of the DIO must be obtained prior to the non-accredited trainee’s presence on the teaching service.
c. Credentialing of non-accredited trainees is the responsibility of the hospital credentialing committee, and not the responsibility of the GME Office. The GME office will provide no verification of training for non-accredited trainees.

d. The respective department chairman is responsible for ensuring that the non-accredited trainee complies with all applicable Tulane University, and affiliated hospital policies, including, but not limited to, HIPAA training and compliance.

e. Non-accredited trainees are the responsibility of the sponsoring department, and not of the Tulane University Graduate Medical Education Office or of any of Tulane University’s ACGME-accredited programs. Non-accredited trainees will not be provided financial compensation or benefits, including malpractice and health insurance, by the Tulane GME office.

f. The rights afforded to trainees in accredited programs are not to be extended to non-accredited trainees, including, but not limited to, due process and grievance. Applicable rights are the responsibility of the sponsoring department. Non-accredited trainees may be removed from a teaching service at any time, at the discretion of the program director or the DIO, if their presence is found to disrupt or diminish the educational experience of trainees in an accredited program.

L. Observerships

1. Observers are defined as trainees who have not completed, nor are they enrolled in, an ACGME-accredited training program.

2. Observerships may be extended with the following provisions:

   a. The approval of the respective program director must be obtained before initiation of the observership. The program director is responsible for ensuring that the observer’s presence does not disrupt or diminish the educational experience of the residents in the training program.

   b. A Tulane University faculty physician must agree to sponsor the observer. He or she is responsible for ensuring that the observer is in compliance with Tulane GME and other University policies and procedures.

   c. The approval of the DIO must be obtained before initiation of the observership.

   d. Observers may not participate in clinical decision-making or provision of care. The observer’s role is as would be afforded to a medical student.

   e. The respective sponsoring faculty is responsible for ensuring that the observer complies with all Tulane University, and affiliated hospital policies, including, but not limited to, HIPAA training and compliance.

   f. Observers are not employees or trainees of Tulane University.

      i. Tulane University will not provide financial compensation or benefits, including malpractice insurance, to observing residents.

      ii. The rights afforded to Tulane employees and trainees, including but not limited to, due process and grievance, are not extended to observers.

      iii. Observerships are a privilege, and may be revoked without cause for any reason, including but no limited to, failure to comply with the standards noted above.

   g. Observing residents will be offered no credit towards training requirements.

3. Programs may not charge observers for services.

Approved by the GMEC; December 17th, 2015
II. POLICY ON EQUAL OPPORTUNITY, AFFIRMATIVE ACTION, AND DISABILITY ACCOMMODATIONS

A. EQUAL EMPLOYMENT OPPORTUNITY STATEMENT
Tulane University is committed to providing equal employment opportunity to qualified persons without regard to race, color, sex, religion, national origin, age, disability, genetic information, sexual orientation, gender identity, gender expression, pregnancy, marital status, military status, veteran status, or any other status or classification protected by federal, state or local law. This commitment to equality extends to all personnel actions, including recruitment, advertising for employment, selection for employment, compensation, performance evaluation, and selection for training or education, treatment during employment, promotion, transfer, demotion, discipline, layoff and termination. Discrimination on the basis of any protected classification will not be tolerated.
Tulane maintains a written Affirmative Action Policy. Tulane invites qualified individuals with disabilities, special disabled veterans, Vietnam-era veterans, Armed Forces service medal veterans, recently separated veterans from all wars, and other protected veterans who served during a war or in a campaign or expedition for which a campaign badge has been authorized to identify themselves if they wish to do so. Questions regarding Tulane’s Equal Employment Opportunity Policies or its Affirmative Action Policies should be directed to the Office of Institutional Equity. Furthermore, Tulane takes affirmative action to recruit and employ special disabled veterans, disabled veterans, recently separated veterans, other protected veterans, Armed Forces Service Medal veterans, in accordance with The Vietnam Era Veterans Readjustment Assistance Act of 1974, as amended, 38 U.S.C. 4212.
Complaints of discrimination, harassment and/or retaliation must be filed in accordance with the policies set forth below. Individuals must promptly report discrimination, harassment and retaliation so that prompt and appropriate action can be taken.

B. ANTI-DISCRIMINATION STATEMENT
Tulane is committed to and encourages a diverse and inclusive community that respects and values individual differences. In support of this commitment, Tulane University prohibits discrimination in its employment practices or educational programs/activities on the basis of race, color, sex, religion, national origin, age, disability, genetic information, sexual orientation, gender identity, gender expression, pregnancy, marital status, military status, veteran status, or any other status or classification protected by federal, state or local law. Tulane University complies with applicable federal and state laws addressing discrimination, harassment and retaliation. Discrimination or harassment on the basis of any protected classification will not be tolerated.
Complaints of discrimination must be filed in accordance with the policies set forth below. Individuals must promptly report discrimination so that prompt and appropriate action can be taken.
Deborah Love, Vice-President for the Office of Institutional Equity, is Tulane’s designated investigation coordinator for the Americans with Disabilities Act, and Section 504 of the Rehabilitation Act of 1973. Deborah Love and Wendy Stark, Director of OIE, also serve as Deputy Title IX Coordinators for Tulane. They may be contacted at the Office for Institutional Equity, 200 Broadway Street, Suite 105-A, New Orleans, LA, 70118 or reached by telephone at (504) 862-8083. OIE’s email address is oie@tulane.edu.
Meredith M. Smith has been designated as the University’s Title IX Coordinator. Any alleged violations of these policies or questions with respect to sexual misconduct or sexual harassment should be directed to Meredith M. Smith, Office of Academic Affairs & Provost; Lavin-Bernick Center for University Life, Suite G02, Tulane University, New Orleans, LA 70118; (504) 314-2160; msmith76@tulane.edu; titleix.tulane.edu.
A person may also file a complaint with the Department of Education’s Office for Civil Rights regarding an alleged violation of Title IX by calling (800) 421-3481 or visiting: www2.ed.gov/about/offices/list/ocr/complaintintro.html.
C. The Americans with Disabilities Act (ADA)
The University is committed to equal employment and educational opportunity and nondiscrimination of qualified faculty, students, and staff with physical and mental disabilities in accordance with the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act of 1973, as amended, and state and local laws and ordinances. An individual is considered to have a disability if they have a physical or mental impairment that substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such impairment.
The ADA prohibits discrimination against a qualified individual with a disability in employment practices such as job application procedures, hiring, promotion, discharge, compensation, training, benefits and other conditions of employment. A qualified individual is one who can perform the essential functions of his or her job with or without a reasonable accommodation. The ADA also requires that employers provide reasonable accommodations to qualified individuals with known disabilities. A reasonable accommodation is designed to assist an employee in the performance of his or her job without placing an undue hardship on Tulane or posing a direct threat to the employee or to other individuals.
In addition, Section 504 of the Rehabilitation Act of 1973 states that no otherwise qualified individual with a disability shall, solely by reason of his or her disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance from the U.S. Department of Education.
The Goldman Center for Student Accessibility (Goldman) is committed to providing equal access and a friendly environment for all who study and work at Tulane University. Goldman offers accommodations and modifications of the academic or work environment to qualified students and employees with psychological, medical/physical, and learning/developmental disabilities.
Goldman has been designated to coordinate student and employee requests for accommodations. Students and employees should make accommodation requests directly to Goldman. It is your responsibility to request an accommodation. Tulane may require written documentation from your health care provider with knowledge of your limitations.
Concerning employees, if Goldman notifies the Office of Human Resource (OHR) that an accommodation has been approved, implementation of the accommodation will be handled by the employee’s department.
If you requested and were granted an accommodation, you must report changes in your ongoing need for accommodation. Goldman staff may be contacted at http://www2.tulane.edu/studentaffairs/support/accessibility/index.cfm.
The University has adopted an internal grievance procedure providing for prompt resolution of complaints alleging violation of the University’s ADA policy. If you have concerns regarding denial of a reasonable accommodation or the specific accommodation selected by the University, you are encouraged to review the process with Goldman. In the event you disagree with the determination or proposed accommodation or believe you have been discriminated against based on a disability, you should contact the Office of Institutional Equity at (504) 862-8083, located at 200 Broadway Street, Suite 105-A, New Orleans, LA, 70118, or file a report on line at: www.Tulane.edu/concerns.

D. Individuals with disabilities may apply to Tulane residency training programs. Each program is required to have a job description, outlining the minimum mental and physical requirements of the training program. Applicants with disabilities will not be discriminated against provided they meet the minimum job requirements outlined in the program’s job description.

E. TITLE IX
It is the policy of Tulane University to comply with Title IX of the Education Amendments of 1972, which prohibits discrimination (including sexual harassment and sexual misconduct) based on sex in the University's educational programs and activities. Title IX also prohibits retaliation for asserting claims or sex discrimination. Tulane has a designated Title IX Coordinator. The Title IX Coordinator oversees the University’s centralized review, investigation, and resolution of reports of sex discrimination, including sexual harassment and violence.

Meredith M. Smith, Title IX Coordinator
Tulane University Title IX Office
Lavin-Bernick Center, Suite G03 New Orleans, LA 70118 msmith76@tulane.edu
(504) 865-5615

Faculty, Staff or Students may contact the following for information:
Deborah Love, Deputy Title IX Coordinator Tulane University
Office of Institutional Equity 200 Broadway, Suite 105 A New Orleans, LA 70118 dlove1@tulane.edu
(504) 862-8083

Wendy Stark, Deputy Title IX Coordinator Tulane University
Office of Institutional Equity 200 Broadway, Suite 105 A New Orleans, LA 70118 wstark@tulane.edu
(504) 862-8083

Erica Woodley, Deputy Title IX Coordinator for Student Affairs Tulane University
Division of Student Affairs 6823 St. Charles Avenue
Lavin-Bernick Center for University Life, Room G03 New Orleans, LA 70118
ewoodley@tulane.edu (504) 314-2188

Approved by the GMEC; November 29th, 2017
III. POLICY ON PROGRAM CLOSURE, REDUCTION OR EXPANSION

A. Program Reduction:
1. Should an affiliated training location close or reduce the funding of residency positions, an attempt will be made to relocate affected residents to other affiliated training locations that meet the educational requirements for the resident’s training.
2. Should appropriate educational opportunities or funding not be available among Tulane affiliates, and it thus becomes necessary to reduce the number of residency positions in the affected program, the residents of the affected program will be informed as soon as possible.
   a. If educational opportunities are sufficient for a reduced complement of residents, but not for the current complement of residents, the program will first attempt to reduce the program’s size by sequentially decreasing the incoming match class to the program.
   b. If this is still insufficient to bring the program to a right-size for the educational opportunities that do exist, the DIO will work with the program director in assisting current residents in finding a training position at another ACGME- accredited program such that their training may continue.
   c. No resident will be released from employment due to financial exigency until another training position at another ACGME- accredited program is ascertained.

B. Program Closure
1. If it becomes necessary to close a program, the residents already in the affected program will be informed as soon as possible.
2. The residents in the affected program will be allowed to complete their education at Tulane as long as educational opportunities consistent with accreditation continue to exist.
3. If such educational opportunities do not exist, the DIO and the respective program director will assist the residents in enrolling in another ACGME- accredited program in which they can continue their education.
4. No resident will be released from employment due to financial exigency until another training position at another ACGME- accredited program is ascertained.
5. Program closure due to an institutional-level disaster is addressed in Chapter IV. Policy on Disaster/Interruption of Resident Training.

C. Program Expansion
1. Expansion of a residency’s complement is based upon approval by the ACGME, and upon the educational opportunities afforded by the residency program. The following requirements must be met in order to request expansion of a residency program.
2. A request must be made in writing to the Designated Institutional Official. The request must include the following:
   a. The current resident complement in the program, the ACGME residency complement cap for the program, the requested number of expansion positions, and a prospectus of the program’s size for each of the future “x” number of years. “X” is defined as the duration of the residency program.
   b. Clear delineation of educational rationale for an increase in complement. Include:
      i. The educational opportunities (patient volume) that now exist that did not previously exist for the residents in the training program.
      ii. The faculty supervision that now exists that did not previously exist for the residents in the training program. Include a current faculty list from the program’s WebADS.
      iii. The impact the expansion, or failure to expand, will have upon current residents’ education. This should include commentary on how the expansion will or will not dilute the educational experience of other residents currently in the program, and include the impact expansion may have on work hours regulations.
as it regards current residents.
iv. This should include a current rotation schedule for the residents, and a
prospectus of how this rotation schedule would change with additional residents.
c. Case Logs and Procedures. If the program is required by the RRC/ACGME to submit
case logs for board certification, include the following:
i. Current residents case logs.
ii. The last set of graduating residents case logs
iii. Institutional data for faculty procedures (from participating sites)
iv. Commentary on how sufficient case logs will be fulfilled for all residents in
the program with the proposed expansion
d. The most recent ACGME accreditation letter, including citations and the program’s
response to these citations. Include a statement of how the resident expansion will affect
these citations.
e. The most recent ACGME resident survey.
f. A prospectus on how the additional resident(s) will be funded.
3. Completed applications will be brought before the GMEC with a recommendation from the
DIO for either expansion or denial of expansion. The GMEC will vote upon the proposal
4. The program director may not appoint more residents than approved by the ACGME Review
Committee. The program’s educational resources must be adequate to support the number of
residents appointed to the program. Program directors may submit the above information to the
DIO’s office as a proposed request to petition the ACGME for an expansion in their residency
cap. If the above is approved by the DIO and the GMEC, the DIO will endorse the petition in
concert with the program director to the ACGME. If the ACGME subsequently approves the
increase in cap, the DIO and the GMEC will consider the proposal provided that adequate
financial resources are available.

Approved by the GMEC; August 17th, 2011
IV. POLICY ON DISASTER/INTERRUPTION OF RESIDENCY TRAINING

A. Subject to Tulane University School of Medicine’s policy regarding closures and reductions of training programs, in the event of a disaster or an event that causes the interruption of resident training, the Tulane University School of Medicine has adopted the following policy related to its residents.

1. The Office of Graduate School Medical Education will annually collect/update emergency contact information from all House Officers each spring.

2. The GME office will annually send out emails to residents with emergency information.

3. Tulane will continue to provide administrative support that may include continued payment of salary and benefits depending on the overall circumstances, scope and duration of the Emergency, subject to Tulane’s Policy on Residency Training Program Closure or Reduction.

4. In the event of an Emergency, Tulane will work closely with the ACGME and other accrediting bodies to ensure that minimal interruption occurs in a House Officer’s training experience and that House Officers are transferred (if needed) temporarily or permanently, to new sites.

5. In the event of an Emergency, Tulane will assess, in consultation with the appropriate accrediting bodies, whether certain programs may need to be temporarily or permanently withdrawn in order to ensure a quality training experience.

B. Hurricane-specific Policies

1. Hurricane Watch-
   a. Upon a Hurricane Watch, the GME office will ensure that all files related to current residents are portable via electronic storage. This will include information vital for resident and fellow credentialing, licensing and transfer.
   b. The GME office will contact each residency program administrator. The office will ensure that each program coordinator has a portable electronic version of all resident/fellow files containing information vital for resident and fellow credentialing, licensing and transfer. The office will ensure that the program administrator has up-to-date emergency contact information for each resident, including a non-university email account through which the resident/fellow can be contacted in the event of an emergency.
   c. The DIO will contact each program director and confirm that the program director has communicated the warning to his or her residents. For applicable programs, the DIO will ensure that the program director is prepared to activate his or her program’s Code Grey or Code Cloud plan.

2. Code Cloud (Tropical Storm or Hurricane Category 1 or 2)
   a. A Code Cloud will be called for an impending Tropical Storm, or Category 1 or 2 Hurricane.
   b. Upon activation of a Code Cloud, the hospital administrations will notify the Dean and the DIO.
   c. The DIO will then contact each program director and the department chair and instruct him or her to provide the names of the individuals, as specified below, who will be providing coverage on the day of the Code Cloud activation, and the day following the Code Cloud activation.
   d. The DIO will then inform the hospitals of the personnel who will be providing coverage.
   e. Principles of the Code Cloud
      i. The goal of the Code Cloud Coverage is to ensure the on-going operation of the hospital for two days surrounding the storm, without burdening the hospital with excessive staff or residents.
ii. The presumption underlying the Code Cloud is that access to the hospital immediately following the storm may be impaired; ensuring the next day’s clinical services will be addressed proactively by housing the next day’s teams in the hospital prior to the storm.

iii. As opposed to a Code Grey, a Code Cloud assumes that the damage from the storm will not be sufficiently severe to warrant mandatory city evacuations, nor prolonged hospital stays for the faculty and staff. As such, there is a greater degree of comfort in selecting residents and faculty who are already on the call schedule.

iv. Staying with the call schedule ensures a less disruptive and more effect “re-entry” following the storm’s abatement (i.e., residents’ call cycle frequency and duty hours are not disrupted).

f. While the Code Cloud Coverage operates on pre-existing call schedule coverage, program directors and chairs should make suitable substitutions for personnel who, due to life issues (i.e., child care, etc.), cannot afford to be in the hospital for 48 hours.

g. Essential services

i. Residents on-call for essential services (as defined below) will report on the day of the activation of the Code Cloud (as they ordinarily would), and will be provided housing on the day of call, and the day following call in the event that they cannot return home following the storm.

ii. Residents that are pre-call for essential services (as defined below) will also report on the day of the activation of the Code Cloud (their pre-call day), and will be provided housing on the day prior to their call day, and the day of their call day.

iii. Essential services will include the following. Personnel for these services will consist of the previously scheduled on-call team, the pre-call team, and faculty for these two teams. A listing of Code Cloud departmental assignments is in Appendix E

   a. General internal medicine
   b. Intensive care medicine
   c. General surgery
   d. General pediatrics (Lakeside only)
   e. Pediatric ICU (Lakeside only)
   f. OB/Gyn (Lakeside only)

h. Precautionary Services. Services for which the hospital must have access, but are not imminently necessary, will be provided by faculty (at the numbers listed below) but not residents. These services include the following. A listing of Code Cloud departmental assignments is in Appendix E

   i. Ophthalmology *(will sign-out their patients to the General Surgery Service)* (1 faculty at Tulane; 1 faculty at UMC/VA)
   ii. Urology *(will sign-out their patients to the General Surgery Service)* (1 faculty at Tulane; 1 faculty at UMC/VA)
   iii. Orthopaedics *(will sign-out their patients to the General Surgery Service)* (1 faculty at Tulane; 1 faculty at UMC/VA)
   iv. Otolaryngology *(will sign-out their patients to the General Surgery Service)* (1 faculty at Tulane; 1 faculty at UMC/VA)
   v. Neurosurgery *(will sign-out their patients to the General Surgery Service)* (1 faculty at Tulane)
   vi. Nephrology (1 faculty at Tulane; 1 faculty at UMC/VA)
   vii. Gastroenterology (1 faculty at Tulane; 1 faculty at UMC/VA)
   viii. Interventional cardiology (CCU teams will sign out their patients to the medical ICU Service. (1 faculty at Tulane; 1 faculty at UMC/VA)
   ix. Interventional Radiology (1 faculty at Tulane)
   x. Diagnostic Radiology (1 faculty at Tulane)
   xi. Anesthesia (2 faculty at Tulane)
i. Non-essential services will not have residents or faculty present, but faculty will be available for telephone consultation. These include:
   i. Pathology and Pathology Fellowships
   ii. Psychiatry
   iii. Allergy/Immunology
   iv. Endocrinology
   v. Infectious Diseases
   vi. Child Psychiatry
   vii. Preventive Medicine
   viii. Neurology *(will sign-out their patients to the General Medicine Service)*
   ix. Hematology/Oncology *(will sign-out their patients to the General Medicine Service)*
   x. Dermatology
   xi. Hepatology *(will sign-out their patients to the General Surgery Service)*

j. Call rooms will for all in-house personnel will be assigned proactively ahead of the Code Cloud activation, and will be on file with the DIO.
k. Once the storm has passed and access to the hospital is assured to be safe, the Code Cloud will be lifted. Hospital leadership will inform the DIO, who will then inform the residents and faculty. Access to the hospitals will be allowed for all personnel as it is deemed to be safe.

3. Code Grey Army (Hurricane Category 3 or above)
   a. A Code Grey will be called for an impending Hurricane Category 3 or above.
   b. Upon activation of a Code Grey, the hospital administrations will notify the Dean and the DIO.
   c. The DIO will then contact each program director and the department chair to ensure that the previously provided names for the Code Grey Army (as provided on July 1st of each academic year) are accurate.
   d. The DIO will then inform the hospitals of the personnel who will be providing coverage.
   e. Principles of the Code Grey Army
      i. The goal of the Code Grey Army is to ensure the on-going operation of the hospital for three to four days surrounding the storm.
      ii. Like a Code Cloud, the goal is to provide necessary person without burdening the hospital with excessive staff or residents. Unlike a Code Cloud, it is possible that all personnel will require evacuation, and will consume more resources (food, water) because of a prolonged hospital stay. As such, it is imperative that the necessary number of people are present, but not more than that.
      iii. The presumption underlying the Code Grey is that a prolonged hospital stay is to be expected. As such, Code Grey personnel should be proactively selected such that the right personnel capable of handling the assignment are chosen. Each program is to choose personnel for the Code Grey Army by July 1st of each academic year.
      iv. As opposed to a Code Cloud, a Code Grey assumes that the damage from the storm will be sufficiently severe to warrant mandatory city evacuations. Because all personnel on the Code Grey Army have been proactively chosen (as of July 1st of each academic year), residents not on the Code Grey Army therefore have the luxury of timely and safe evacuation from the city.
      v. Because a Code Grey Army assignment has a reasonable probability of executing patient evacuations, the Code Grey Army should be selected in sufficient advance to become trained in the hospital policies regarding patient evacuation policies and procedures.
f. The goal of the Code Grey Army is to ensure the emergent operation of the hospital for up to 4 days surrounding the storm. Because this will be an extended tour of duty, programs and departments must proactively choose personnel for this assignment (i.e., personnel should not be assigned arbitrarily by who is on service for that month, or who is on call for those days). Directors and chairs should follow the following principles in selecting personnel:
   i. No resident may be conscripted into service. Only residents volunteering for duty should be selected.
   ii. It is preferable to not choose residents and faculty with dependent children or adults whose hospital service during the Code Grey would thus be compromised because of concerns for their family.
   iii. It is preferable to not choose residents and faculty with medical issues that could be compromised by an extended stay in the hospital.
   iv. The GME office recognizes that not every resident is equally prepared to endure the responsibilities required of disaster duty. From the pool of volunteers, the director and chair should choose personnel who they believe will have the mental stamina to endure up to four days in the hospital.
   v. Interns should not be chosen for Code Grey assignments; by definition of the hurricane season (July- November), they will lack sufficient familiarity with the hospital system, and cannot provide the necessary procedures that upper-level residents can perform.
   vi. Programs should anticipate that those selected to be on the disaster team might not be available during the disaster (due to vacations, etc.). Programs should select and train two people for each position to which they are assigned. Those not assigned during an emergency situation will constitute the “Relief Team” as outlined below. Programs are required to submit their Code Grey roster to the GME Office prior to the onset of hurricane season (July 1st).

g. Essential services. Essential services will include the following. Personnel for these services will consist of the previously scheduled on-call team, the pre-call team, and faculty for these two teams. A listing of Code Grey Army departmental assignments is in Appendix E.
   a. General internal medicine
   b. Intensive care medicine
   c. General surgery
   d. General pediatrics (Lakeside only)
   e. Pediatric ICU (Lakeside only)
   f. OB/Gyn (Lakeside only)

h. Precautionary Services. These are services for which the hospital must have access, but are not imminently necessary. As a general rule, surgical services will consolidate their patients onto the general surgery service for on-going management through the hurricane; neurology and medical subspecialty services will consolidate their patients onto the general medicine service for on-going management through the hurricane. A listing of Code Grey Army departmental assignments is in Appendix E.
   i. Ophthalmology (will sign-out their patients to the General Surgery Service)
   ii. Urology (will sign-out their patients to the General Surgery Service)
   iii. Orthopaedics (will sign-out their patients to the General Surgery Service)
   iv. Otolaryngology (will sign-out their patients to the General Surgery Service)
   v. Neurosurgery (will sign-out their patients to the General Surgery Service)
   vi. Nephrology
   vii. Gastroenterology
   viii. Interventional cardiology (CCU teams will sign out their patients to the medical ICU Service).
ix. Interventional Radiology  
x. Diagnostic Radiology  
xi. Anesthesia  

i. Non-essential services will not have residents or faculty present, but faculty will be available for telephone consultation. These include:  
i. Pathology and Pathology Fellowships  
ii. Psychiatry  
iii. Allergy/Immunology  
iv. Endocrinology  
v. Infectious Diseases  
vi. Child Psychiatry  
vii. Preventive Medicine  
viii. Neurology (*will sign-out their patients to the General Medicine Service*)  
ix. Hematology/Oncology (*will sign-out their patients to the General Medicine Service*)  
x. Dermatology  
xi. Hepatology (*will sign-out their patients to the General Surgery Service*)  

j. The Activation Team. Once a hurricane warning has been called, the Activation Team will be deployed to their respective stations. All other residents will sign-out their patients to the activation team residents, and then depart the city. If a full evacuation of all patients in the hospital is required, the Activation Team will sequentially accompany the evacuated patients to evacuation centers per hospital protocol.  

k. The Relief Team. Each program will be asked to proactively assign residents and faculty to a Relief Team. For simplicity, the composition of the relief team should match the activation team. Interns may be used for the relief team. Once a Code Grey has been called, the Relief Team will begin preparations to evacuate to Jackson, Mississippi. Hotel or dormitory rooms will be provided by the University for designated Relief Team members.  
i. Relief team members will remain in Jackson, MS, until they are activated to return to New Orleans. At which time, the relief team will convoy to New Orleans.  
ii. The Activation Team will subsequently be relieved of their duties. The Activation Team will convoy to Jackson, MS, unless the city has been deemed safe for inhabitation, in which case they will be free to return to their homes.  
iii If a full evacuation of all patients in the hospital is required, the Relief Team will be directed to evacuation centers to provide relief for the activation team.  

l. As with a Code Cloud, program directors and chairs will instruct all students, residents, and faculty who have not been designated as the Code Cloud Army to stay away from the hospital facilities until the Code Grey has been lifted.  

4. All programs are required to provide emergency contact information (cell phone numbers, secondary email addresses, and preferred relocation destinations) for all residents.  

*Approved by the GMEC; July 17th, 2012*
SECTION 2: POLICIES ON RESIDENT SUPPORT & CURRICULUM
V. POLICY ON FINANCIAL & RESOURCE SUPPORT OF RESIDENTS

A. Parking is provided for residents assigned to UMC, TMC, and SLVHCS (VANO) at the downtown medical campus, and through individual affiliated training locations as specified in affiliation agreements.

1. All residents will be provided parking at the downtown medical campus.
2. Select programs will be provided additional parking for residents at UMC and the SLVHCS (VANO).
   a. These positions are prioritized for programs that have:
      i. Prolonged shifts in the hospital (whereby they would be leaving at odd hours of the night when the shuttles do not run),
      ii. Programs that are already up against the 80 hour/week duty limit, such that waiting for shuttles on the afferent and efferent side of transportation would risk non-compliance with the 80 hour limit.
3. For residents that do not have additional parking at UMC and the VA, a shuttle service will be provided that rotates on a downtown-only campus loop.
   a. Shuttle times can be found at http://www2.tulane.edu/universityservices/transportation/medical-loop.cfm
   b. Residents can access the SmartTraxx app for real-time GPS shuttle locations and the TAP-RIDE app, which enables a resident to request a shuttle when needed.
   c. All residents will be provided the Rave Guardian app, enabling residents to request a virtual safety escort regardless of method of transportation. http://www2.tulane.edu/universityservices/transportation/index.cfm
4. Residents coming into the VA or UMC after hours, or those on a service where they are emergently called over to the hospital for an emergent procedure/operation, can stop by the security desk next to the ED and get their parking validated for a free exit. And if you are on a you can also have the parking ticket validated.

B. Pagers are provided for the duration of the residencies. Each resident is responsible for returning the pager at the completion or termination of training; a seventy (70) dollar charge will be accessed for lost of stolen pagers. The GME Office provides each program with an adequate number of pagers; distribution is the responsibility of the program coordinators.

C. Technology Services Support. Tulane University has a dedicated office for free informational and tech support for all resident/faculty computer questions/assistance, available through the Technology Services Help Desk (988-8888).

1. Each resident is given an email account and password, providing twenty-four hour access to educational materials on the Tulane University website, including on-line streaming video of important lectures and the Tulane Library. Through the Tulane Library website, residents have 24-hour access to Up-to-Date, Medline, Ovid, DynaMed Program, and ExamMaster. These services provide access to full-text journal subscriptions as well as other on-line medical textbooks, providing access to specialty-specific and other appropriate reference material in print as well as electronic format.
2. On-line evaluation services are provided at no charge for each resident, allowing for the convenience of at-home evaluation review and completion.
3. Each resident is provided HIPAA training as a part of the orientation, and after completing this training, can receive additional training at no cost to learn how to access the electronic medical records of the three primary training locations at Tulane: UMC (EPIC), TMC (Meditech and E-Clinical Works) and The VA (CPRS). For residents enrolled off-cycle, it is the responsibility of the sponsoring training program to ensure that the resident has received appropriate HIPPA training at each clinical institution through which he or she will rotate.
4. Each call room is to contain a telephone and a computer, to ensure 24-hour access to the medical literature and educational resources necessary for optimal learning and patient care, as well as access to the electronic medical record of the hospital in which the resident is providing patient care.

D. Each hospital in which residents perform inpatient and home-call care must have the following components:
1. Safe, quiet, and private sleep/rest facilities for those residents on call. Each call room must have access to a computer and a telephone.
2. Each facility must offer 24-hour access to food for those residents who are on-duty at that location.
3. Security and safety measures appropriate to the participating site.

E. Simulation Center. Each resident is offered access to Tulane University’s simulation center at no additional cost.

F. Health Insurance- health insurance is provided to residents at no cost. Family health coverage is available at an additional cost to the resident. Health insurance eligibility is available to the resident on the first date that the resident is to report for employment, as specified in the resident contract.

G. Optional dental and/or vision insurance is available to residents and their families as an optional expense. Dental and vision insurance eligibility is available to the resident on the first date that the resident is to report for employment, as specified in the resident contract.

H. Life & Disability Insurance- A $25,000 life insurance policy is provided at no cost to residents. Supplemental insurance may be purchased by the resident. Disability insurance is provided at no cost to the residents. Life and disability insurance eligibility is available to the resident on the first date that the resident is to report for employment, as specified in the resident contract.

I. Malpractice insurance is provided at no cost to the residents through the Office of the General Counsel. Tulane residents are included in the Self-Insurance Trust Program for professional liability coverage (Occurrence Coverage). Under the following circumstances, this coverage is secondary to coverage that is otherwise provided. Official documentation of the details of liability coverage are available to the resident at the request of the individual. Any questions about the coverage addressed below can be addressed to the Director of Risk Management for Tulane University (504-865-5783) or The Office of Associate General Counsel for the Health Sciences Center (504-988-5031).

1. Private Healthcare Institutions Within the State. Under the Tulane coverage, the first $100,000 is covered by Tulane, the remaining $400,000 (up to the statutory limit of $500,000) is provided through the Patient’s Compensation Fund. As a safety net in case the statutory cap is removed, the Tulane Self-Insurance Trust program provides an additional $900,000 coverage under a separate policy. The coverage provided by Tulane through its Self-Insurance Trust and through the Patient’s Compensation Fund is an occurrence-based coverage and therefore when residents leave Tulane, no tail coverage would be required.
2. Rotations at State-operated Facilities. Residents are provided coverage through the State Malpractice Program. This is statutory coverage that provides that health care providers, including residents, who treat patients at any of the state institutions are considered State employees and the State is liable for their conduct. UMC is now a privately-operated facility and, therefore, the above provision #1 will apply.
3. Veterans Administration Rotation. Those Residents on rotation within the VA system are considered covered under the Federal Tort Claims Act and therefore would be immune from any personal liability. In those situations, the federal government is obligated to provide the cost of defense and the satisfaction of any judgments and/or settlements.
4. In all of the above cases, insurance is available to the resident on the first date of employment, as specified in the resident contract.
5. Out of State Rotations. The primary coverage is determined pursuant to the affiliation agreement between Tulane and the affiliate institution. Residents would have primary coverage by the Tulane program, which includes a Self-Insurance component and/or coverage under a commercial insurance policy purchased by the University.
6. Moonlighting. Tulane does not provide any coverage for moonlighting activities of a resident.
j. Vacations & Educational Leave- With the approval of the program director, educational leave is allowed in some programs as outlined in Policy on Vacation and Leave. Each resident is allowed no less than three (3) weeks of vacation per academic year. Additional weeks are at the discretion of the each residency program.

K. Stipend- 2018-2019 annual salaries for residents are as follows:

<table>
<thead>
<tr>
<th>Year</th>
<th>Salary</th>
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<tbody>
<tr>
<td>PGY I</td>
<td>$51,770</td>
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<tr>
<td>PGY II</td>
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<td>PGY III</td>
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<td>PGY VII</td>
<td>$62,496</td>
</tr>
<tr>
<td>PGY VIII</td>
<td>$62,496</td>
</tr>
</tbody>
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L. Counseling Services and Physician Impairment Resources.
Tulane University is committed to fostering an environment in which residents feel safe in identifying and correcting academic and professional deficiencies without fear of reprisal or implications to their career. Residents are provided confidential counseling and behavioral health services, at no cost to the resident, as outlined in Chapter XV. Policy on Remediation, Suspension, Termination and Grievance, and Chapter XVI. Policy on Residents’ Assistance Program. Residents are not reported to licensing agencies or The Tulane Administration for self-referral except in the extenuating circumstances as noted in Chapter XV. Policy on Remediation, Suspension, Termination and Grievance.

M. Other Program Personnel and Support Services. The DIO, on behalf of the Sponsoring Institution, the respective chair and program director must jointly ensure:
1. The availability of all necessary professional, technical, and clerical personnel for the effective administration of the program.
2. The appropriate number of program coordinator(s) to sustain the effective operation of the training program. Program coordinators must have sufficient support and time to effectively carry out their responsibilities.
3. The availability of adequate resources for resident education, including space, technology, and supplies, are available to provide effective support for ACGME-accredited programs.
4. All clinical rotations have support services to minimize residents’ work that is extraneous to their ACGME-accredited programs’ educational goals and objectives.
5. Residents’ educational experience is not compromised by excessive reliance on residents to fulfill non-physician service obligations. These support services and systems must include:
a. Peripheral intravenous access placement, phlebotomy, laboratory, pathology and radiology services and patient transportation services provided in a manner appropriate to and consistent with educational objectives and to support high quality and safe patient care;
b. Medical records available at all participating sites to support high quality and safe patient care, residents’ education, quality improvement and scholarly activities.

Approved by the GMEC; January 28th, 2018
VI. POLICY ON MOONLIGHTING

A. Residents who wish to engage in the practice of medicine outside of their formal training program must have the explicit written approval of their program director. The program director’s written permission must be included in the resident’s file.

B. All residents who engage in moonlighting activities must be fully licensed to practice medicine; have state and federal (DEA) license to prescribe; and must carry individual malpractice insurance coverage. All licenses and insurance coverage provided by Tulane University, School of Medicine or by its affiliated teaching hospitals for purposes of graduate medical education cannot be used for purposes of moonlighting.

C. Moonlighting may be conducted only within the established institutional principles of duty hours (Chapter VIII). The program director is responsible for monitoring the effect of moonlighting on a resident’s performance in the educational program. Hours devoted to moonlighting are to be counted towards the duty hours regulations as outlined in Chapter VIII.

D. Moonlighting is a privilege. Resident’s who choose to moonlight will be monitored by their program director, and the moonlighting privilege may be revoked by the program director, or the DIO, if he or she feels that the moonlighting is adversely affecting the resident’s patient care or education, or is putting the resident at risk for work hours violation or excessive sleepiness/fatigue.

E. Violation of this policy may result in immediate suspension or termination.

F. No resident may be forced to moonlight.

Approved by the GMEC; August 17th, 2011
VII. POLICY ON INTERACTION WITH VENDORS

A. Residents of the Tulane University School of Medicine are prohibited from accepting gifts from pharmaceutical and medical device company representatives and other industry representatives that are intended to influence, or may have the effect of influencing, the residents’ health care decisions. Residents should refrain from accepting gifts and participating in activities offered by industry representatives, with the exception of the generally permitted items and activities included on the list below:

1. Receipt of medical textbooks.
2. Participation in industry-supported educational programs. Attendance at educational programs that are not accredited by an ACCME accredited provider should be approved in advance by the Program Director and/or the Associate Dean, Graduate Medical Education, School of Medicine. Registration fees and other support for participation in educational programs should not be accepted directly by any resident from an industry representative. Questions regarding attendance at and support for educational programs should be addressed to the Tulane Center for Continuing Medical Education in conjunction with the Office of Graduate Medical Education.
3. Individual gifts of minimal value that are related to the work of the resident, such as pens and notepads.

B. Residents should not participate in activities or accept gifts not included on the list above without specific permission from the DIO. In addition to the Tulane University policy, Tulane residents are expected to comply with the policies on vendor interactions in effect at each hospital to which a resident rotates. Where there is discordance between the University’s policy and a hospital’s policy, the more stringent of the two will apply.

C. Questions regarding this policy should be directed to the respective Program Director, the Tulane University Medical Group Compliance Officer or the Office of General Counsel.

Approved by the GMEC Board; August 17th, 2011
VIII. POLICY ON RESIDENTS' DUTY HOURS

A. Each residency program must be committed to and responsible for promoting patient safety and resident well-being, and to providing a supportive and safe educational environment. Regardless of where affiliated rotations are offered, duty hours and on-call time periods must not be excessive for the residents. Duty hours must be consistent with the ACGME Institutional and Specific Program Requirements. In specific:

1. 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. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.
2. Didactic and clinical education must have priority in the allotment of residents’ time and energy.
3. The learning objectives of the program must not be compromised by excessive reliance upon residents to fulfill service obligations.

B. Duty hours must comply with the following standards:

1. A resident must not work more than 80 hours per week.
2. The program director is responsible for including “moonlighting” hours toward the 80 hours limitations noted above. (See Chapter VI, Policy on Moonlighting).
3. A resident must work no longer than 24 hours of continuous on-site duty. Up to 4 additional hours are permitted for patient transfer and other activities as defined in RRC requirements; however no new patients may be admitted after the 24 hours of continuous duty.
4. A resident must have at least 8, and preferably 10, hours off for rest and personal activities between duty periods and after call.
5. A resident must have at least 14 hours off after each call duty.
6. Residents must have at least one day off per week. A day off is defined as 24 hours of continuous time free of all patient care obligations each month.
7. In-house call may not occur more frequently than every third night.

C. Home Call

1. For residents assigned home call, the actual time spent answering calls, or delivering in-house patient care is to be counted toward the 80 hour standard.
2. A resident on home-call who is called into the hospital for an extensive period of time should be released from duty the following day. The program director is responsible for establishing a jeopardy system involving other residents or faculty, which ensures that the resident may be released from duty the following day if the previous night’s requirements were excessive.
3. Residents on home-call must still have one day off in seven without holding the pager.

D. Program directors & faculty are responsible for adopting policies to prevent, monitor and counteract effects of fatigue.

1. The GME Office is responsible for ensuring an on-boarding sessions for all new residents and faculty to Tulane on the signs, risk, and methods of counteracting fatigue.
2. Program directors are responsible for ensuring a yearly in-service to educate residents and faculty on the signs, risk, and methods of counteracting fatigue.
3. The program leadership is responsible for ensuring that residents have alternative means of transportation home should they feel too fatigued to safely return home following a shift. In such cases, residents should:
   a. First seek alternative transportation from colleagues, program faculty, or program administration.
   b. If this option is not feasible, the resident should take a taxi, and produce the receipt for the trip home to the program leadership. The resident will subsequently be reimbursed for the taxi expenses to their home.

E. Tulane University allows no exceptions to the duty hours as listed above.

F. Reporting Fall-Outs in Duty Hours

1. Each program is responsible for monitoring duty hours, inclusive of moonlighting hours. The method of monitoring must be presented to and approved by the DIO as part of the annual review process.
2. It is the responsibility of all residents and faculty to report events that violate the program and institution’s duty hour policies. Residents and faculty are to report such events via one or more of the following mechanisms.
   a. Anonymous reporting via resident-of-rotation or Resident-of-faculty E-value evaluations.
   b. Direct reporting to attending physicians or the program director.
   c. Anonymous reporting via the affiliated institution’s (ie hospital/clinic) near-miss/adverse event reporting system
   d. Reporting to the Residency Education Committee, either directly or via the resident’s/faculty’s representative
   e. Tulane Resident and Fellows Congress, either directly or via the resident’s representative
   f. Resident-of-Program annual evaluation
   g. Direct reporting to the Department Chair
   g. Direct reporting to the DIO

Approved by the GMEC; August 17th, 2011
IX. RESIDENTS’ PARTICIPATION & REPRESENTATION ON INSTITUTIONAL COMMITTEES AND COUNSELS

A. Residents must have appropriate representation on institutional committees and counsels whose actions effect their education and patient care. Residents must be aware of, and participate in, institutional programs and medical staff activities. They must be knowledgeable about, and adhere to, established practices, procedures, and policies of each institution participating in the educational experiences and activities of their training program.

B. The GME Office advocates on behalf of the Tulane Residency Programs to ensure that residents have representation on each of the following committees. During their course of training, each resident will have the opportunity to participate in one or more of the following institutional committees: as well as other similarly established institutional committees as they occur in all affiliated training institutions

1. Tulane University Hospital & Clinic:
   Cancer
   Critical Care Advisory
   Ethics
   Emergency Services
   Infection Control
   Information and technology committee
   Medical Records
   Operating Room
   Pharmacy & Therapeutics
   Performance Improvement
   Transfusion
   Utilization Review
   Quality Improvement Counsel, Hospital

2. Tulane University Medical School
   Code Blue
   Infection Control
   Environment of Care
   Utilization Review
   PI Council
   Stroke
   Blood Utilization
   QDC
   Pharmacy/Therapeutics
   Ethics
   Critical Care
   Perinatal
   Radiation Safety
   IRB work group
   QIC
   Chest Pain
   SMAT

3. VA Medical Center, New Orleans Executive Committee of the Medical Staff:
   Cancer
   Patient Rights/Ethics
   Infection Control
   Information and technology committee
   Medical Records
   Operative/Invasive Procedure
   Pharmacy & Therapeutics
   Performance Improvement
   Utilization Review
   Quality of Care

4. ILH
   Cancer Care Committee (Quarterly; 12 N)
   Critical Care Committee (1st Friday of Even Months; 11:30 AM)
   Department Directors Meeting (3rd Thursday of every other month; 9:30 AM)
Environment of Care Committee (3rd Tuesday of the Month; 10 AM)
Ethics Committee (Last Wednesday of the month; 12 N)
Lasers Committee (3rd Tuesday the last Month of the quarter; 1 PM)
Medicine Surgical Unit PI Committee (1st Thursday of the Month; 9 AM)
Mortality Review Committee (2nd Wednesday of the Month; 11 AM)
Nutrition Committee (2nd Tuesday of the Month; 12 N)
Patient Safety & Satisfaction (2nd Tuesday of the Month; 10 AM)
Prisoner Care Committee (2nd Wednesday of every other Month; 10:30 AM)
Research Committee (First Monday of odd months; 2 PM)
Stroke Committee (2nd Thursday of the Month; 12 N)
Trauma Care Committee (Every Monday at 1 PM)
Trauma Peer Review Committee (Every Monday at 2 PM)
Anesthesia/OR Committee (2nd Wednesday of the Month; 7AM)
Comprehensive QM Committee (Last Thursday of the every month; 9AM)
Credentials Committee (1st Thursday of the Month; 7AM)
Infection Control Committee (4th Thursday of the Month; 12 N)
Medical Records Committee (2nd Wednesday of the Month; 1 PM)
Pharmacy and Therapeutics (3rd Tuesday of the Month; 12 N)
Transfusion Committee (Last Monday of the Month; 10 AM)

5. External Organizations: Orleans Parish Medical Society, Local and National Specialty and Subspecialty Organizations

Approved by the GMEC; March 19th, 2014
X. POLICY ON CORE CURRICULUM AND THE CORE COMPETENCIES

A. General Competencies: For the purposes of promotion and graduation, all Tulane residents must demonstrate progressive competency in the following areas. Failure to demonstrate competence in any one area is grounds for non-promotion.

1. Patient care,
2. Medical knowledge,
3. Practice-based learning and improvement, and
4. Interpersonal and communication skills,
5. Professionalism,

B. PATIENT CARE
Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents are expected to:

1. Communicate effectively and demonstrate caring and respectful behavior when interacting with patients and their families.
2. Gather essential and accurate information about their patients.
3. Make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment.
4. Develop and enact patient management plans.
5. Counsel and educate patients and their families
6. Use information technology to support patient care decisions and patient education.
7. Perform competently all medical and invasive procedures considered essential for the area of practice.
8. Provide health care services aimed at preventing health problems and maintaining health.
9. Work with health care professionals, including those from other disciplines, to provide patient-focused care.

C. MEDICAL KNOWLEDGE
Residents must be able to obtain a sufficient expertise in their field of practice, with requisite medical knowledge necessary to practice their chosen medical discipline. In specific, residents should be able to:

1. Demonstrate knowledge about established and evolving biomedical, clinical, and cognitive (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.
2. Demonstrate an investigatory and analytic thinking approach to clinical medicine.
3. Know and apply the basic sciences appropriate to their discipline.

D. PRACTICE-BASED LEARNING AND IMPROVEMENT
Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices. Residents are expected to:

1. Analyze practice experience and perform practice-based improvement activities using a systematic methodology
2. Locate, appraise, and assimilate evidence from scientific studies related to their patients’ health problems
3. Obtain and use information about their population of patients and the larger population from which their patients are drawn
4. Apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness
5. Use information technology to manage information, access on-line medical information; and support their education
6. Facilitate the learning of students and other health care professionals

E. INTERPERSONAL AND COMMUNICATION SKILLS
Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients’ families, and professional associates. Residents are expected to:

- Create and sustain a therapeutic and ethically sound relationship with patients
- Use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills
- Work effectively with others as a member or leader of a health care team or professional group
- Foster the development of the profession through effective teaching strategies.

F. PROFESSIONALISM
Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. Residents are expected to:

- Demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society that supersedes self-interest; accountability to patients, society, and the profession; and a commitment to excellence and on-going professional development
- Demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices
- Demonstrate sensitivity and responsiveness to patients’ culture, age, gender, and disabilities.

G. SYSTEMS-BASED PRACTICE
Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value. Residents are expected to:

- Understand how their patient care and other professional practices affect other health care professionals, the health care organization, and the larger society and how these elements of the system affect their own practice
- Know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources.
- Practice cost-effective health care and resource allocation that does not compromise quality of care.
- Advocate for quality patient care and assist patients in dealing with system complexities.
- Know how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance.
- Understand and be able to apply the Plan-Do-Check-Act (PDCA) method of systems improvement.

H. TRANSITIONS OF CARE
Residents must demonstrate knowledge and proficiency in the safe and effective transition of care for patients under their stewardship. Residents are expected to:

- Understand the importance of in-person sign-in and sign-out of patients who will require on-going care via a colleague (i.e., a night-float resident).
- Identify the components of closed-loop communication, and successfully demonstrate proficiency of this communication strategy.
- Identify the component of the written (or electronic) sign-out form that ensures patient safety.
- Recognize the importance of timely completion of documents essential to facilitating successful transitions of care from one arena to the next (i.e., off-service notes, post-operative notes, discharge dictations).

I. PATIENT SAFETY AND QUALITY IMPROVEMENT
Residents must develop competence in the core components of patient safety and quality improvement. Residents are expected to:

- Develop competency, through active participation, in Root Cause Analysis and Failure Modes Effect Analysis.
- Identify how to report actual and near-miss patient safety events at each of the training facilities at which they rotate.
3. Demonstrate competence in the attitude of patient safety by regularly reporting such events, including:
   a. Medication errors
   b. Adverse medication reactions
   c. Falls
   d. Decubitus ulcers
   e. Deep vein thrombosis
   f. Unexpected changes in levels of care
   g. Transitions of care fallouts
   h. Hospital acquired infections (CAUTI, CLASBI, Vent-associated pneumonia, Surgical site infections)
   i. Antibiotic stewardship
   j. And other events specific to the resident’s field of practice

4. Identify the importance of closed-loop communication and situational awareness in the prevention of patient safety events

5. Identify common heuristics that lead to misdiagnosis or inappropriate assignment of treatment regimens.

6. Identify the role the healthcare system plays in augmenting or closing the gap in healthcare disparities

7. Recognize the role the healthcare system plays in making patient safety events more or less probable:

8. Recognize the importance of receiving data on physician performance in identifying areas for improvement in the healthcare system

9. Identify the components of the Plan-Do-Act-Study quality improvement model.

10. Demonstrate competence in the attitude of quality improvement, by regular participation in team-based, multidisciplinary quality improvement projects.

J. THE RESIDENCY PROGRAM’S RESPONSIBILITIES FOR ENSURING COMPETENCY IN EACH OF THE CORE COMPETENCIES

1. Each residency program director must ensure that the residency program curriculum addresses each of the six core competencies, and that all residents in the program are taught and evaluated in each of the six core competencies. Further, residents must be provided the entrustable professional activities (EPA’s) within each of the core competencies, and the associated milestones of performance in each of these EPA’s.

2. Resident evaluations must include an assessment of each of the six core competencies, as outlined by the milestone performance in each of the EPA’s

3. Resident evaluations must utilize a 360° evaluation system to ensure an accurate assessment of professionalism and communication/interpersonal skills, including evaluations by faculty, patients, nurses, students, peers and other ancillary staff, as applicable to the rotation.

4. Mid-year and end-of-year summary evaluations must include an assessment of each of the six core competencies as detailed in Chapter XIV. Policy on Evaluation of Residents.

5. Decisions for promotion or graduation must be made based upon demonstrated competency in each of the six core competencies. Failure to achieve competence in any one of the six core competency areas is grounds for non-promotion, as detailed in Chapter XIV. Policy on Evaluation of Residents.

6. In addition to the above requirements, procedural-based specialties must monitor procedure, operative, and case logs, and incorporate an assessment of procedural competency into mid-year/end-year evaluations and promotion and graduation decisions.

7. Program directors must ensure that all residents entering a training program at Tulane University have successfully completed the TeamSTEPPS training.

8. Program directors must ensure that all residents receive formal instruction in the principles of safe and effective transitions-of-care.

9. Program directors, or their designees, must ensure that interns are directly observed in their transitions of care (i.e., sign out) until which point the program director is satisfied that the intern has demonstrated sufficient mastery of transitions communication to warrant transitions of care duties without direct supervision.
12. Program directors must ensure that residents understand how to report, and regularly report, patient safety events, including near-miss events.

13. Program directors must ensure that residents receive training in conducting RCA’s and FMEA’s, and that residents regularly participate in actual or simulated RCA’s and FMEA’s.

14. Each program must have a regularly occurring Morbidity/Mortality series throughout the year, with an emphasis on how the system contributed to the adverse events, and how the system could be changed to prevent such events in the future.

15. Program directors must ensure that residents receive data from their respective hospitals on their practice habits such that there is an opportunity to improve in these areas.

16. Program directors must ensure that each resident participates in at least one team-based quality improvement project each year.

17. Program directors must submit an annual “State of the Program” document in June of each year to the GME Office as outlined in Chapter XXII, Policy on Program Evaluation, Improvement and Annual Program Reports. This document must contain a description of how the residency program teaches and evaluates the core competencies, and ensures compliance with the responsibilities outlined above.

K. THE RESIDENCY PROGRAM’S RESPONSIBILITIES FOR ENSURING COMPETENCY IN RESIDENTS’ TEACHING, EVALUATION AND SUPERVISION ABILITIES

1. In a medical school, residents provide an essential role in the instruction and supervision of medical students. Further, the act of teaching provides insight into the teacher’s own understanding of medicine, enabling him or her to identify areas of weaknesses, and subsequently to improve. Tulane Graduate Medical Education, therefore, is committed to the development of residents as teachers.

2. Training programs whose residents regularly interact with medical students are required to integrate the following principles of medical education into their curriculum:
   a. Identify and understand the goals and objectives of the medical student curriculum, as applicable to the residents’ training program.
   b. Develop and execute tangible expectations for the day-to-day activities of the clinical team.
   c. Identify and effective utilize strategies to optimize learner engagement in the learning content (motivation)
   d. Apply visualization techniques such that learners can identify the utility of the teaching topic for their career, and identify areas of weakness they might encounter in utilizing the skill.
   e. Anticipate areas of confusion, or areas prone to errors in the learners’ application of the material, and provide solutions proactively in preventing those areas.
   f. Effectively utilize formative and summative feedback strategies to improve learner performance.
   g. Identify strategies to ensuring an effective and respectful learning environment.

3. Training programs whose residents regularly interact with medical students are required to regularly assess residents’ teaching and supervision abilities using student evaluations of residents’ teaching abilities and direct observation by peers or supervisors of residents’ teaching and feedback abilities.

L. SUPPLEMENTAL TRAINING IN CORE COMPETENCY TRAINING UNIVERSAL TO ALL TRAINING PROGRAMS

1. The Tulane University GME Office provides initial training, as part of orientation, to all residents newly matriculating to a training program at Tulane. This training includes the following areas:
   a. Sleep Deprivation and Fatigue Mitigation
b. Introduction of GME Staff/ Review of Policies and Procedures

c. Review of the Six Core Competencies

d. Clinical Coaching: Motivation, Visualization, Anticipation, Retention

e. Feedback Strategies

f. Medical Malpractice, Error Reporting and Patient Apologies

g. Sexual Harassment

h. Transitions of Care

i. Patient Safety

j. Quality Improvement

2. Following orientation, the Tulane University GME Office provides supplemental training in the core competencies, particularly for training modules that are universal to all training programs. These modules are not to preclude a training program from integrating similar or more in-depth training in each area, but rather to ensure that all Tulane residents receive foundational and on-going training in these topics.

3. The on-line module approach is designed to allow residents to engage in self-directed learning that is conducive to their life schedule. Further, it is designed such that residents have the time to appropriately address and reflect upon the subject matter.

4. Each module in the online course has a post-test, course evaluation and certificate of completion for users who successfully complete the course requirements. The respective program director is responsible for ensuring that each resident in his or her training program has successfully completed the required module.

5. The Designated Institutional Official is responsible for ensuring that each resident completes his or her required modules prior to promotion to the next level of training, or in the case of the final year of training, prior to graduation. Promotion to subsequent years of training or graduation from the training program is contingent upon each resident completing the required modules.

6. Requirements by PGY Level are as follows.

a. LEVEL I (PGY-1)
   1. Sleep Deprivation and Fatigue Mitigation
   2. Confidentiality
   3. Resident and Student Intimidation
   4. Patient Safety
   5. Building the Patient Physician Relationship
   6. Working Effectively Within an Inter-professional Team
   7. Thriving Through Residency: The Resilient Resident (Burnout)

b. LEVEL II (PGY-2)
   1. Sleep Deprivation
   2. Residents as Teachers
   3. Cultural Competency
   5. Physician Health: Physicians Caring for ourselves
   6. Creating a Respectful Learning Environment: Avoiding Medical Student Mistreatment
   7. Providing Effective Feedback for Medical Trainees-

c. LEVEL III (PGY-3)
   1. Sleep Deprivation
   2. End of Life Myths
   3. Patient Safety - National Patient Safety Goals
   4. Patient Safety - Further Steps to Prevent Patient Harm
   5. Quality Improvement Panel and Q & A
   6. Health Care Quality: Measuring Physician Performance
   7. Physician Health: Physicians Caring for ourselves

d. LEVEL IV+ and Above.
   1. Sleep Deprivation
   2. Physician Employment Contracts: What You Need to Know
e. Any resident from a non-Tulane training program who has matriculated into Tulane University GME programs at the PGY 4 or above level will be required to complete Level II training for their first year at Tulane, and Level III for their second year at Tulane, in addition to the Level IV+ training requirements.

L. THE OFFICE OF GRADUATE MEDICAL EDUCATION’S RESPONSIBILITY FOR ENSURING COMPETENCY IN EACH OF THE CORE COMPETENCIES

1. The Office of Graduate Medical Education must ensure that residency programs are fulfilling their obligation to ensuring that each resident develops competency in each of the six core competencies, and the components of patient safety and quality improvement.

2. The Annual Review Process will include specific questions as to how the program’s educational curriculum teaches and assesses the six core competencies, and the components of patient safety and quality improvement. See Chapter XXII Policy on Program Evaluation, Improvement and Annual Program Reports.

3. The Office of Graduate Medical Education will receive and review annual “State of the Program” reports from each program each year.
   a. Programs not in compliance with ensuring the teaching and evaluation of the core competencies will undergo an additional internal review to identify and correct the deficiencies in the core competency curriculum.
   b. State of the Program reports will be compiled into the annual GME report, that will be delivered orally and by writing to: The TUHC Administrative Board, the UMC Executive Committee, and the Tulane Executive Faculty. A written copy will be delivered to each of the affiliated training institutions.

4. The DIO or his/her representative will meet with each group of residents (i.e., each program) at least once per year to ensure compliance with the core competencies and other RRC requirements.

5. The DIO or his/her representative will meet with each program director at least once per year to ensure that the residency program’s curriculum ensures compliance with respect to the instruction and supervision of the core competencies.

6. The Office of Graduate Medical Education will ensure that each incoming resident or fellow new to the Tulane GME system receives formal training in the TeamSTEPPS curriculum.

7. The Office of Graduate Medical Education will ensure that affiliated hospitals provide effective electronic sign-out systems for those patients requiring on-going care across residency shifts (i.e., hospitalized patients for which nightfloat coverage is provided).

8. The Office of Graduate Medical Education will facilitate communication between affiliated hospitals and the Tulane residency training programs regarding quality and patient safety initiatives, including ensuring residents know the hospital’s patient safety priorities.

9. The Office of Graduate Medical Education will facilitate communication between affiliated hospitals and the Tulane residency training programs regarding how to report errors, adverse events, unsafe conditions, and near misses in a protected manner that is free from reprisal.

10. The Office of Graduate Medical Education will facilitate communication between affiliated hospitals and the Tulane residency training programs regarding receiving appropriate data streams necessary to provide residents with information on their practice habits, and to enact meaningful quality and patient safety initiatives designed to improve systems of care, reduce health care disparities, and improve patient outcomes.

11. The Office of Graduate Medical Education will facilitate communication between affiliated hospitals and the Tulane residency training programs to ensure that residents have an opportunity to participate in actual RCA’s/FMEA’s, hospital-based quality improvement projects, and to participate on committees essential for patient safety. See Chapter IX. Residents’ Participation on Institutional Committees

12. The DIO or his/her representative will facilitate communication between hospital leadership and program director leadership regarding any resident/fellow event that is judged to be inconsistent with patient safety and quality.

Approved by the GMEC; November 29th, 2017
XI. POLICY ON VACATION AND LEAVE

A. LEAVE OF ABSENCE
A Leave of Absence may be granted only with written permission of the residency program director. Such leave may prolong the duration of residency training according to each specialty's Board requirements, and the requirements unique to programs at Tulane University. In all cases, the number of total months required to complete program requirements for graduation is to be determined by the program director and the program’s clinical competency committee.

B. MILITARY LEAVE
Eligible employees who are members of the National Guard, Naval Militia or of a reserve component of the United States military forces and who are required to undergo annual field or periodic weekend training or active duty training shall be granted a leave of absence for such period as provided by regulation or emergency situation. The employee shall be entitled to full pay for a period of two weeks per year. This pay will be the difference between his/her regular salary and the money received from National Guard or other reserve unit. Any such hours granted will be in addition to the employee's regular vacation hours. Any remaining military obligation will be granted without pay or, if the employee wishes, he/she may use accumulated vacation time. Armory drills or multiple training assemblies do not qualify for short-term military leave with or without pay. If you enter the Armed Forces of the United States while an employee of the University, you will have certain re-employment rights, as required by Federal law, after completing your military service. Contact the Personnel Department for details.

C. SICK LEAVE
A period of sick leave of two weeks is allowed per resident per year. If a resident calls in sick, it is the prerogative of the program director to ask for a doctor's excuse from the resident. Sick leave in excess of two weeks will be taken from vacation time. Each resident must be aware that each particular specialty allows only a certain amount of absence from training per year. Absence beyond that designated time, be it for vacation or sick leave, may extend the resident’s time in training. There can be no accrual of sick leave from one year to the next; i.e., two week maximum sick-leave is allowed per year.

D. LEAVE TIME ALLOWED BY SPECIALTY BOARDS WITHOUT MAKE UP
The amount of aggregate leave time that can be allowed without an extension of training time is at the discretion of the program director, as directed by the respective Board’s maximum allowable leave time. It is the responsibility of the program director to communicate to residents the maximum amount of leave time that can be taken without an extension of training time.

E. PARENTAL LEAVE (MATERNITY & PATERNITY LEAVE)
1. Parental leave will be granted upon request to all residents. All or a portion of the six weeks may be requested.
2. Parental leave applies to births or adoption of a child.
3. Parental leave applies to biologic, adoptive and domestic-partner parents.
4. Parental leave is an un-paid leave of absence.
5. Benefits will continue during the six weeks of Parental leave. The resident will have the option of continuing his or her benefits, at the resident’s cost, for leave that exceeds the six weeks.
6. Parental leave will be a paid leave of absence for the portion that the resident chooses to devote remaining vacation and/or sick leave for that year.
7. Parental leave greater than six weeks duration, except in cases of illness of the mother or infant, requires approval by the program director. This time will be unfunded.
8. Where possible, the resident must notify the program director, providing at least a four-month notice of the leave, and when he or she plans to return to work following the parental leave.
9. Duration of leave exceeding that period of time defined by the resident's specialty board as an acceptable leave of absence will extend the resident’s time in training.
10. The resident may choose to use his or her parental leave anytime from one month prior to the
birth/adoption of the child up until six months after the birth/adoption of the child.

F. BEREAVEMENT LEAVE
1. A leave of absence will be granted for a death in resident’s or the resident’s significant other’s immediate family.
2. The leave will be paid leave with benefits provided the resident uses allotted sick leave or vacation time.
3. This leave shall not exceed three working days for a funeral that is held within a 300-mile radius of New Orleans and shall not exceed five working days for a funeral outside this radius. For purposes of this policy, immediate family is defined as the resident's, or the resident’s significant other’s, mother, father, sister, brother, children, grandparents, grandchildren, or significant other.
4. Leave in excess of remaining sick leave or vacation time will be un-paid leave, though benefits will continue up to six weeks of absence.
5. The program director may request verification of the death and location of the funeral prior to approving this leave.

I. VACATION
The amount of vacation per academic year is at the discretion of the program director, but shall not be less than three weeks per academic year. For vacation guidelines, the resident should consult his or her residency program director. There can be no accrual of vacation time from one academic year to the next.

J. EDUCATIONAL LEAVE
1. It is the policy of Tulane University School of Medicine to ensure that the residents are allowed to attend and to participate in educational and scientific meetings that would contribute to the medical education of the resident physician.
2. Each resident may be granted up to five (5) working days per year of educational leave for the purpose of participating in educational or scientific meetings that contribute to the medical education of the resident physician. Permission for and approval of the leave must be granted in writing by the program director or his/her designee.
3. This policy does not address expenses or reimbursement of expenses as a part of education leave; such reimbursement or payment is at the discretion of the program director.

Approved by the GMEC; January 28th, 2015
XII. POLICY ON IMMUNIZATION PROCEDURES & OCCUPATIONAL HAZARDS

Residents may be at risk for developing infectious diseases from patients, and, in some cases, be at risk for infecting patients and colleagues.

A. Tuberculin Testing.
   1. Tulane provides PPD skin tests at the time of orientation. A routine PPD test will be placed on each resident at orientation, unless the resident has a history of prior positive tuberculin reactivity.
   2. Routine annual PPD testing is required for continuation in the training program.
      a. In May of each year, residents will receive a PPD history form from their program coordinator.
      b. It will be their individual responsibility to complete this form and schedule an appointment with the Travel Medicine Clinic. The PPD will be placed at that time (with no charge to the resident).
      c. The resident should return in 48 hours to this clinic or to the Resident Concierge Clinic to have the PPD read.
      d. The result of the test should be communicated, via the signed TB form, to the program coordinator.
      e. Residents with a history of a positive PPD must complete the Positive PPD form, documenting treatment (if any), and assessing any signs/symptoms that would prompt radiographic evaluation. A baseline radiograph should be obtained on any resident with a positive PPD (or history of positive PPD).
      f. More frequent, or alternative, testing may be indicated for residents at high risk for TB exposure.

B. Hepatitis B Vaccination. Any resident who has not received a series of three hepatitis B injections during medical school should have a baseline titer. Hepatitis B vaccine should be offered to any resident with a negative titer. There is evidence to suggest that titers wane after five years after the series; therefore, these individuals should also obtain a titer and a booster injection if indicated.

C. Influenza Vaccination. All residents are required to obtain an annual influenza (flu) vaccination. Those residents who are vaccinated will receive a sticker for their name badge demonstrating their compliance. Those residents who refuse, or have contra-indications to vaccination, will be required to wear a mask in all clinical areas during the flu season, as defined by the clinical site.

D. Occupational Exposures. In the event of an occupational exposure to blood or body fluids (i.e., needle-stick), the resident should follow the following procedures. Detailed instruction can also be found at http://www2.tulane.edu/oehs/what-do-immediately-after-a-blood-exposure.cfm
   1. Scrub the wound for 5 minutes with betadine, hibiclens or soap. If there is a splash of blood or body fluids to the eye, then it should be irrigated for 5 minutes with water or normal saline.
   2. The resident should report immediately to the Emergency Department of the facility at which the exposure occurred. If there is no such Emergency Department, the resident should report to the Tulane University Hospital Emergency Department.
   3. The resident should complete the Exposure Form. (http://www2.tulane.edu/oehs/upload/1st-Report-of-Injury-2.pdf).
      a. This form will collect information on the event, the resident’s salient medical history, and any information known about the patient from whom the exposure occurred.
      b. This form should be return to workcomp@tulane.edu or fax to 504-865-6796.
   4. The resident should then page the Infectious Disease resident on-call to review the information on the form and discuss treatment options.
   5. The following day, the resident should schedule an appointment with the Resident Concierge Clinic to review the incident and the recommendations.
   6. In all cases, the resident should report the injury to his or her program director and the Bloodborne
Pathogens Coordinator at (504) 419-1391 or kmayer@tulane.edu.

7. An occupational exposure can be psychologically devastating, as the event is often colored by fear, guilt or shame. All of these emotions frequently prevent residents from seeking timely help and/or counseling. Residents should not underestimate the emotion associated with an occupational exposure, and should err on the side of seeking psychological counseling following the event. Free counseling is available via the Residents’ Assistance Program Director, Dr. Andrew Moroson; (504)-322-3837 or email him at dr.morson@ibhnola.com

D. Worker’s Compensation
1. As employees, residents are covered under Workers’ Compensation for an occupational injury. Residents should inform the treating healthcare provider that the injury is work-related and to bill accordingly. Employees should NOT show their personal insurance as this can complicate the billing issues. You should call the Workers’ Compensation Manager by phone, (504) 988-2869 to verify benefits available.

2. Important Facts:
   a. Employee is entitled to medical benefits once compensable injury occurs.
   b. Employee is entitled to indemnity benefits after a seven (7) day waiting period. Indemnity benefits are paid at a calculation of 66 and 2/3 percent of wages.
   c. All medical expenses related to a compensable injury are paid per fee schedule.
   d. If necessary, seek medical treatment at nearest hospital or clinic.
   e. Provide all medical documentation to your supervisor and Workers’ Compensation Manager.
   f. Keep copies of documentation.

Approved by the GMEC; July 27th, 2016
SECTION 3:
SUPERVISION, EVALUATION & REMEDIATION OF RESIDENTS
XIII. POLICY ON SUPERVISION OF RESIDENTS

A. The Program Director. Each residency program must be supervised by one program director responsible for the quality of the educational experience for the training program.

1. Qualifications of the Program Director. The program director must:
   a. Be board certified in the specialty of the training program.
   b. Have requisite experience in graduate medical education deemed appropriate by the ACGME.
   c. Have current medical licensure and the appropriate medical staff appointment at Tulane.
   d. Engage in professional development applicable to their responsibilities as educational leaders

2. Responsibilities of the Program Director. The program director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency areas. In specific, the program director must:
   a. Oversee and ensure the quality of didactic and clinical education in all sites that participate in the program.
   b. Approve a local director at each participating site who is accountable for resident education and supervision (See XIII.C.), as defined by the program letter of affiliation with that site.
   c. Approve the selection of program faculty as appropriate for supervision and education of residents
   d. Evaluate program faculty and approve the continued participation of program faculty based on these evaluations
   e. Monitor resident supervision at all participating sites and ensure compliance with evaluation requirements (See XIII.C.).
   f. Provide each resident with a written summary evaluation in each of the core competencies on a semi-annual basis (See Chapter XIV. Policy on Evaluation of Residents). The program director or his/her designated liaison should meet in person with each resident at least twice per year to review this evaluation.
   g. Comply with milestone reporting to the ACGME, as dictated by program-specific required intervals, and provide each resident with a written summary of their milestone progress.
   g. Provide an end-of-training summary letter meeting the requirements as outlined in Chapter XIV. Policy on Evaluation of Residents
   h. Prepare and submit all information required and requested by the ACGME and the GME Office, including
      i. The program information forms prior to site visits.
      ii. The annual program updates on Web ADS
      iii. The Tulane annual report as outlined in Chapter XXII. Policy on Program Evaluation, Improvement and Annual Program Reports
      iv. The program information for any scheduled internal reviews as outlined in Chapter XXII. Policy on Program Evaluation, Improvement and Annual Program Reports
   i. Ensure compliance with grievance and due process procedures as set forth Chapter XV. Policy on Remediation, Suspension, Termination and Grievance.
   j. Provide verification of residency education for all residents, including those who leave the program prior to completion, and those that enter the program as outlined in Chapter I. Policy on Resident Eligibility and Selection
   k. Ensure compliance with policies and procedures for selection, evaluation and promotion of residents, disciplinary action, and supervision of residents Chapter I. Policy on Resident Eligibility and Selection
   l. Implement and ensure compliance with policies and procedures regarding the duty hours and the working environment, and moonlighting as outlined in Chapter: VIII. Policy on Residents’ Duty Hours, and Chapter VI. Policy on Moonlighting.
      i. Distribute these policies and procedures to the residents and faculty.
      ii. Monitor resident duty hours with a frequency sufficient to ensure compliance with ACGME requirements
      iii. Adjust schedules as necessary to mitigate excessive service demands and/or fatigue
iv. If applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue.

m. Ensure compliance with Chapter XXII, Policy on Program Evaluation, Improvement and Annual Program Reports, by obtaining approval of the sponsoring institution’s DIO before submitting information to the ACGME.

n. Monitor resident stress, and the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged.

o. Maintain familiarity with, and comply with, ACGME and Residency Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures.

p. Ensure that clinical rotations minimize residents’ work that is extraneous to their ACGME-accredited programs’ educational goals and objectives, ensuring that residents’ educational experience is not compromised by excessive reliance on residents to fulfill non-physician service obligations.

3. Program Director Support.

a. The DIO, on behalf of the Sponsoring Institution, and the respective departmental chair will ensure that each program director has sufficient financial support and protected time to effectively carry out their educational, administrative, and leadership responsibilities as described in the Institutional, Common, and Specialty/Subspecialty-specific Program Requirements;

B. Faculty.

1. Supervision of Patient Care: Proper supervision of residents is expected in all areas of all affiliated institutions to assure consistently high standards of patient care. The overall responsibility for the treatment of each patient lies with the faculty to whom the patient is assigned and who supervises the resident physician.

a. All inpatients and outpatients will have one faculty listed as the physician in charge of the patient’s medical treatment, and the name of this practitioner will be clearly designated on each patient's medical record.

b. The faculty will be involved in the care of the patient to the extent necessary to assure consistently high standards of patient care. This faculty will be responsible for, and must be familiar with, the care provided to the patient, and is expected to fulfill this responsibility, at a minimum, in the following manner:

i. Direct the care of the patient and provide the appropriate level of supervision based on the nature of the patient's condition, the likelihood of major changes in the management plan, the complexity of care, the experience and judgment of the resident being supervised and within the scope of the approved clinical privileges of the staff practitioner.

ii. Document this supervision via admission, operative, procedure or progress notes, or an acceptable linking-note to the resident’s documentation. The faculty member’s involvement in the patient’s care and supervision of the resident should be reflected in both the resident’s note and the faculty’s addendum.

iii. Assure that all technically complex diagnostic and therapeutic procedures which carry a significant risk to the patient are: medically indicated, fully explained to and understood by the patient to meet informed consent criteria, properly executed, correctly interpreted, and evaluated for appropriateness, effectiveness and required follow-up. Evidence of this assurance should be documented.

iv. Direct appropriate modifications of care as indicated in response to significant changes in diagnosis or patient status. Evidence of this assurance should be documented.

2. Educational Responsibilities: Faculty must devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; and to demonstrate a strong interest in the education of residents. Faculty must:

a. Actively participate in attending (teaching and management) rounds on a daily basis.

b. Review the goals and objectives of the rotation with the resident at the outset of the clinical rotation.
c. Administer and maintain an educational environment conducive to educating residents in each of the ACGME competency areas, as outlined in Chapter X. Policy on Core Curriculum and the Core Competencies.
d. Administer and maintain an educational environment that is compliant with all duty hours and work environment requirements, as outlined in Chapter VIII. Policy on Residents’ Duty Hours.

3. Evaluation Responsibilities.
   a. Provide oral evaluations of the resident’s performance at the mid-point of the rotation assignment. This evaluation should provide feedback on the resident’s performance in each of the core competencies.
   b. Faculty are responsible for the timely completion of all resident evaluations, as outlined in the Evaluation requirements below (Chapter XIV. Policy on Evaluation of Residents).

4. Faculty Qualifications
   a. The physician faculty must have current board certification in their specialty.
   b. Possess current medical licensure and appropriate medical staff appointment.
   c. Be appointed to their teaching responsibilities by the program director, based upon their educational abilities.

5. Non-physician faculty: Non-physician faculty may play a valuable role in the education of residents. The use of non-physician faculty must comply with the following standards:
   a. Non-physician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments.
   b. Non-physician faculty must not be responsible for the direct supervision of resident physicians providing patient care.

6. Faculty responsibilities as a whole
   a. Participate in organized clinical discussions, rounds, journal clubs, and conferences.
   b. Establish and maintain an environment of inquiry and scholarship with an active research component. Faculty should encourage and support residents in scholarly activities.
   c. Some members of the faculty should also demonstrate scholarship by one or more of the following:
      i. publication of original research or review articles in peer-reviewed journals, or chapters in textbooks
      ii. publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings
      iii. participation in national committees or educational organizations.
   d. Engage in professional development applicable to their responsibilities as educational leaders;

7. Faculty Support.
   a. The DIO, on behalf of the Sponsoring Institution, and the respective departmental chair will ensure that core faculty receive adequate support to ensure both effective supervision and quality resident/fellow education.

C. Supervision at Affiliated Training Locations.
   1. All clinical training sites must be certified by JCAHO, an entity granted “deeming authority” for participation in Medicare under federal regulations, or an entity certified as complying with the conditions of participation in Medicare under federal regulations. All clinical training sites must be judged to be satisfactory by the DIO and GMEC in meeting the educational needs of the Tulane resident, and be approved by the respective ACGME RRC committee.
   2. Master Affiliation Agreements must exist between the University and each affiliated training site, and individual program letters of agreement must exist between individual programs that send residents to a training site. Master Affiliation Agreements must be updated at least every five years. Program Letters of Agreement must be updated on an annual basis, reflecting the ACGME institutional, training location, and common program requirements.
   3. At each participating site, there must be a sufficient number of faculty with documented qualifications to instruct and supervise all residents at that location, as outlined in XIII.B.
   4. Each clinical site must have a liaison with the Office of Graduate Medical Education. The DIO is
responsible for meeting with each liaison at least once per year. During these meetings, the DIO will tour
the learning environment (call rooms, meal availability, computer access, patient care venues, conference
space) and review and confirm the affiliation agreement with the training site’s liaison. The DIO will
ensure compliance with the University and ACGME requirements contained within the Master Letters of
Affiliation and individual program letters of agreement.
5. The individual program director is responsible for compliance with all Tulane and ACGME policies at
all affiliated training locations in which his or her residents rotate. The program director must have a
designated liaison with each affiliated training location. This person is responsible for ensuring
compliance with all program, University, and ACGME policies and procedures, as outlined in the
program letter of affiliation. The training site liaison should be in regular communication with the
program director, and the two should meet in person at least twice per year. The affiliated training site
liaison should provide an assessment of the training location, as it regards compliance with program,
University, and ACGME policies and procedures, and this input should be documented in the annual
report of the program.
6. Each program must have a Program Letter of Affiliation with the training institution. The PLA must be
approved by the DIO, and must:
   a. Identify the faculty who will assume both educational and supervisory responsibilities for
      residents;
   b. Specify the faculty’s responsibilities for teaching, supervision, and formal evaluation of
      residents
   c. Specify the duration and content of the educational experience; and,
   d. State the policies and procedures that will govern resident education during the assignment.

D. Job Descriptions and Graduated Levels of Responsibility:
   1. The program director is responsible for developing a job description for the residency program. This
      job description should outline the physical and mental requirements of the job. No candidate who is able
to perform the physical and mental components contained within the job description can be discriminated
against based upon a disability (See Chapter II. Policy on Equal-Opportunity, Affirmative Action, &
Disabilities).
   2. The program director must establish an outline of progressive levels of responsibility for each training
level within the residency program. Residents who advance in the training program should incur
progressively greater levels of responsibility and independent practice as outlined in the progressive lines
of responsibility.
   3. Assignment of the level of responsibility must be commensurate with the resident’s performance in the
core competencies, and this should be documented in the resident’s end-of-the-year promotion letter.
Residents who fail to meet expected competency, based upon the milestones, should not be promoted.

E. Supervision of Residents Performing Invasive Procedures in the Operative Suite. The inherent risks associated
with all types of surgery and invasive procedures require that staff practitioners provide appropriate levels of
supervision of all residents performing such procedures.
   1. Faculty must be present for all invasive procedures performed by residents in the operating room or
      procedural suite.
   2. Faculty supervising residents will review the indications for the procedure, and will document in the
      patient’s medical record their concurrence with the indication, risks and benefits, the resident’s
      performance, the interpretation of the results and the complications, if any.
   3. Faculty physicians will supervise the evaluation of patients, scheduling of cases, assignment of case
      priorities, the preoperative preparation, and the intra-operative and postoperative care of surgical patients
      and patients undergoing invasive procedures. This supervision will be reflected in the faculty’s progress
      notes at appropriate times in the course of each patient’s hospitalization.
   4. As residents advance in their education and training, they may be given progressively increasing levels
      of responsibility, as defined in the program’s Progressive Lines of Responsibility. The degree of
      responsibility and autonomy will depend upon the individual’s general aptitude, demonstrated
      competence, prior experience with similar procedures, the complexity and degree of the risks involved in
the anticipated surgical/invasive procedure. Program directors will document a resident’s assigned level of responsibility in the resident's record. This will include the types of diagnostic or therapeutic procedures the resident may perform, the degree of autonomy afforded to the resident in performing those procedures, and those procedures for which the resident may act as a teaching assistant.

5. An important aspect of a resident’s learning experience is the opportunity of a senior resident to supervise more junior residents. As a general rule, senior residents, when acting in the role of a teaching assistant to less experienced residents, may supervise the performance of surgical/invasive procedures of lesser or more routine complexity. This, however, does not release the Faculty practitioner's responsibility for the oversight of the patient's care. When a resident is acting as a teaching assistant, the staff practitioner remains responsible for the quality of care of the patient, providing supervision and meeting medical recorded documentation requirements as defined within this policy.

F. Supervision of Residents Performing Invasive Procedures at the Bedside.

1. Faculty do not need to be physically present for supervision of invasive procedures performed by residents at the bedside, but they remain responsible for ensuring that the procedure is safely performed. This includes reviewing with the resident the indications for the procedure; faculty will document in the patient’s medical record their concurrence with the indication, risks and benefits, the resident’s performance, the interpretation of the results and the complications, if any.

2. As residents advance in their education and training, they may be given progressively increasing levels of responsibility, as defined in the program’s Progressive Lines of Responsibility. The degree of responsibility and autonomy will depend upon the individual's general aptitude, demonstrated competence, prior experience with similar procedures, the complexity and degree of the risks involved in the anticipated invasive procedure.

3. Program directors will maintain a list of bedside procedures that can be performed by their residents at the bedside without direct supervision.
   a. Program directors will assign to each resident which procedures he or she can perform without direct faculty or senior resident supervision. This assignment should not be based solely upon the resident’s PGY status, but rather assigned individually based upon the resident’s aptitude, demonstrated competence, and prior experience with similar procedures.
   b. Residents who have been deemed competent to perform a procedure without direct supervision will be given a hologram sticker, specific to that procedure, to be placed on the back of their ID.
   c. Nurses and appropriate consulting providers should ask to see a resident’s validation sticker prior to allowing a resident to perform the bedside procedure.
   d. Residents without such a validation sticker may still perform the procedure, but must have a senior resident (who has such a validation sticker) or faculty member present at all phases of the procedure.

G. Supervision of Transitions of Care

1. Program directors must facilitate professional development for core faculty members and residents/fellows regarding effective transitions of care. This instruction should include:
   a. The principles and purpose of close-loop communication
   b. Appropriate identification of illness severity
   c. Appropriate patient summaries, as defined by the patient’s complexity and tenuousness
   d. Appropriate action lists, as defined by the patient’s complexity and tenuousness
   e. Situation awareness and contingency planning

2. Program directors, in concert with the DIO, must ensure that participating sites engage residents/fellows in standardized transitions of care consistent with the setting and type of patient care.
   a. First-year residents (i.e., interns) must be directly supervised in their transitions of care (i.e., sign-out) by senior residents or in-house faculty until which time the program director has determined that the intern can safely conduct transitions of care.
   b. Program directors, working with local site directors, must ensure that interns are directly observed in their transitions of care (i.e., sign out) until which point the program director is satisfied that the intern has demonstrated sufficient mastery of transitions communication to
warrant transitions of care duties without direct supervision.

H. Reporting Fall-Outs in Supervision

1. The GME Office recognizes that the clinical environment can be complex, heterogeneous and dynamic on a day-to-day basis. Nonetheless, there should not be an occasion in which residents are inadequately supervised or in a position where they believe their clinical responsibilities are above their clinical responsibilities.

2. It is the responsibility of all residents and faculty, regardless of whether they were directly involved in the incident or not, to report events of inadequate supervision. Residents and faculty are to report events involving inadequate supervision via one or more of the following mechanisms.
   a. Anonymous reporting via resident-of-rotation or Resident-of-faculty E-value evaluations.
   b. Direct reporting to attending physicians or the program director.
   c. Anonymous reporting via the affiliated institution’s (ie hospital/clinic) near-miss/adverse event reporting system
   d. Reporting to the Residency Education Committee, either directly or via the resident’s/faculty’s representative
   e. Tulane Resident and Fellows Congress, either directly or via the resident’s representative
   f. Resident-of-Program annual evaluation
   g. Direct reporting to the Department Chair
   g. Direct reporting to the DIO

Approved by the GMEC; May 26th, 2015
XIV. POLICY ON EVALUATION

A. Evaluations
It is the responsibility of the program director, and the associated faculty, to ensure that
1. Residents receive timely, accurate and meaningful evaluations of their performance in each of the six core competencies.
2. Residents receive an accurate assessment of their developmental progress along the milestones of each entrustable professional activities (EPA) for their respective training program.

B. Afferent Evaluations
1. Faculty-of-Resident Evaluations.
   a. This evaluation must be conducted at the conclusion of each rotation assignment. For assignments greater than one month, the evaluation must be conducted at the conclusion of the rotation, as well as at the midpoint of the rotation, or every two months, whichever is less.
   b. The evaluation should consist of both numerical scores (objective) and written comments.
   c. The evaluation should evaluate each of the core competencies (See Chapter X: Policy on Core Curriculum and the Core Competencies) and the components of the job description for the resident’s level of training.
   d. The evaluation should be conducted electronically such that residents have immediate and 24 hour access to reviewing the evaluation.
   e. The evaluation should be discussed in person with the resident prior to the conclusion of the rotation.
   f. The program director and the Residency Education Committee will use data from these evaluations in making the determination for promotion or graduation.
   g. Each program is required to use faculty-of-resident evaluation template provided by the Graduate Medical Education Office. Tailoring of the evaluation questions to the unique feature of the training program is allowed, but the modifications must not deviate from the intent of each question on the evaluation, as it relates to the ACGME common program requirements.

2. Resident-of-Resident Evaluations
   a. In rotations where residents are routinely supervising other residents (i.e., a resident supervising an intern), both residents should be given the opportunity to evaluate each other.
   b. The evaluation should consist of both a numerical score and written comments.
   c. The evaluation should evaluate each of the core competencies (See Chapter X: Policy on Core Curriculum and the Core Competencies) and the components of the job description for the resident’s level of training (See XIII: F below).
   d. The evaluation should be conducted electronically such that residents have immediate and 24 hour access to reviewing the evaluation.
   e. Collectively, data from these evaluations should be used by the program director in making the determination for promotion or graduation.
   f. Each program is required to use the resident-of-resident evaluation template provided by the Graduate Medical Education Office. Tailoring of the evaluation questions to the unique feature of the training program is allowed, but the modifications must not deviate from the intent of each question on the evaluation, as it relates to the ACGME common program requirements.

3. Student-of-Resident Evaluations
   a. In rotations where residents are routinely supervising students, students must be given the opportunity to evaluate the resident.
   b. The evaluation should consist of both a numerical score and written comments.
   c. The evaluation should evaluate at a minimum the resident’s teaching, communication, interpersonal skills, professionalism and patient care skills.
   d. The evaluation should be conducted electronically such that residents have immediate and 24 hour access to reviewing the evaluation.

hour access to reviewing the evaluation.
e. Collectively, data from these evaluations should be used by the program director in making the
determination for promotion or graduation.
f. Each program is required to use the student-of-resident evaluation template provided by the
Graduate Medical Education Office. Tailoring of the evaluation questions to the unique feature of
the training program is allowed, but the modifications must not deviate from the intent of each
question on the evaluation, as it relates to the ACGME common program requirements.

4. Patient-of-Resident Evaluations
   a. In rotations where residents routinely provide patient care, patients must be given the
      opportunity to evaluate the resident overseeing his or her care.
   b. While not every patient needs to evaluate the resident, at least one patient evaluation should be
      solicited during each of the clinical rotations that the program director designates as core clinical
      rotations.
   d. . The evaluation should evaluate at a minimum the resident’s communication, interpersonal
      skills, professionalism and patient care skills.
   d. The evaluation may be collected by paper or in person by a supervisor, but should eventually
      be converted to an electronic format such that the resident has immediate and 24 hour access to
      reviewing the evaluation.
   e. Collectively, data from these evaluations should be used by the program director in making the
determination for promotion or graduation.
   f. Each program is required to use the patient-of-resident evaluation template provided by the
Graduate Medical Education Office. Tailoring of the evaluation questions to the unique feature of
the training program is allowed, but the modifications must not deviate from the intent of each
question on the evaluation, as it relates to the ACGME common program requirements.

5. Nurse/Allied Health Provider-of-Resident
   a. In rotations where residents routinely provide patient care, nursing and ancillary staff (i.e., OR
      staff, respiratory therapy, etc.) must be given the opportunity to evaluate the resident with whom
      they have worked during the rotation.
   b. While not every staff needs to evaluate the resident, at least one nurse evaluation should be
      solicited during each of the clinical rotations that the program director designates as core clinical
      rotations appropriate and feasible for nurse-of-resident evaluations.
   d. The evaluation should evaluate at a minimum the resident’s communication, interpersonal
      skills, professionalism and patient care skills.
   d. The evaluation may be collected by paper or in person by a supervisor, but should eventually
      be converted to an electronic format such that the resident has immediate and 24 hour access to
      reviewing the evaluation.
   e. Collectively, data from these evaluations should be used by the program director in making the
determination for promotion or graduation.
   f. Each program is required to use the nurse-of-resident evaluation template provided by the
Graduate Medical Education Office. Tailoring of the evaluation questions to the unique feature of
the training program is allowed, but the modifications must not deviate from the intent of each
question on the evaluation, as it relates to the ACGME common program requirements.

   a. This evaluation must be conducted at least twice per year.
   b. The evaluation should consist of both a numerical score and opportunity for written, self-
      reflection comments.
   c. At a minimum, the evaluation should allow the resident to evaluate the following components
      i. A self-evaluation in each of the six core competencies areas
      ii. A listing of medical errors from the previous six months, and self-reflection on how
            these errors could have been prevented.
iii. A reflection on the resident’s progress in professional/career goals
iv. A reflection on the resident’s progress in personal goals.
d. The evaluation should be conducted electronically, and in a manner that ensures the residents anonymity to enable effective evaluations without the fear of reprisal.
e. Each program is required to use the resident-of-self evaluation template provided by the Graduate Medical Education Office. Tailoring of the evaluation questions to the unique feature of the training program is allowed, but the modifications must not deviate from the intent of each question on the evaluation, as it relates to the ACGME common program requirements.

B. Efferent Evaluations

1. Resident-of-Resident Evaluations
   a. In rotations where residents are routinely supervising other residents (i.e., a resident supervising an intern), both residents should be given the opportunity to evaluate each other.
   b. The evaluation should consist of both a numerical score and written comments.
   c. The evaluation should evaluate each of the core competencies (See Chapter X: Policy on Core Curriculum and the Core Competencies) and the components of the job description for the resident’s level of training (See XIII: F below).
   d. The evaluation should be conducted electronically such that residents have immediate and 24 hour access to reviewing the evaluation.
   e. Collectively, data from these evaluations should be used by the program director in making the determination for promotion or graduation.
   f. Each program is required to use the resident-of-resident evaluation template provided by the Graduate Medical Education Office. Tailoring of the evaluation questions to the unique feature of the training program is allowed, but the modifications must not deviate from the intent of each question on the evaluation, as it relates to the ACGME common program requirements.

2. Resident-of-Faculty.
   a. This evaluation must be conducted monthly, or, for rotations that are longer than one month, at the conclusion of the rotation, or every three months, whichever is less.
   b. The evaluation should consist of both a numerical score and written comments.
   c. The evaluation should evaluate the faculty on his or her effectiveness in teaching, commitment to the educational program, clinical knowledge, and professionalism.
   d. The evaluation should be conducted electronically, and in a manner that ensures the residents anonymity to enable effective evaluations without the fear of reprisal. All programs use EVALUE’s lock-out feature to ensure that faculty cannot see their evaluations until at least five learners have evaluated the faculty; all comments are aggregated to de-link the comment from the time period in which it was receive.
   e. The results of these evaluations should be used by the program director in deciding which faculty are invited to continue to supervise residents on clinical rotations.
   f. Each program is required to use the resident-of-faculty evaluation template provided by the Graduate Medical Education Office. Tailoring of the evaluation questions to the unique feature of the training program is allowed, but the modifications must not deviate from the intent of each question on the evaluation, as it relates to the ACGME common program requirements.

3. Resident-of-Rotation.
   a. This evaluation must be conducted monthly, or, for rotations that are longer than one month, at the conclusion of the rotation, or every three months, whichever is less.
   b. The evaluation should consist of both a numerical score and written comments.
   c. At a minimum, the evaluation should evaluate the following components
      i. The call rooms (if applicable)
      ii. The nurses and ancillary staff involved in the clinical rotation
      iii. The safety of the rotation (parking, secure place for personal belongings)
iv. The communication infrastructure of the rotation (access to medical records and patient data, access to educational resources).

v. The balance between education and service of this rotation.

vi. The rotation’s compatibility with duty-hours requirements.

d. The evaluation should be conducted electronically, and in a manner that ensures the residents anonymity to enable effective evaluations without the fear of reprisal.

e. Collectively, data from these evaluations should be used by the program director in making the determination for continuation of a clinical rotation.

f. Each program is required to use the resident-of-rotation evaluation template provided by the Graduate Medical Education Office. Tailoring of the evaluation questions to the unique feature of the training program is allowed, but the modifications must not deviate from the intent of each question on the evaluation, as it relates to the ACGME common program requirements.

4. Resident-of-Program.

a. This evaluation must be conducted at least once per year.

b. The evaluation should consist of both a numerical score and opportunity for written comments.

c. At a minimum, the evaluation should evaluate the following components

i. The goals and objectives of each clinical rotation, including the balance between education and service of each rotation

ii. The curriculum and core educational conferences.

iii. The supervision by the faculty, and the faculty’s clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.

iv. The effectiveness of faculty in providing meaningful evaluations to the residents.

v. The effectiveness of the program director.

vi. The program’s compliance with duty-hours requirements and other program policies.

d. The evaluation should be conducted electronically, and in a manner that ensures the residents anonymity to enable effective evaluations without the fear of reprisal.

e. Collectively, data from these evaluations should be used by the program director in making adjustments in the residency program. The results of these evaluations must be included in the annual report.

f. Each program is required to use the resident-of-program evaluation template provided by the Graduate Medical Education Office. Tailoring of the evaluation questions to the unique feature of the training program is allowed, but the modifications must not deviate from the intent of each question on the evaluation, as it relates to the ACGME common program requirements.

5. Resident-of-Self.

a. This evaluation must be conducted at least twice per year.

b. The evaluation should consist of both a numerical score and opportunity for written, self-reflection comments.

c. At a minimum, the evaluation should allow the resident to evaluate the following components

i. A self-evaluation in each of the six core competencies areas

ii. A listing of medical errors from the previous six months, and self-reflection on how these errors could have been prevented.

iii. A reflection on the resident’s progress in professional/career goals

iv. A reflection on the resident’s progress in personal goals.

d. The evaluation should be conducted electronically, and in a manner that ensures the residents anonymity to enable effective evaluations without the fear of reprisal.

e. Each program is required to use the resident-of-self evaluation template provided by the Graduate Medical Education Office. Tailoring of the evaluation questions to the unique feature of the training program is allowed, but the modifications must not deviate from the intent of each question on the evaluation, as it relates to the ACGME common program requirements.
C. Case Logs
In programs that require minimum numbers of procedures to ensure promotion, graduation, or eligibility for certifying examinations (i.e., board licensure), a case log must be compiled and updated on a semi-annual basis, or more frequently if specified by the training program. The case log should be reviewed with the resident at each semi-annual meeting with his or her program director.

D. Access to Evaluations
The Family Educational Rights and Privacy Act, requires educational agencies or institutions to provide access to educational records with certain limitations. Resident and fellow education records, other than publicly available directory information, are private and shall not be disclosed except as appropriate to the following:

1. The resident or fellow, who may review his or her record with supervision
2. The program director and the Associate Dean for Graduate Medical Education
3. Persons specifically authorized by the resident or fellow in writing to receive the information;
4. Other educational institutions in which the resident or fellow seeks to enroll or obtain employment, with permission of the resident or fellow, provided the disclosure is limited to official copies of resident or fellow’s transcripts from the appropriate University office;
5. Other organizations conducting educational research studies approved by their respective Institutional Review Boards, provided the studies are conducted in a manner that does not permit identification of residents and provided the information will be destroyed when no longer needed for the specified purpose;
6. Persons in compliance with a court order or lawfully issued subpoena provided that a reasonable attempt is made to notify the resident or fellow where required prior to release;
7. Appropriate members of the court system when legal action against the University is initiated by the resident or fellow and the disclosure is part of the University’s defense;
8. Appropriate persons during an emergency, provided the information is necessary to protect the health or safety of the resident or fellow or other individuals;
9. Accrediting organizations and state or federal education authorities using information for auditing, evaluating, or enforcing legal requirements of educational programs, provided the data is protected to prohibit the identification of the resident or fellow and all personally identifiable information is destroyed when no longer needed; and
10. Appropriate persons or agencies in connection with a resident or fellow’s application for or receipt of financial aid to determine eligibility amount, or conditions of financial aid and to enforce the terms and conditions of the aid.

E. Promotion and Graduation
1. Each residency program is required to create and maintain a criteria for promotion for each year of training (See Progressive Lines of Responsibility). This criteria should be based upon the entrustable professional activities (EPA’s) for the respective field, and the eventual requirements for board certification. Decisions as to promotion and/or renewal of a resident’s appointment must be made in context of this criteria.
2. Residents must receive a written summary of their performance, based upon the core competencies, at least twice per year. The summary letter must contain a description of the resident’s progress along each of the entrustable professional activities (EPA) in the training program, as based upon their collective faculty, patient, nurse, and peer evaluations to that point in the year.
   a. Mid-Year Evaluation Summaries. The program director or his or her designee must meet with each resident in person to review the mid-year evaluation. The summary letter must contain a numerical assessment of the resident’s milestones progress on each entrustable professional activity (EPA), as based upon their collective faculty, patient, nurse, and peer evaluations to that point in the year; the summary must also provide a narrative commentary on his or her level of performance, or note that such written comments are available to the resident on the E-Value
summary report. If the resident is at risk for not being promoted based upon this evaluation, this should be discussed with the resident at this time.

b. End-of-Year Evaluation Summaries. The program director or his or her designee must meet with each resident in person to review the end-of-year evaluation. The summary letter must contain a numerical assessment of the resident’s milestones progress on each entrustable professional activity (EPA), as based upon their collective faculty, patient, nurse, and peer evaluations throughout the year; the summary must also provide a narrative commentary on his or her level of performance, or note that such written comments are available to the resident on the E-Value summary report. If so warranted, the promotion letter to the next year of training should be given to the resident at this time, and the letter must clearly state that the resident is being promoted to the next year of training. The letter must be accompanied by a description of the progressive level of responsibility commensurate with the PGY level to which he or she is being promoted.

3. Adverse promotion or graduation decisions
   a. Promotion and graduation decisions must be made by the Clinical Competency Committee’s incorporation of a global assessment of the resident. Decisions for promotion cannot be based solely on in-service scores.
   b. If the resident is not to be promoted, or to repeat rotations that would require extension of total training time, the program should inform the resident, and follow the policies and procedures as outlined in (Chapter XV. Policy on Remediation, Suspension, Termination and Grievance).

4. End-of-Training Evaluation Summaries. The program director or his or her designee must meet with each resident in person to review the end-of-training evaluation. The summary letter must contain a description of the resident’s milestone progress on each entrustable professional activity (EPA), as based upon their collective faculty, patient, nurse, and peer evaluations throughout the year; the summary must also provide written commentary on his or her level of performance, or note that such written comments are available to the resident on the E-Value summary report. This evaluation should document the resident’s performance during the final period of education.
   a. If so warranted, the graduation letter should be given to the resident at this time, and the letter must clearly state that the resident has completed the training program and “The program director, in consultation with the program’s clinical competency committee, has deemed the resident sufficiently competent to enter practice in “x” independently and without direct supervision.” Where “X” is the field of the resident’s training program.
   b. If the resident is not to be graduated, a description of the rationale, referencing failure to meet satisfactorily the core competencies, should be included in this letter.
      i. If the resident is asked to extend total training time, he or she must be given an opportunity to appeal this decision to the Clinical Competency Committee. If upon appeal, the Clinical Competency Committee upholds the decision to extend training, the resident has a right to grieve this decision through the University’s Grievance Committee (Chapter XV. Policy on Remediation, Suspension, Termination and Grievance).
      ii. If the decision is to terminate the resident from the training program, the resident must be given the opportunity to appeal (grieve) this decision to the University’s Grievance Committee, as outlined in the Tulane University GME policies and procedures (Chapter XV. Policy on Remediation, Suspension, Termination and Grievance).

Approved by the GMEC; May 26th, 2015
XV. POLICY ON REMEDIATION, SUSPENSION, TERMINATION AND GRIEVANCE

A. DEFINITIONS

1. Personnel
   a. Resident – refers to all interns, residents and fellows participating in a Tulane University School of Medicine post-graduate training program.
   b. Residency Program – refers to a residency or fellowship educational program.
   c. Program Director - refers to the Director of the Residency Program.
   d. DIO- refers to the Designated Institutional Official, also known as the Associate Dean of Graduate Medical Education.
   e. Administrative Personnel- Program directors, departmental chairs, and CEO’s of affiliated training locations.

2. Actions
   a. Probation – a formal level of discipline in which the resident may still engage in his or her training program within the confines of a probationary plan. Implicit in “probation” is that failure to successfully complete the probation plan will result in either extension of the probation or termination of the contract, at the clinical competency committee’s discretion.
   b. Remediation- the process of improving resident performance. Remediation may occur either within, or separate from, probation.
   c. Suspension- a formal level of discipline in which the resident will temporarily no longer engage in his or her training program.
   d. Termination – the act of severing employment prior to the expiration date of the resident’s contract. If a resident is terminated, his or her resident contract will not be renewed.
   e. Non-Renewal – a decision to not renew a resident’s participation in a residency program. In the absence of extenuating circumstances, such a decision should ideally be made no later than four months prior to the initiation of the resident’s next contract start date. Termination and non-renewal after this date remains an option.
   f. Grievance- a formal process of contesting the decision made by the evaluation and remediation procedure.

B. GENERAL PRINCIPLES

1. Residents are expected to meet and adhere to all academic, clinical and professional standards set forth in the institutional, departmental, and residency program requirements. Inadequate performance or unprofessional behavior is grounds for disciplinary action, up to, and including, termination.
2. Unprofessional behavior includes, but is not limited to, acting improperly towards patients, supervisors and/or peers; disrespect for faculty, patients, supervisors and/or peers; dishonest, unethical and/or illegal behavior; failure to meet clinical responsibilities; and failure to correct deficiencies in academic performance in a responsible and timely fashion.
3. Inadequate performance should be clearly communicated to the resident, preferably in writing, as early as possible.

C. REMEDIATION AND PROBATION.

Probation and remediation are used to correct academic and/or professional deficits, including, but not limited to, deficits in medical knowledge, time management, organizational abilities, communication skills, and procedural skills.

1. Remediation is the process of improving resident performance. Remediation may occur either within, or separate from, probation.
   a. Where remediation is separate from probation, it is a voluntary exercise on the part of the resident to engage in activities to improve his or her performance. As such, remediation is not reportable, nor may a resident be mandated to participate in stand-alone (i.e., separate from probation) remediation.
2. Probation is a formal level of discipline in which the resident may still engage in his or her training program within the confines of a probationary plan. Implicit in “probation” is that failure to successfully complete the probation plan will result in either extension of the probation or termination of the contract, at the clinical competency committee’s discretion.
The Office of Graduate Medical Education, in concert with the resident’s program director, oversees all probations as outlined above.

a. The decision for probation should be made by the respective program’s Clinical Competency Committee, after this committee has reviewed the resident’s performance evaluations.
b. If after reviewing the resident’s performance evaluations, the CCC agrees that probation is appropriate, the resident will be so notified, and he/she will be informed that he or she has the right to address the CCC to contest the decision. The decision for probation is otherwise not grievable.
c. The resident will be given a probation agreement that will outline the terms and timeframe of the probation.
d. Should the resident refuse the probation agreement, his or her contract with the University will be terminated. He/she will then have an opportunity to grieve this decision as outlined below in the provisions of termination.
e. Guidelines for Probation and Remediation. A probation plan will be developed by the program director, in concert with Clinical Competency Committee for the respective program. The probation plan will generally have the following components:
   i. Documentation of deficiencies. Except in extenuating circumstances, probation should not be evoked for a one-time event, including isolated performances on in-service examinations. A pattern of deficiency should be documented in the resident’s file.
   ii. Formal and explicit presentation of the deficiency. The resident will be presented a written account of the deficiency.
   iii. The probation plan will have a defined time-line, no less than three, but not more than 12 months.
   iv. The probation plan will have an a priori end-point(s) that will define the success or failure of the remediation effort. The probation plan’s end-points must be achievable within the time-frame outlined in the program.
   v. The focus of the remediation effort will match the deficiency.
      a. Medical Knowledge
      b. Time Management& Organization
      c. Clinical Reasoning
      d. Communication
      e. Patient Interaction
      f. Attitude & Motivation
      g. Inter-personal and Team Skills
      h. Procedural Skills
   f. The program director will design, in concert with the CCC, the remediation plan and have the probation plan reviewed by the DIO prior to meeting with the resident.
g. The probation plan will include planned efforts by the program director or the program faculty to help the resident improve. While the resident is ultimately accountable for improvement, the program and the program director are responsible for helping the resident to improve.
h. The accounts of the probation plan will be documented, with at least one mid-point evaluation that will be communicated to the resident.
i. The consequences of failure to successfully complete the remediation program will be clearly outlined.
j. Upon successful completion of the probation plan, the resident will be removed from this status. Documentation will remain part of the resident’s permanent file.
k. Upon failure to successfully complete the probation plan, the resident will be asked to either repeat training, extend training, be subject to non-renewal, or be terminated. The remediation may be extended for a period not to exceed six months, at the program director’s discretion.
termination or non-renewal actions, the resident will be provided a copy of the grievance and fair
hearing policy, and will sign acknowledgment of receipt of this document.

D. NON-RENEWAL, NON-PROMOTION, DELAYED GRADUATION AND TERMINATION

1. Non-Renewal is a decision to not renew a resident’s participation in a residency program.
   a. In the absence of extenuating circumstances, such a decision should ideally be made no later
      than four months prior to the initiation of the resident’s next contract start date. Termination and
      non-renewal after this date remains an option.
   b. If a Resident’s contract is not to be renewed, he or she will be given written notice, and he or
      she must be given an opportunity to appeal this decision to the Clinical Competency Committee.
      If upon appeal, the Clinical Competency Committee upholds the decision to extend training, the
      resident has a right to grieve this decision through the University’s Grievance Committee (See
      XIV. H Below)

2. Non-Promotion is a decision to not promote the resident to higher levels of training based upon merit-
based competency. The decision to not promote a resident rests with the program’s Clinical Competency
Committee.
   a. If the decision does not necessitate extended training time, the decision is not grievable.
   b. If the decision will require extended training time, the resident will be given written notice, and
      he or she will be given an opportunity to appeal this decision to the Clinical Competency
      Committee. If upon appeal, the Clinical Competency Committee upholds the decision to extend
      training, the resident has a right to grieve this decision through the University’s Grievance
      Committee (See XIV. H Below)

3. Delayed Graduation
   a. If the resident is asked to extend total training time (i.e., delay graduation) for performance
      reasons, he or she will be given written notice, and he or she will be given an opportunity to
      appeal this decision to the Clinical Competency Committee. If upon appeal, the Clinical
      Competency Committee upholds the decision to extend training, the resident has a right to grieve
      this decision through the University’s Grievance Committee (See XIV. H Below)
   b. The decision to extend total training time because of time missed (i.e., leave of absence) that
      exceeds the maximal amount of time-missed allowed by the respective Board is not a grievable
      decision.
   c. Preliminary interns cannot be made to extend their preliminary training time. Inadequate
      performance should result in the decision to not grant credit for the year of training.

4. Termination is a decision to end a resident’s contract with the University.
   a. Termination can arise in the following circumstances:
      i. This decision is generally reserved for, but not limited to, academic and/or professional
         deficits that, in the discretion of the DIO, are significant, repeated, or irremediable.
      ii. Termination decisions may also be evoked for failure to participate in, or successfully
          complete, probation agreements.
      iii. Failure to maintain the requirements of employment, as outlined in the resident
          contract.
   b. In all cases of termination, the resident will be informed of the decision by written notice. The
      resident will be informed of the grievance policy. He or she will have five business days after
      being informed of the decision to file a grievance with the DIO.

E. SUSPENSION-

1. Suspension is a formal level of discipline in which the resident will temporarily no longer engage in his
or her training program. The purpose of suspension is to allow time to investigate a resident issue and to
fine determine the appropriate pathway to resolve that issue, and/or to ensure the resident receives
appropriate assistance to ensure that he or she is fit for duty.
a. Suspension to enable time to investigate a complaint and determine the appropriate action will be suspension with pay and benefits.
b. Suspension to ensure the resident receives appropriate assistance to ensure that he or she is fit for duty (i.e., the Physicians Health Foundation) will be suspension with benefits but without pay, unless designated by the DIO.

2. Suspensions can only be reversed by the DIO or the Dean.

F. SELF-REFERAL PATHWAY
1. The Self-Referral Pathway is designed to engage residents to seek evaluation and/or treatment of psychiatric impairment, drug or alcohol abuse.
2. The Self-Referral Pathway is described in Chapter XV: Residents’ Assistance Program.

G. THE ADMINISTRATIVE-REFERRAL PATHWAY
1. Any resident whose performance is assessed to be unsatisfactory by Administrative Personnel may be referred to the DIO for evaluation and remediation through the Administrative-Referral Pathway. Once referred, a resident is preliminarily suspended; pay and benefits will continue during the preliminary suspension. This preliminary suspension is not disciplinary in nature. Rather, it is designed to allow the DIO sufficient time to investigate the referral.
2. A written request must be made by the Administrative Personnel to the DIO. The DIO may also directly initiate the Administrative Referral process.
3. Upon receiving or initiating the request, the DIO will conduct an investigation that may include, but is not limited to, a review of the resident’s file, police reports, interviews with the resident and/or any member of Tulane University or applicable training locations.
4. After review, the DIO will render one of five decisions:
   a. The resident requires no corrective action. The resident will be re-instated. The program director and the Administrative Personnel who made the referral will be informed.
   b. The resident requires remediation without probation. The resident will be re-instated, and the DIO will work with the respective program director to design an appropriate remediation strategy. The Administrative Personnel who made the referral will be informed.
   c. The resident requires probation.
      i. The DIO will lift the suspension and communicate to the respective program director that the resident should be evaluated by the respective program’s Clinical Competency Committee, if this has not already been done, as to whether probation is appropriate.
      ii. The program director will then instruct the program’s Clinical Competency Committee (CCC) to review the inciting event(s) and the resident’s performance evaluations and to render a decision as to whether probation is appropriate.
      iii. If the CCC determines that the resident does not require probation, he/she will be reinstated, at the CCC’s discretion, either with no further action required, or a remediation plan without probation.
      iv. If the CCC determines that the resident requires probation, the procedure outlined in Chapter XIV. Section D will be followed.
   d. The resident should be referred to The Resident’s Assistance Program (see Chapter XVI, Residents’ Assistance Program). This decision is generally reserved for, but not limited to, residents who are psychiatrically impaired, or impaired because of excessive use or abuse of drugs, including alcohol. If the resident refuses to be evaluated for fitness-for-duty, he or she will be terminated from the University. He/she will then have an opportunity to grieve this decision as outlined below in the provisions of termination.
      i. The DIO will sustain the suspension and refer the resident to the Residents’ Assistance Director for formal evaluation.
      ii. After the resident has been referred, Administrative Personnel other than the DIO should have no communication with the Residents’ Assistance Director, unless so authorized by the resident.
      iii. Upon completion of the evaluation, the Residents’ Assistance Director will
communicate the results of the evaluation to the DIO, who will in turn, notify the program director.

e. The resident should be terminated from the University. See XV. D.4

H. GRIEVANCE & FAIR HEARING COMMITTEE COMPOSITION

The Grievance-Fair Hearing procedure is used in the adjudication of all actions resulting in termination, or non-renewal. The Grievance-Fair Hearing procedure is to be followed as below:

1. A resident may request a Grievance-Fair Hearing for termination, non-renewal, or a contested CCC decision to not graduate the resident.
2. Contesting evaluations, letters of recommendation, documentation of performance, and probation are not grounds for a Grievance-Fair Hearing.
3. A Grievance-Fair Hearing must be filed in writing within five business days of the decision being grieved, addressed to the DIO in the Office of the Graduate Medical Education.
4. The purpose of the Grievance-Fair Hearing is to ensure that the house officer’s due process rights have been met.
5. A resident may be removed from clinical responsibility pending the Grievance-Fair Hearing, if the DIO determines that patient care may be compromised.
6. Once the request has been received, the DIO will assure that a Grievance-Fair Hearing is an appropriate means for adjudicating the complaint. If the request is not appropriated for a Grievance-Fair Hearing, the resident will be notified.
7. If the DIO deems the Grievance-Fair Hearing request is an appropriate means for adjudicating the complaint, he or she will convene the Grievance-Fair Hearing board as outlined below. Subject to the availability of all parties, the first meeting of the Fair Hearing Board will occur within 30 days of the written request.
8. The Fair Hearing Board will consist of the following five voting members, appointed by the DIO or his or her designee in cases of conflict of interest or inability to attend. The chair will be a nonvoting member.
   a. Three (3) faculty members from programs not directly associated with the resident who has filed the Grievance-Fair Hearing.
   b. Two (2) house officers from programs not directly associated with that of the resident who has filed the Grievance-Fair Hearing.

I. GRIEVANCE AND FAIR HEARING PROCEDURE.

Unless otherwise specified, the following procedures are to be used in all Grievance/Fair Hearing Procedures. All capitalized terms shall have the meaning as set forth in the Tulane University School of Medicine: Graduate Medical Education Policies and Procedures.

1. The Chair of the Grievance/Fair Hearing Board, along with the committee members, will be identified at least three weeks prior to formally convening the Fair Hearing Board. The resident then has 4 business days to formally submit an objection to one or all of the committee member’s participation.
   a. In making an objection, the resident must establish reasonable evidence that the Board member’s participation in the Grievance/Fair Hearing would unduly bias the proceedings.
   b. The Chair of the Grievance/Fair Hearing Board will make the decision as to the objection.
2. At least 5 business days before the hearing date, both the Resident and the Institution shall submit witness lists and documents to be presented at the Grievance/Fair Hearing Board. These items shall be delivered to the Chair of the Grievance/Fair Hearing Board.
3. If the Resident fails to appear, the hearings will proceed and the Grievance/Fair Hearing Board will render a decision. A resident who fails to appear after proper written notice will be deemed to have waived his/her right to contest the Institution’s decision.
4. Neither the Resident nor the Institution shall be represented by counsel at the hearing. The Resident and the Institution may have an advisor present at the Grievance/Fair Hearing Board (which may include counsel) but the advisor may not participate in the proceedings except to advise the Resident or the Institution.
5. All persons shall be asked to affirm that their testimony is truthful. Furnishing false information to the University may result in formal charges.
6. Both the Resident and the Institution shall be offered the opportunity to present their witnesses and to question the other’s witnesses.
7. Prospective witnesses shall be excluded from the Grievance/Fair Hearing during the testimony of other witnesses. All parties and witnesses shall be excluded during deliberations of the Grievance/Fair Hearing Board except at that time at which they are providing testimony.
8. The burden of proof shall be on the Resident, who must establish that the Institution’s decision was in error by preponderance of the evidence. Formal rules of evidence shall not be applicable, nor shall harmless or technical procedural errors be grounds for appeal. All evidence reasonable people would accept in making decision about their own affairs is admissible. Irrelevant or immaterial evidence will be excluded, as determined by the Chair of the Grievance/Fair Hearing Board.
9. Final decision of the Grievance/Fair Hearing Board shall be by the majority vote of all members of the Board present and voting.
10. Written findings and recommendations of the Grievance/Fair Hearing Board will be forwarded to the Dean of the Tulane School of Medicine within 10 working days of the Grievance/Fair Hearing with a copy to the Resident and the Institution. At this time, either the Resident or Department Chair has the right to request a meeting with the Dean to review these issues.
11. The Dean will render his or her final decision within ten (10) working days of receipt of the Grievance/Fair Hearing written findings and recommendations or ten (10) working days after meeting with the parties, if these meetings were so requested.
12. All hearings of the Grievance/Fair Hearing Board will be taped for use in deliberation by the Grievance/Fair Hearing Board, although the Grievance/Fair Hearing Board deliberations will not be taped. Any tape recording may only be made by the Chair of the Fair Hearing Board and shall be private and used for Grievance/Fair Hearing deliberations only.
13. The final decision of the Dean of the School of Medicine shall be reported to the DIO, the Graduate Medical Education Committee and the applicable program director.

J. REPORTING SUSPENSIONS, TERMINATIONS, NON-RENEWALS, SURRENDERS, RESIGNATIONS OF RESIDENTS.

1. Pursuant to the Louisiana State Board of Medical Examiners rule (LAC 46XLV.422), all suspension, non-renewal, surrender, resignation or withdrawal of a resident’s participation in training for any reason other than impairment by drugs or alcohol must be reported to the Louisiana State Board of Medical Examiners within thirty days of the final decision.
2. Reporting to the board of impairment by drugs or alcohol is addressed via the Physicians Health Foundation. Resident participation the Physicians Health Foundation is outlined in Chapter XV: Residents’ Assistance Program.
3. Reporting to the board is the responsibility of the DIO. All program directors are responsible for reporting any of the actions noted above to the DIO, who will then report the action to the LSBME.
4. Reporting to the LSBME will only occur after the grievance procedure, where applicable, is complete.

Approved by the GMEC; May 26th, 2015.
XVI. RESIDENTS' ASSISTANCE PROGRAM:

A. Resident Wellness Position Statement

B. Resident Wellness Initiatives

The program and the institution have instituted several initiatives to augment wellness and reduce the risk of burnout. The institution has put forth more support for the Tulane Resident and Fellow Congress (the TRFC is comprised of peer-elected residents from all programs). The TRFC has in turn executed a more robust calendar of social events, each of which are designed to enhance peer and social support networks, and encourage residents to interact in and out of work with residents from other programs as well as additional hospital staff. The institution has raised resident salaries to be above the AAMC Southern mean, and expanded healthcare and other benefits (particularly enhancing affordable healthcare for residents with spouses and dependents). The University is now self-insured for resident healthcare, and as part of that initiative, the University pays for a general internist and nurse practitioner to be available on site, Monday to Friday for a resident-only drop in clinic. While residents can still choose their own provider, the drop-in service is free for the residents, and provides immediate access without using days off to take care of smaller medical issues. As in the past, the University continues to pay for a psychiatrist to provide the same type of service to the residents (no cost to the resident, and no associated paperwork). This service also includes couples counseling. The maternity leave policy has been replaced with a “parental leave” policy to be more inclusive of same-sex couples, and inclusive of adopted children. The new policy provides for more paid time off, and it is more flexible (allowing residents to take leave anywhere in the nine months following the birth/adoption of the child, thereby allowing two married residents to stagger their time off for optimal child care). The program is piloting an initiative focusing on assessing (and subsequently, adjusting) work intensity independent of census (medical intensity, social intensity). Further, the program has instituted systematic/curricular initiatives to improve resilience. Finally, the program and institution are initiating faculty development sessions to empower faculty with mentorship techniques to augment resilience and manage work intensity. Individual firm members now meet with their Associate Program Director and Chief Resident four times a year.

The Internal Medicine Practice Clinic is offering a primary care clinic for AGCME residents and fellows and spouses covered under the School of Medicine health plan for their acute and primarycare needs. Convenient, same-day appointments in-between rounds or on a lunch break.

C. Impaired Physicians Assistance

1. It is the policy of Tulane University School of Medicine to ensure that the highest quality physicians are practicing medicine in the hospitals and clinic. The Residents' Assistance Program is intended to provide residents with access to confidential counseling and behavioral health services, and/or for the identification and treatment of resident physicians with psychiatric or substance abuse impairment.

2. Definition. An impaired resident physician means a physician involved in training or research, licensed to practice medicine in the State of Louisiana who is unable to practice medicine with reasonable skill and safety to patients because of a mental disorder, physical illness, and/or excessive use or abuse of drugs, including alcohol.
3. Self-Referral. Tulane encourages residents who feel that they may have a psychiatric or substance abuse problem to seek confidential assistance with the Residents’ Assistance Program. A resident who feels that he or she may have a problem, may contact the Residents’ Assistance Program Director, Dr. Andrew Moroson, by calling (504-322-3837) or email him at dr.morson@ibhnola.com.
   a. Upon self-referral, The Residents’ Assistance Director will evaluate the resident and make one of the following recommendations.
      i. The resident needs no further therapy or evaluation.
      ii. The resident remains in a therapeutic relationship with the Residents’ Assistance Program Director or one of his or her staff.
      iii. The resident is referred to another physician or therapist.
      iv. The resident is referred to the Physicians’ Health Foundation for further evaluation and treatment.

b. Tulane University is committed to fostering an environment in which residents feel safe in identifying and correcting conditions that may impair their personal and professional performance, without fear of reprisal or implications to their career. Residents who self refer are not reported to Administrative Personnel unless:
   i. The resident poses imminent threat to self or others.
   ii. The resident is determined by the Residency Assistance Director to not be fit for duty, and is subsequently referred to the Physicians’ Health Foundation for further evaluation and treatment for fitness for duty.
   iii. Should this occur, the DIO will be notified, and the resident will cease to be in the Self-Referral Pathway. The resident will be transferred to the Administrative Pathway for remediation, as outlined in The Administrative Referral Pathway (See Chapter XV. Policy on Remediation, Suspension, Termination and Grievance).
      a. In such a case, the DIO will be informed of the referral, but will not be informed of the details of the resident’s care, unless so authorized by the resident.
      b. It will be the responsibility of the Residents’ Assistance Program Director to inform the DIO when and if the resident is deemed fit to return to duty, and any requirements of this re-entry (i.e., monitoring, etc.).
      c. Tulane administrative personnel other than the DIO should have no communication with the Residents’ Assistance Director, nor the Physicians Health Foundation, unless so authorized by the resident.

4. Administrative Referral. Whenever there is a reasonable belief that a resident physician is practicing while under impairment, the DIO should be notified immediately.
   a. Upon such notification, the DIO will conduct a preliminary investigation and if he/she finds a reasonable belief that such impairment exists, he/she will report such information to the director of the Residents’ Assistance Program.
   b. The resident will be temporarily suspended, with pay and benefits, from his/her training program until evaluation of the case is complete.
   c. After the resident has been referred, either self, or administratively, Administrative Personnel other than the DIO should have no communication with the Residents’ Assistance Director, unless so authorized by the resident. All communications regarding residents who have been referred to the Residents’ Assistance Program Director should be directed to DIO.
   d. A physician suspended due to psychological, chemical and/or alcohol impairment will be required to successfully complete a rehabilitation program approved by the Physicians’ Health Foundation.
   e. Upon completion of a rehabilitation program, the resident may be required by the DIO, the treating physician or The Physicians’ Health Foundation to enter an aftercare program. Aftercare treatment programs will be approved by the DIO, the treating physician and the Physicians’ Health Foundation. If the resident physician is in aftercare when reestablishment of training and
credentials is granted, the program director is required to make time available in the resident physician’s schedule to allow total participation in the aftercare program. The DIO will document compliance in the rehabilitation program with the treating physician of the impaired resident physician while the resident physician is in a rehabilitation program.

f. If the resident physician fails to comply with the rehabilitation program or the aftercare program, he/she is automatically terminated from residency training and a notice to that effect will be placed in his/her file and the appropriate state and national bodies will be notified. This decision for termination is not grievable.

g. If, after successful completion of the aftercare program, the resident subsequently redevelops a psychiatric, chemical or alcohol impairment, termination from residency will be recommended unless there are extenuating circumstances. The final decision shall rest with the DIO.

h. The Physicians’ Health Foundation of the state to which the resident is moving will be notified by the DIO if a resident physician is involved in inpatient or aftercare treatment at the time the resident is completing residency training.

Approved by the GMEC; November 11th, 2015
XVII. POLICY ON SUBSTANCE ABUSE

A. The abuse of alcohol and other drugs can seriously damage physical and mental health, and may jeopardize safety and the safety of others. Whenever use or abuse of any mood altering or other controlled substance (such as alcohol or other drugs) interferes with a safe workplace, appropriate action will be taken.

B. According to the provisions of the Drug-Free Workplace Act of 1988, and the Drug-Free Schools and Communities Act amendments of 1989, the unlawful manufacture, distribution, sale, possession or use of controlled substances in the workplace is prohibited. Residents may not report to work under the influence of alcohol or other drugs. Residents who violate this policy will be sanctioned in accordance with Tulane policy and federal and state law.

D. Residents convicted of illegal drug activity in the workplace must notify Tulane within five (5) business days of conviction. Failure to do so may be grounds for immediate termination.

E. Residents are encouraged to take advantage of the diagnosis, counseling and treatment services that are available through the Office of Graduate Medical Education’s Residents’ Assistance Program. (See Chapter XVI, Residents’ Assistance Program).

Approved by the GMEC; September 28th, 2011
XVIII. POLICY ON ARREST
A. The Tulane University Health Sciences Center Police Department will make reasonable efforts to help in
arranging for release of that individual but there may be occasions for reasons beyond the control of Tulane
University Health Sciences Center Police Department that efforts to secure the release cannot be arranged.
B. Normally the release will be accomplished by contacting persons who have parole powers designated by state
law. There are times when the seriousness of the crime may be such when this cannot be accomplished. The plan
is as follows:
1. The person arrested or an acquaintance must notify the Tulane University Health Sciences Center
Police Department at 988-5531. The information needed will be the name of the individual arrested, the
program he/she is in such as surgery, or medicine, also a listing of the charges and the jail or parish prison
at which the individual is being detained.
2. The Crime Prevention Coordinator or his/her designee shall either be called or paged by the Tulane
University Health Sciences Center Police Department. The Crime Prevention Coordinator will have a
listing of persons with parole powers. A call will be placed by the Crime Prevention Coordinator to that
individual, and that person will be provided with the necessary information to help in obtaining the
release.
3. In the event that the seriousness of the crime is beyond the scope of parole powers, a call will be place
to the University’s Attorney-at-Law, or a designee. This office will then provide legal counsel to that
person as to his/her rights or to an appropriate bail agency unless that individual chooses to obtain other
counsel which is his/her option.
4. The Crime Prevention Coordinator will then notify the respective section head, such as the Associate
Dean for Graduate Medical Education, the chair of the department, or the program director. A report of
what has occurred will be provided with as much information as possible.
5. Should the individual arrested be in need of transportation from the jail or parish prison, the Crime
Prevention Coordinator will arrange for transportation to either the health sciences center or his/her
residence.
6. Once the individual is returned to his/her residence, a confidential report will be compiled and
forwarded to the appropriate section head.
7. The arrested individual will also be provided with the office number of a University attorney, should
that individual wish to find out answers to any legal questions. The arrested individual is not obligated to
accept the assistance of the Tulane University Health Sciences Center Police Department, Tulane
University School of Medicine or any representatives of the University. The individual is also free to
contact any lawyer of his/her choice or make other arrangements for release.
8. In the event that a signature bond is imposed (a signature bond guarantees the appearance of the
individual), it will not be the responsibility of the Tulane University Health Sciences Center Police or its
representative to sign the bond. A friend, faculty member, program coordinator or other responsible
person can sign the bond which will secure the release of the individual. The person signing the bond
personally guarantees that the arrested person will make all court appearances.

Approved by the GMEC; September 28th, 2011
XIX. POLICY ON SEXUAL HARASSMENT

A. HARASSMENT POLICY

1) Statement of Philosophy
a) Tulane University is committed to creating and maintaining a campus environment where all individuals are treated with respect and dignity and where all are free to participate in a lively exchange of ideas. Each student has the right to learn and each employee has the right to work in an environment free from all forms of unlawful harassment or discrimination, including sexual harassment and sexual misconduct. At Tulane University, harassment or discrimination, whether verbal, physical, written, or visual, is unacceptable and will not be tolerated. Discrimination is unlawful and hurts all members of the educational community and contributes to a negative atmosphere where victims and others may feel their safety and equality are compromised. Discrimination has no legitimate educational purpose. Anyone who engages in conduct prohibited by this policy shall be disciplined as provided by law, university policies, and applicable employment agreements.
b) Tulane will not tolerate unlawful discrimination or harassment by anyone affiliated with Tulane (including non-employees, such as vendors and independent consultants), and will not tolerate adverse academic or employment actions, including but not limited to, termination of anyone reporting discrimination or providing information related to such a complaint.

2) Principles
a) Tulane University recognizes the tension between protecting all members of the University community from harassment and protecting academic freedom and freedom of expression. It is the policy of the institution that no member of the community may harass another. Conduct that reasonably serves a legitimate educational purpose, including pedagogical techniques, does not constitute harassment. In the educational setting within the University, wide latitude for professional judgment in determining the appropriate content and presentation of academic material is required. Those participating in the educational setting bear a responsibility to balance their right of free expression with a consideration of the reasonable sensitivities of other participants. Therefore, this policy against harassment shall be applied in a manner that protects academic freedom and freedom of expression including but are not limited to the expression of ideas, however controversial, in the classroom setting, academic environment, university-recognized activities, or on the campus.
b) Nothing contained in this policy shall be construed to limit the legitimate exercise of free speech, including but not limited to written, graphic, or verbal expression that can reasonably be demonstrated to serve legitimate educational or artistic purposes nor shall this policy be construed to infringe upon the academic or artistic freedom of any member of the University. Artistic expression in the classroom, studio, gallery and theater merits the same protection of academic freedom that is accorded to other scholarly and teaching activities.

3) Policy Coverage
a) All faculty, administrators, staff, students, and individuals affiliated with Tulane University by contract (including non-employees, such as vendors and independent contractors) are bound by this policy. This policy protects all individuals equally from harassment, including same-sex harassment, and protects students from harassment by other students.

4) Sexual Harassment
a) Definition of Sexual Harassment - Sexual harassment is unwelcome behavior of a sexual nature by faculty, administrators, staff, students, and individuals affiliated with Tulane University by contract (including non-employees, such as vendors and independent contractors) or by anyone with whom one interacts in order to pursue educational or employment activities at the University. For the purposes of this policy, sexual harassment is defined as unwelcome advances, requests for special favors, and any other verbal, written, physical or other conduct of a sexual nature when:
   i) Submission to such conduct is implicitly or explicitly made a condition of an individual's participation in University programs, activities, employment, or educational status;
Submission to or rejection of such conduct is used as a factor in employment or academic decisions; or

Such conduct would be objectively regarded by a reasonable person as having the purpose or effect of interfering with an individual's ability to learn or work or participate in University programs or activities by creating an intimidating, hostile, or offensive environment even if the person engaging in the conduct does not intend to interfere, intimidate, or be hostile or offensive.

b) Examples of Sexual Harassment - Sexual harassment may include, but is not limited to, the following:
   (i) Physical assaults of a sexual nature, such as rape, sexual battery, molestation, or attempts to commit these assaults; and intentional physical conduct that is sexual in nature such as touching, pinching, patting, grabbing, poking, or brushing against another individual's body.
   (ii) Any nonconsensual sexual behavior; lack of consent may result from, among other things, use of force, threats, or intimidation or advantage gained by use of the victim's mental or physical incapacity, impairment, or helplessness of which the accused was aware or should have been aware. Offering or implying an employment-related reward (such as a promotion, raise, or different work assignment) or an education-related reward (such as a better grade, a letter of recommendation, favorable treatment in the classroom, assistance in obtaining employment, grants or fellowships, or admission to any educational program or activity) in exchange for sexual favors or submission to sexual conduct.
   (iii) Threatening or taking a negative employment action (such as termination, demotion, denial of an employee benefit or privilege, or change in working conditions) or negative educational action (such as giving an unfair grade, withholding a letter of recommendation, or withholding assistance with any educational activity) or intentionally making the individual's job or academic work more difficult because sexual advances were rejected.
   (iv) Unwelcome sexual advances, requests for a romantic or sexual relationship to an individual who indicates or has indicated in any way that such conduct is unwelcome, propositions or other sexual comments, such as sexually-oriented gestures, noises, remarks, jokes, questions, or comments about a person's sexuality or sexual experience.

5) Other Forms of Harassment or Prohibited Discrimination
   a) Prohibited discrimination or harassment, other than sexual harassment, is verbal, physical, written, or other conduct that denigrates or shows hostility or aversion to an individual on the basis of race, color, sex, religion, national origin, age, disability, genetic information, sexual orientation, gender identity, gender expression, pregnancy, marital status, military status, veteran status, or any other status or classification protected by federal, state or local law. Discrimination or harassment based on any of the above categories is strictly prohibited by this policy. Discrimination includes failing to provide reasonable accommodations, consistent with state and federal law, to a qualified person with a disability.
   b) Complaints of harassment will be investigated and resolved in accordance with applicable legal guidelines and the terms of this policy.

6) Retaliation
   a) No member of the University community will be disciplined or otherwise retaliated against for refusing sexual advances, objecting to sexual, racial, or other forms of discrimination, harassment, or retaliation or making a good faith report of discrimination, harassment, or retaliation, or for making requests for accommodations on the basis of religion or disability.
   b) Retaliatory or intimidating conduct against any individual who has made a good faith discrimination, harassment, or retaliation complaint or who has testified or assisted in any manner in an investigation is specifically prohibited and shall provide grounds for a separate complaint. Examples of such retaliatory or intimidating conduct include disciplining, changing working or educational conditions, providing inaccurate information to or about, or refusing to cooperate or discuss work- or school-related matters with any individual without a legitimate business reason because that individual complained about or resisted harassment. The initiation of a good faith complaint of discrimination, harassment, or retaliation by a student will not reflect negatively on that student nor will it affect the student’s academic standing, rights, or privileges. Likewise, the initiation of a good
faith complaint by an employee will not reflect negatively on that employee nor will it affect the employee's working conditions, rights, or privileges.

7) Confidentiality
   a) Confidentiality will be maintained throughout the entire investigatory process to the extent practicable and appropriate under the circumstances to protect the privacy of persons involved. The persons charged with investigating the complaint will discuss the complaint or the underlying behavior only with persons involved in the case who have a need to know the information, which must include the complainant and the accused harasser.
   b) Students who need to seek resources in a confidential setting without triggering a report for investigation should go to Counseling and Psychological Services or the Student Health Center. Concerns reported to Counseling and Psychological Services or the Student Health Center are not shared with the Office of Institutional Equity for investigation.
   c) The University is required by law to investigate complaints of discrimination, harassment, or retaliation and will strive to protect, to the greatest extent possible, the confidentiality of persons reporting or accused of discrimination, harassment, or retaliation. However, the University cannot guarantee complete confidentiality where it would conflict with the University's obligation to investigate or where confidentiality concerns are outweighed by the University's interest in protecting the safety or rights of others. Individuals who desire to discuss possible claims of discrimination, harassment, or retaliation in a more confidential setting may want to consult with a counselor, therapist, or member of the clergy, who is permitted by law to assure greater confidentiality.
   d) While Tulane is committed to respecting the confidentiality and privacy of all parties involved in the investigation process, Tulane cannot guarantee complete confidentiality. Examples of situations when confidentiality cannot be maintained include:
      • If Tulane is required by law to disclose information (such as in response to legal actions),
      • If disclosure of information is determined by the Office of Institutional Equity, its designee, and/or Tulane’s Office of General Counsel to be necessary for conducting an effective investigation, or
      • When confidentiality concerns are outweighed by Tulane’s interest in protecting the safety or rights of others.

8) Complaint Procedures
   a) All are encouraged to promptly report discrimination, harassment, or retaliation so that appropriate action can be taken. The complaint procedures are designed to ensure the rights of the complainant while at the same time according due process to involved parties.
   b) Form of Complaint - Complaints of discrimination, harassment, or retaliation will be accepted orally or in writing. Anonymous complaints will be accepted and investigated to the extent possible. Complaint forms are available at the Office of Institutional Equity or may be filed online at: www.Tulane.edu/concerns.
   c) Content of Complaint - Any individual who believes that they are being discriminated, harassed, or retaliated against in violation of this policy should promptly file a complaint including the following information, if known to the complainant: the name of the complainant, a brief description of the offending behavior including times, places, and the name of or identifying information about the alleged perpetrator, and the names or descriptions of any witnesses to the discrimination, harassment, or retaliation.
   d) Reporting the Complaint - It is not necessary to first confront the harasser prior to instituting a complaint under this policy. However, it is appropriate to promptly report a complaint so that a full and complete investigation is possible. Any person designated to receive complaints from students, employees, or faculty must notify the Office of Institutional Equity within 24 hours of receiving a complaint pursuant to this policy.
   (i) Complaints by Students - A student who believes that they have been discriminated, harassed, or retaliated against in violation of this policy must report the alleged behavior to any of the following individuals:
      • Office of Institutional Equity, 862-8083
      • Vice President for Student Affairs, 314-2188
      • Associate Dean for Student Affairs, Tulane University Health Sciences Center, 988-5331
(ii) Complaints by Staff - An employee who believes they have been discriminated, harassed, or retaliated against in violation of this policy must report the alleged behavior to any of the following individuals:
• Office of Institutional Equity, 862-8083
• Dean (or person designated by same) with which complaining employee is affiliated
• Associate Vice President for Workforce Management Organization, 247-1758

(iii) Complaints by Faculty - A faculty member who believes they have been discriminated, harassed, or retaliated against in violation of this policy must report the alleged behavior to any of the following individuals:
• Office of Institutional Equity, 862-8083
• Department Chairperson
• Dean (or person designated by same) of the school with which the complaining faculty is affiliated
• Senior Vice President for Academic Affairs, 865-5261

c) Failure to Cooperate - Failure to cooperate in an OIE investigation will be considered a breach of responsibility. If a Respondent fails to cooperate, his or her Department Head, Supervisor, or Dean will be notified of such non-cooperation. A Respondent’s silence or lack of cooperation will not prevent a complaint from going forward. Failure to cooperate in a formal review proceeding may result in the investigation proceeding solely on the basis of the available evidence.

9) Investigation & Informal Resolution of Complaints
a) Initial Investigation - After receiving a complaint of discrimination, harassment, or retaliation the Office of Institutional Equity shall promptly conduct an initial investigation.
b) Informal Process - The University has an informal process to provide those who believe they are subject to discrimination, harassment, or retaliation with a range of options designed to bring about a resolution of their concerns. Depending upon the nature and severity of the complaint and the wishes of the person(s) claiming discrimination, harassment, or retaliation, informal resolution may involve one or more of the following or other appropriate actions:
(i) Advising the person(s) about how to communicate the unwelcome nature of the behavior to the alleged harasser;
(ii) Distributing a copy of this policy as a reminder to the department or area with which the alleged harasser is affiliated;
(iii) If both parties agree, arranging and facilitating a meeting between the person(s) claiming discrimination, harassment, or retaliation and those accused to work out a mutual resolution.

Students are also encouraged to seek advice or counseling from Student Resources and Support Services, 314-2160, whether or not they decide to pursue a formal complaint. Informal resolution may not be appropriate in certain circumstances. For instance, informal resolution would never be appropriate in cases involving allegations of sexual assault. While dealing informally with a problem of discrimination, harassment, or retaliation may be preferable to the complainant, a formal grievance procedure must be followed in order for the University to impose any kind of discipline on the offender. The University will proceed with the investigation and formal resolution process when deemed appropriate by the Office of Institutional Equity.

10) Investigation & Formal Resolution of Complaints
a) Formal Investigation - If the complaint cannot be informally resolved after the initial investigation, the Office of Institutional Equity shall continue the investigation or designate someone to promptly conduct further investigation of the complaint, which may in some circumstances be a neutral third party. The persons charged with investigating the complaint must discuss the complaint or the underlying behavior only with persons involved in the case who have a need to know the information, including the complainant and the accused harasser.

In the case of a complaint against a faculty member, the Office of Institutional Equity will work with the grievance committee of his or her school within the University to investigate discrimination, harassment, or
retaliation complaints. The committee chair shall notify the Office of Institutional Equity in writing of the findings as well as any action taken or recommendations made by the committee based on those findings. In the case of a complaint against a student, the Office of Institutional Equity will investigate, or will designate the Office of Student Conduct to investigate, and shall notify the Office of Student Affairs in writing of the findings of the investigation. The Office of Student Affairs will, in turn, determine whether to process the matter through the Tulane Code of Student Conduct.

In the case of a complaint against a staff member or non-employee individual affiliated with Tulane (including vendors and independent contractors), the Office of Institutional Equity shall investigate and make recommendations to the appropriate supervisor as to any action to be taken.

b) Resolution - Resolution will be concluded as promptly as possible and in most cases within 60 days unless extenuating circumstances arise. Within 60 days of receiving the complaint, the Office of Institutional Equity or its designee, including the appropriate school grievance committee, shall make a finding of whether it was determined that discrimination, harassment, or retaliation occurred. If the investigation cannot be concluded within that time, the Office of Institutional Equity shall notify the complainant, and the University’s General Counsel, who shall designate the appropriate person or faculty committee to conclude the investigation as promptly as reasonably possible.

c) Objectivity - The complainant and the accused are entitled to an investigation conducted by an impartial investigator. Thus, if the person(s) charged with overseeing or investigating complaints is implicated in the complaint, or has any personal issue that would cause a conflict of interest, the person(s) with the conflict shall recuse themselves from the proceeding. Alternatively, the Institutional Equity Officer shall conduct the investigation and make findings or shall designate someone impartial to do so, which may in some circumstances be an outside neutral third-party.

d) Standard of Review - Claims of violations of this policy will be reviewed based upon the preponderance of evidence whether more likely than not a policy violation occurred.

e) Notice of Outcome -

(i) Complaints against Faculty, Staff and Non-Employee Individuals Affiliated with the University. No more than ten (10) working days or as promptly as possible after a decision has been reached, the Institutional Equity Officer shall notify the parties to the proceeding in writing of the findings and the outcome of the investigation.

(ii) Complaints against Students. The Office of Student Affairs shall notify the parties to the proceeding in writing of the findings and the outcome of the investigation in a manner consistent with the Code of Student Conduct.

f) Sanctions - Individuals found to have violated this policy shall be disciplined appropriately. Appropriate sanctions, ranging from a warning to dismissal, will be determined based on the severity of the conduct and in accordance with the provisions of applicable statutes, employment contracts, University policies, disciplinary procedures for faculty as described in the Faculty Handbook, disciplinary procedures for staff as described in the Staff Handbook, and disciplinary procedures for students as described in the Code of Student Conduct and other student discipline codes.

11) Appeals
An appeal by either the complainant or the accused must be filed in writing with the Office of Institutional Equity within ten (10) working days of receiving written notice of the outcome of the investigation. Responsibility for reviewing appeals will turn on the identity of the accused. Where the accused is a student, the appeal shall be reviewed in accordance with appeals procedures described in the Code of Student Conduct. Where the accused is a staff member, the Chief of Staff and Vice President will review appeals. Where the accused is a faculty member, the Faculty Tenure Freedom and Responsibility Committee of the University Senate will review appeals in accordance with the grievance procedures described in the University Senate Constitution, By-Law III: Standing Committees, Section 1: Committee Functions, Committee on Faculty Tenure, Freedom and Responsibility: Functions.

In exceptional circumstances, except in cases involving faculty, an appeal may be reviewed by an outside neutral third party.

12) Other Legal Resources
The procedures above apply to internal complaints of discrimination, harassment, or retaliation. In addition to this internal complaint procedure, victims of discrimination, harassment, or retaliation may file a complaint with an appropriate government agency or, where allowed, file a civil lawsuit. Federal and state laws contain statutes of limitation barring claims filed outside of the applicable limitations period.

a) Office for Civil Rights - The Office for Civil Rights (OCR) is charged with investigating complaints of harassment under Title IX, a federal law that governs harassment of students by teachers or other students. Prior to filing a lawsuit, a charge should be filed with the OCR within the time period designated by law. A student wishing to file an administrative complaint should contact:

U.S. Department of Education
U.S. Department of Justice
Office for Civil Rights Dallas Office
Civil Rights Division 1999 Bryan Street, Suite 2600
P.O. Box 66560
Dallas, TX 75201
Washington, D.C. 20035
(214) 880-2459 (202) 307-2222

b) Equal Employment Opportunity Commission - The Equal Employment Opportunity Commission (EEOC) is charged with investigating complaints of harassment under Title VII, a federal law that governs harassment of faculty members and staff. Prior to filing a lawsuit, Title VII requires that a charge be filed with the EEOC within the time period designated by law. An employee wishing to file an administrative complaint should contact:

Equal Employment Opportunity Commission
Regional Office
1555 Poydras, Suite 1900 New Orleans, LA 70112 (504) 589-2826

13) Dissemination of Policy
This policy will be available to faculty, staff, students, administrators, and will be available to third-parties connected with the University. All University employees and students who subsequently become part of the educational community shall be informed of this policy during their orientation. This policy may be revised from time to time and such revisions will be posted on the University's web site located at www.tulane.edu. Any incident reported under this policy will be governed by the policy posted on the University's web site at the time the incident is reported.

14) Revisions to Policy
Proposed revisions to this policy will be presented to the University Senate for approval or disapproval.

15) False Accusations
While we encourage all to report good faith claims of discrimination, harassment, or retaliation, false accusations can have a serious effect on innocent people. If an investigation results in a finding that an accusation of discrimination, harassment, or retaliation was maliciously or recklessly made, the accuser may be disciplined appropriately.

Appropriate sanctions, ranging from a warning to dismissal, will be determined based on the severity of the conduct and in accordance with the provisions of applicable statutes, employment contracts, University policies, disciplinary procedures for faculty as described in the Faculty Handbook, disciplinary procedures for staff as described in the Staff Handbook, and disciplinary procedures for students as described in the Code of Student Conduct and other applicable student discipline codes.

D. TITLE IX
It is the policy of Tulane University to comply with Title IX of the Education Amendments of 1972, which prohibits discrimination (including sexual harassment and sexual misconduct) based on sex in the University's educational programs and activities. Title IX also prohibits retaliation for asserting claims or sex discrimination. Tulane has a designated Title IX Coordinator. The Title IX Coordinator oversees the University’s centralized review, investigation, and resolution of reports of sex discrimination, including sexual harassment and violence.
Meredith M. Smith, Title IX Coordinator
Tulane University Title IX Office
Lavin-Bernick Center, Suite G03 New Orleans, LA 70118  msmith76@tulane.edu
(504) 865-5615

Faculty, Staff or Students may contact the following for information:
Deborah Love, Deputy Title IX Coordinator Tulane University
Office of Institutional Equity 200 Broadway, Suite 105 A New Orleans, LA 70118  dlove1@tulane.edu
(504) 862-8083

Wendy Stark, Deputy Title IX Coordinator Tulane University
Office of Institutional Equity 200 Broadway, Suite 105 A New Orleans, LA 70118  wstark@tulane.edu
(504) 862-8083

Erica Woodley, Deputy Title IX Coordinator for Student Affairs Tulane University
Division of Student Affairs 6823 St. Charles Avenue
Lavin-Bernick Center for University Life, Room G03 New Orleans, LA 70118
ewoodley@tulane.edu (504) 314-2188

Approved by the GMEC; November 29th, 2017
XX. POLICY ON SOCIAL MEDIA & OUT-OF-WORK CONDUCT

A. General Principles:
This policy is based upon the following fundamental principles:
1. Patient confidentiality is of primary importance, as outlined in The Health Information Portability and Accountability Act [HIPAA].
2. Tulane University, as a University, values the importance of free speech and open discourse. As such, the University, being respectful of free speech and expression of ideas, does not prohibit residents from engaging in social media and/or voicing opinion outside of the workplace.
3. Maintaining respect for colleagues and co-workers is requisite for establishing a professional environment in the workplace, thereby ensuring optimal team-based patient care.
4. Enrollment in a Tulane University residency or fellowship program bestows upon the resident the reputation and prestige of Tulane University. In exchange, it is the responsibility of each resident to uphold and protect the reputation of Tulane University.

B. Policy on Social, Electronic and Print Media:
1. Patients
   a. Any and all depictions or descriptions of patients must comply with The Health Information Portability and Accountability Act [HIPAA]. Personal health information is defined by HIPAA as any information about an individual in oral or recorded form, where the information identifies an individual or for which there is a reasonable basis to believe it can be used to identify the individual.
   b. At no time shall patient information be shared without the signed consent of the patient. The University does not govern the content, format or process for obtaining this consent; Tulane residents must strictly adhere to the policies and procedures of the respective hospital, clinic or healthcare system in which the patient received care.
   c. These guidelines apply even if the individual patient is the only person who may be able to identify him or herself on the basis of the posted description. Anonymous descriptions must not contain information that will enable any person, including people who have access to other sources of information about a patient, to identify the individuals described. This encompasses all emails and text messages sent from personal phones.
   d. At no time shall patients, or patient stories, be depicted in a disparaging, demeaning, or insulting manner. Even if patients are not identified (by name, record number, image), or even if consent has been obtained from the patient, any description of patient care should be professional and respectful of the patient.

2. Description of the Patient Care/Work Environment
   a. All descriptions of the workplace environment shall respect the privacy rights of colleagues and co-workers. Individuals shall not be identified by name, or be described in such a fashion that their identity is easily apparent, without explicit consent of that individual.
   b. The tone and content of all conversations, social media and otherwise, shall remain professional and respectful of all healthcare and University colleagues. Posting demeaning or insulting comments or images about colleagues and co-workers to third parties is unprofessional behavior, and a violation of the Tulane University GME Policy on Harassment (Chapter XIX).
   c. While the University does not prohibit describing disagreements on issues and with people in the workplace, residents are strongly cautioned to not express these disagreements in social, electronic and print media for the following reasons:
      i. The description of the disagreement is likely to be one-sided, without the “other side” having the opportunity to present their side of the agreement.
      ii. Readership of the described disagreement is likely to take the description out of context.
      iii. The description on social, electronic or print media is unlikely to result in a meaningful solution/resolution of the disagreement.
3. Description of Self and/or Self Opinions
   a. The resident retains the right to express their individuality via pictures, opinions and posts on social, electronic and print media.
      i. All posted opinions and images, however, are to be professional; unprofessional statements evoking, but not limited to, racism, sexism, and discriminatory statements will not be allowed, and are grounds for review by the program’s clinical competency committee with respect to the professionalism core competency.
      ii. Residents are advised to be cognizant of the image being portrayed, particularly with respect to posted images and photographs, and how that image would be viewed as being consistent with the professional physician. Employers, patients, and administrators can search and view all information posted in any forum. Enacting privacy settings does not necessarily mean that information will not end up in a public format.

   b. In engaging in social, electronic or print media communications, residents are reminded of the following:
      i. The resident has full responsibility for the content of individual online postings (for example: blogs, social networking sites and other digital media).
      ii. The permanency of published material on the Web. Most electronic media becomes cached. This means that even if the information is subsequently “taken down,” it likely still endures as accessible to the rest of the world on the Internet.
      iii. The importance of your individual safety when posting personal materials, such as phone/pager numbers or daily schedules online.

C. Association With, and Naming of Tulane University:
   1. In expressing opinions via external communications, residents should exercise caution in identifying themselves as Tulane University employees; comments made by an individual are easily ascribed to the opinion/position of the University as a whole. If the resident does disclose their association with Tulane University, the communication should explicitly note that the opinion/position expressed within the communication is solely the position of the resident, and not of Tulane University or the respective healthcare institution (i.e., hospital, clinic or healthcare system) in which they work.
   2. If there is any question as to how an external communication will be received, residents are encouraged to consult with the Tulane University and/or respective hospital’s Office of Public Relations. The Graduate Medical Education Office, and the resident’s Program Director can also provide advice in reference to external communications.

D. Offering Medical Advice:
   1. Residents are not restricted from voicing opinions on medical topics via electronic or print media. Residents are advised, however, to exercise caution in such statements and to utilize the following guidelines in making these statements:
      a. Residents should not misrepresent their qualifications.
      b. The discussion or opinion should be evidenced-based where possible.
      c. The discussion or opinion should be generic to the topic, and not designed to diagnose or treat an individual patient via electronic means.
      d. Advice should not be offered; where the discussion or opinion could be interpreted as offering advice, the communication should include a disclaimer that the reader should consult with a physician prior to making any decision.
   2. Residents are reminded that the terms of their employment with Tulane University limits the provision of medical advice within the context of the teaching environment, where appropriate supervision exists; malpractice insurance may not extend to medical advice outside of the teaching environment.
E. Outside-of-Work Conduct:
1. It is expected that residents behave professionally in and out of work, as behavior in both settings exemplifies the development of the professionalism competency, and reflects upon Tulane University reputation.
2. Tulane University respects the privacy of all of its residents. Tulane does not prospectively monitor residents’ outside-of-work activities.
3. All professionals have a collective professional duty to assure appropriate behavior, particularly as it pertains to professional behavior.
4. Unprofessional behavior outside of work may be investigated if it is brought to the attention of the program director and/or DIO, and may be integrated into the clinical competency committee’s assessment of the resident’s professionalism core competency.

F. The University’s Role in Monitoring and Enforcement:
1. Tulane University will not monitor residents’ social, electronic or print communications without cause to do so. Tulane University assumes no liability or responsibility for resident’s social, electronic or print communications of which it is not aware.
2. All professionals have a collective professional duty to assure appropriate behavior, particularly in matters of privacy and confidentiality. It is the responsibility of each University employee to self-monitor this policy and report violations to the respective program director and/or DIO.
3. Tulane University reserves the right to inspect a resident’s social and/or electronic media for cause, as defined by a report of a violation of this policy.
4. Tulane University reserves the right to monitor a resident’s social and/or electronic media for cause, as defined by a previous violation of this policy.
5. Penalties
   a. If a social, electronic, or print media posts/communication is deemed to be inappropriate by the program director or the clinical competency committee, the resident will be asked to redact or take down the communication. The resident has a right to appeal this decision to the DIO, who shall have the final decision regarding redacting or taking down the communication.
   b. The clinical competency committee is entitled to integrate violations of this policy into their decisions regarding probation, suspension, non-renewal and termination (Chapter XXX), particularly with respect to the professionalism core competency.
   c. Residents in violation of this policy may also be subject to discipline from the respective hospital, clinic or healthcare network. Residents in violation of this policy may also be subject to prosecution or a lawsuit for damages for a contravention of the PHIPA.

G. Electronic communication with residents
1. Afferent communication:
   a. The GME Office recognizes importance of communicating to residents about events, opportunities and additional information necessary for clinical care.
   b. However, the GME Office also recognizes that excessive electronic communication to residents can lead to “alert” fatigue.
   c. Further, the GME Office also recognizes the potential for abuse in sending electronic communications to the residents that are inappropriate.
2. Efferent communication:
   a. The GME Office recognizes the value of obtaining information from residents via surveys.
   b. However, the GME Office also recognizes that excessive communication leads to “survey fatigue.” In such a scenario (i.e., excessive surveys), there is a risk that residents’ compliance with essential surveys (such as the ACGME annual survey) will diminish.
   c. Further, the GME Office also recognizes that the residents’ opinions are the intellectual property of the residents, and residents should not be compelled to express those opinions unless they are essential to the viability of the training programs and the clinical operations in which our residents participate.
3. The GME Office will operate a resident, program director and program coordinator list-serve. All three listserves will be centrally monitored in the GME Office.
a. The list-serve address will only be released to the respective recipients, and entities or individuals approved by the GME Office.
b. Only afferent communications that are within the above guidelines will be allowed to be distributed to the residents.
c. Communications regarding industry or pharmaceuticals will not be authorized, as per the guidelines in the Vendor Policy.
d. Entities or individuals who repeatedly violate the above guidelines regarding appropriate messaging will be excluded from further use of the list-serve.

4. All surveys distributed to the residents must first be approved by the GME Office. Residents will be instructed to disregard any survey that has not been previously approved by the GME Office.

5. Residents’ email addresses will not be shared with any individual outside of the University unless there is, in the judgment of the DIO, direct reason, consistent with the training and clinical care environment, to do so.

Approved by the GMEC; November 29th, 2017
SECTION 4:
INSTITUTIONAL POLICIES & ORGANIZATIONS AS IT RELATES TO GME
XXI. The Office of GME & the GMEC: Composition, Mission, and Responsibilities

A. Composition of the Office of Graduate Medical Education Office
The GME Office is located on the 15th floor at the Murphy Building, empowered with a budget that is derived directly from the Dean of the School of Medicine. The funding of the GME Office occurs on an annual basis, with a budgeting process that allows for periodic needs assessment throughout the year and allowances as needed for both salary and general operating supply increases. The Graduate Medical Education Office is composed of:

1. The Associate Dean of Graduate Medical Education (Designated Institutional Official, DIO).
   a. The DIO’s primary responsibility is to assure a safe, effective and educational work environment for Tulane residents at all participating sites.
   b. The DIO is also responsible for ensuring institutional compliance with all ACGME regulations, as well as assuring that each residency program is in compliance with the Common Requirements and their respective specialty and subspecialty requirements.
   c. All correspondence from the program directors to the ACGME, and all communication to the University’s governance body, must be approved by the DIO.
   d. All financial matters, compliance issues, and major educational decisions, including sites for training, that affect residents and fellows must be approved by the DIO.
   e. All remediation, probation, suspension and termination issues (See Chapter XIV) must be approved by the DIO.
   f. The DIO is responsible for chairing the Graduate Medical Education Committee as well as the Tulane Educational Compliance Committee, which oversees all aspects of education as it relates to compliance with their respective accrediting bodies (LCME, GME, CME).
   g. The DIO is a member of the Executive Medical Faculty and reports directly to the Dean of the School of Medicine.
   h. The DIO is responsible for preparing an annual report on the State of GME at Tulane University, to be delivered to the GMEC, the Executive Faculty (the Organized Medical Staff), and the Administrative Board of Tulane. A written copy of the report is to be delivered to each of the liaisons at the affiliated training locations. The report is to include updates on the current GME training environment as outlined in XX.E
   i. The DIO is responsible for ensuring each program completes their annual self-study (Chapter XXII. Policy on Program Evaluation, Improvement and Annual Program Reports)
   j. The DIO is responsible for conducting Internal Reviews of programs as is warranted. (Chapter XXII. Policy on Program Evaluation, Improvement and Annual Program Reports)
   k. At least 50% of the DIO’s professional efforts must be devoted to the role of being the DIO; compensation and sufficient protected time to effectively carry out his or her educational, administrative, and leadership responsibilities is to be commensurate with this effort.
   l. The DIO is responsible for engaging in professional development applicable to his or her responsibilities as an educational leader.

2. The Assistant Dean of Graduate Medical Education.
   a. The Assistant Dean is responsible for assisting the DIO in all of the above responsibilities.
   b. In the event of the DIO’s absence, the Assistant Dean of GME will fulfill all duties as they relate to the DIO’s position, including supervision of the training programs, reviewing and co-signing program information forms and correspondence with the ACGME and affiliated training sites.
   c. In the event that a matter of business involves the residency program of origin from the DIO, or there is otherwise a perceived conflict of interest in the DIO chairing the GMEC on a matter, the Assistant Dean shall serve as the Chair of the GMEC in overseeing deliberations of that matter of business.

3. Senior Department Administrator. The Senior Department Administrator is responsible for the business and general operations of the GME Office, including assisting the DIO, Assistant Dean, and the financial manager to ensure optimal operation of the GME office.
4. GME Project Manager. The Program Manager is responsible for ensuring accurate payroll for each resident at Tulane, as well as benefits.
5. Credential Manager. The Credential Manager is responsible for ensuring accurate attestation of credentials for inquiries regarding past graduates of the Tulane Medical School and the Tulane GME programs.
6. Executive Secretary. The Executive Secretary supports the administrative functions of the office.
7. The Office of the University’s Legal Counsel works directly with the GME Office, providing guidance for all issues that may involve legal considerations.
8. The GME Office also works closely with the University-supported Residents’ Assistance Program (See Chapter XVI, Residents’ Assistance Program).

B. Composition of the Graduate Medical Education Committee
1. Mission: The Graduate Medical Education Committee (GMEC) governs all activities related to the compliance and strategic mission of all residency programs at the Tulane University School of Medicine. The Tulane GMEC, working in conjunction with the DIO, is responsible for the oversight of all Tulane resident/ fellow assignments, and of the quality of the learning and working environment at all participating sites.
2. Composition: The GMEC is composed of:
   a. The Associate Dean of Graduate Medical Education who shall serve as the chair.
   b. The Assistant Dean of Graduate Medical Education who shall serve as the vice-chair.
   c. A representative from the following components of Tulane’s GME Programs
      i. The Internal Medicine Program Director, who shall also represent the preventive medicine program.
      ii. The Surgery Program Director, who shall also represent the plastic surgery program.
      iii. The Ob/GYN Program Director
      iv. The Pediatrics Program Director, who shall represent the pediatric subspecialties and the med-peds program.
      v. The Psychiatry Program Director, who shall represent the neurology residency program, the child psychiatry program, the forensic psychiatry program, and the combined psychiatry programs (triple board and med psych).
      vi. One representative from the Internal Medicine Subspecialty Fellowships, who shall represent the dermatology residency and the allergy-immunology, cardiology, endocrinology, gastroenterology, heme/onc, infectious disease, nephrology, and pulmonary/critical care fellowships.
      vii. One representative from the Surgical Subspecialty Residencies, who shall represent neurosurgery, orthopedics, otolaryngology, ophthalmology, plastic surgery, and urology.
      vi. One representative from the hospital-based services programs (radiology, anesthesia, pathology, pathology sub-specialties), who shall represent these respective programs.
   d. Two resident representatives as elected from their peers through the Tulane Residency and Fellowship Congress.
   e. Two program administrators as elected from their peers through the Program Administrators Council.
   f. A quality improvement/safety officer or his or her designee from either Tulane Hospital, the VA Hospital, or the University Medical Center
3. Quorum: Quorum is defined by greater than 50% of the voting members, with a minimum of one representative from the Tulane Resident and Fellow Congress.
4. Institutional hierarchy: The decisions of the GMEC are reported through the DIO to the Executive Medical Faculty, of which the Dean of Medicine is the Chair. The Executive Faculty serves as the primary governing body of the Medical School in all matters academic and administrative. In turn, their decisions are reported through the Dean to the Provost of the University. The Provost answers directly to the President of the University. The President answers to the Administrators of the Tulane Educational Fund that has full governing authority of the University (i.e., the “Governing Body”). An organizational chart is displayed in Appendix D.
C. Responsibilities of the GMEC. The GMEC convenes every other month, and has the following responsibilities:

1. Oversight of institutional accreditation, including review the ACGME institutional letter of notification from the IRC and monitoring of action plans for correction of citations and areas of noncompliance
2. Oversight of the individual programs’ ACGME accreditation, including the quality of the GME learning and working environment within the Sponsoring Institution, its ACGME-accredited programs, and its participating sites;
3. Applications for ACGME accreditation of new programs, voluntary withdrawal of ACGME program accreditation; and oversight of all processes related to reductions and closures of individual programs, participating sites and the Sponsoring Institution, as outlined in Chapter III: III. Policy on Program Closure, Reduction, or Expansion and Chapter IV: IV. Policy on Disaster/Interruption of Resident Training
4. Review and approval of all institutional GME policies and procedures
5. Stipends and position allocation. The committee will review and provide recommendations to the Sponsoring Institution’s leadership regarding resident stipends, benefits, and funding for resident positions, as outlined in Chapter III: Policy on Residency Program Closure, Reduction, or Expansion, and Chapter V: Policy on Financial & Resource Support of Residents
6. Responses to Clinical Learning Environment Review (CLER) reports
7. Oversight of the function and effectiveness of the Tulane Residency and Fellowship Congress, as outlined in Appendix A. The Residency Congress, and resident representation on Hospital and University committees, as outlined in Chapter IX. Residents’ Participation on Institutional Committees.
8. Vendor interactions between vendor representatives/corporations and residents/GME programs as outlined in Chapter VII. Policy on Interacting with Vendors.
9. Approval of the DIO’s Annual Report to the Organized Medical Staff as outlined in Chapter XXII. Policy on Program Evaluation, Improvement and Annual Program Reports.
10. Oversight of all GMEC sub-committees.
   a. The composition of ad-hoc or standing subcommittees, unless otherwise explicitly specified, is at the discretion of the GMEC.
   b. Any subcommittee that address required GMEC responsibilities must include at least one peer-selected resident/fellow, as assigned by the Tulane Residents and Fellows Congress.
   c. All subcommittee actions that address required GMEC responsibilities must be reviewed and approved by the GMEC.
11. Program Supervision. The GMEC is responsible for ensuring that each Tulane program is in compliance with all ACGME Common and Program-Specific requirements, and Tulane University rules and regulations. The GMEC, through review of Annual Reports, Programs’ Self-Study/Annual Reports and ACGME site visit reports, will ensure that each program maintains:
   a. Oversight of the ACGME accreditation status of all Tulane ACGME-accredited programs, including a review of all ACGME program accreditation letters of notification, monitoring of action plans for correction of citations and areas of noncompliance, and progress reports requested by a Review Committee
   b. Requests for all temporary or permanent changes in resident complement
   c. Oversight of the quality of educational experiences in each ACGME-accredited program that lead to measurable achievement of educational outcomes as identified in the ACGME Common and specialty/subspecialty-specific Program Requirements
      i. Effective communication and appropriate oversight between Tulane program directors and the site directors at each participating site for their respective programs
      ii. Compliance with resident duty hours for each residency program as outlined in Chapter VIII. Policy on Residents’ Duty Hours.
      iii. Resident supervision, including supervision that enables and ensures safe and effective patient care, educational needs of residents, and progressive responsibility appropriate to residents’ level of education, competence, and experience, as outlined in Chapter XIII. Policy on Supervision of Residents
      iv. Curriculum and evaluation that enables residents to demonstrate achievement of the
ACGME general competencies as defined in *Chapter X. Policy on Core Curriculum and the Core Competencies* and as noted in the ACGME Common and Specialty-specific Program Requirements.

d. Oversight of the programs’ annual evaluation and improvement activities,
e. Oversight of major changes in ACGME-accredited programs’ structure or duration of education
f. Oversight of additions and deletions of ACGME-accredited programs’ participating sites;
g. Oversight of appointment of new program directors
h. Oversight of all requests for exceptions to duty hour requirements, and oversight of all phases of educational experiments and innovations that may deviate from Institutional, Common, and specialty/subspecialty-specific Program Requirements
i. Oversight of requests for appeal of an adverse action by a Review Committee and appeal presentations to an ACGME Appeals Panel.
j. Oversight of selection of residents in compliance with Chapter I: Policy on Resident Eligibility and Selection, and Chapter :II. Policy on Equal-Opportunity, Affirmative Action, & Disabilities, k. Oversight of evaluation, promotion, and transfer or residents in compliance with Chapter I. Policy on Resident Eligibility and Selection
l. Oversight of discipline, and/or dismissal of residents in compliance with Chapter XV. Policy on Remediation, Suspension, Termination and Grievance

12. Deliberations and actions of the GMEC will be documented in minutes from each meeting, which will be reviewed and approved at the subsequent GMEC meeting.

D. Oversight of all ACGME communications

A. The Office of Graduate Medical Education encourages program directors to interact with their respective specialty-specific RRC for matters of guidance and advice as it pertains to their compliance with the Common and Program-specific ACGME regulations.

B. The DIO and the GMEC, must provide approval of all communications with the ACGME that involve the following:
   1. All applications for ACGME accreditation of new programs
   2. Changes in resident complement
   3. Major changes in program structure or length of training
   4. Additions and deletions of participating sites
   5. Appointments of new program directors
   6. Progress reports requested by any Review Committee
   7. Responses to all proposed adverse actions
   8. Requests for exceptions of resident duty hours
   9. Voluntary withdrawal of program accreditation
   10. Requests for an appeal of an adverse action
   11. Appeal presentations to a Board of Appeal or the ACGME.
   12. All requests for experimentation/innovation as it regards exceptions to the ACGME Common and Specialty-specific requirements.

E. Conflicts of Interest.

1. The Associate Dean of GME works directly with the Assistant Dean of GME in oversight of all training programs. The Assistant Dean of GME will assume oversight of all matters pertaining to the program(s) of origin for the Associate Dean of GME, and vice versa.

2. Program Directors who sit on the GMEC are allowed and encouraged to participate and vote in matters related to their respective programs. Program Directors should recuse themselves from a discussion in which they have a personal interest.

F. Annual Institutional Report

1. The GMEC will demonstrate effective oversight of the Sponsoring Institution’s accreditation through an Annual Institutional Review (AIR), and will submit a written annual executive summary of the AIR to
the Governing Body.

2. The annual report will contain the following institutional performance indicators:
   a. Results of the most recent institutional self-study visit
   b. Results of ACGME surveys of residents and core faculty
   c. Notification of ACGME-accredited programs’ accreditation statuses and self-study visits.
   d. Monitoring procedures for action plans resulting from the review.
      i. Resident supervision
      ii. Resident responsibilities
      iii. Resident evaluations
      iv. Compliance with duty-hour standards
      v. Resident participation in patient safety and quality of care education.

Approved by the GMEC; January 31st, 2018
XXII. POLICY ON PROGRAM EVALUATION, IMPROVEMENT & ANNUAL PROGRAM REPORTING REQUIREMENTS

A. Each residency program is required to have a Residency Education Committee (REC).
   1. The REC should be composed of the program director (who shall serve as chair), the associate program directors (where applicable), at least two faculty, and at least one resident from each level of training, as elected by their peers.
   2. The REC should meet at least quarterly to review the residency program.
   3. The responsibilities of the REC include:
      a. A review of at least one component (rotation) of the residency program at each meeting. A summary report of residents’ monthly evaluations of the rotation should be presented and addressed during the evaluation of the rotation. The rotation evaluation should include an assessment of its fidelity to program and institutional policies including the following:
         i. Resident educational resources (Chapter V. Policy on Financial & Resource Support of Residents)
         ii. Resident duty hours and work environment (Chapter VIII. Policy on Residents’ Duty Hours)
         iii. Resident Supervision (Chapter XIII. Policy on Supervision of Residents)
         iv. Resident Evaluation (Chapter XIV. Policy on Evaluation of Residents)
      b. Addressing resident or faculty concerns regarding the program as a whole, as they might arise.
      c. Once per year, the REC should conduct an annual review of the residency program. The review should incorporate the residents’ evaluation of the program and the faculty’s evaluations of the program in constructing this review. This should be used to systematically evaluate the program, including the curriculum, and to construct an annual report as detailed below. If deficiencies are found, the program should prepare a written plan of action to document initiatives to improve performance in the areas. The action plan should be reviewed and approved by the REC and documented via meeting minutes.

B. Each residency program is required to have a Clinical Competency Committee (CCC).
   1. The CCC should be comprised of faculty instrumental to the operation of the training program.
   2. The program director can be a member of the CCC, but should not chair the CCC.
   3. Residents from the program should not be members of the CCC; chief residents who have finished their training and are operating in a faculty role may participate in the CCC.
   4. The CCC should meet at least quarterly to review the performance of each resident in the training program with respect to progress in each entrustable professional activity (EPA).
      a. The CCC should integrate faculty-of-resident, nurse-of-resident, patient-of-resident, resident-of-self evaluations in assessing at which milestone each resident is on each EPA.
      b. The CCC must make an assessment for each resident on each EPA at least twice per year. Decisions for promotion, retention and termination should be made by this committee.
      c. The CCC must communicate their assessment of each resident to the program director, who will be responsible for uploading individual resident’s milestone progress to the ACGME WebAds.
      d. The CCC, in concert with the program director, must ensure that each resident is informed of his or her progress on each EPA at least twice per year. The program director or his/her designee must meet in person with each resident twice a year to discuss their summative performance in each entrustable activity, their performance in each of the six core competencies, and where applicable, their performance on required procedures/cases.
   5. The CCC is responsible for identifying any resident whose performance warrants remediation, probation, non-renewal or termination.
C. Each program is required to provide an annual report at the end of each academic year. The report is due by June 30th of each academic year, and should be posted to the program’s wiki page.

The goal of the annual report is to identify areas of improvement in the training program. The GME Office recognizes that program directors and coordinators are busy, and additional bureaucratic work detracts from time that could be devoted to the residents and the residency program. As such, the Annual Report is divided into three sections: Section 1 is (thereby relieving program directors from repetitive work);

Section 2 is data that the Program Director/Coordinator is responsible for providing on an annual basis.
Section 3 is endurable materials that should be on file with the GME Office, and updated as needed

1. Section 1: Data the GME Office will pull directly from WebAds
   a. The program’s resident roster, including start/end dates, demographic data, and scholarly activity
   b. The program’s faculty roster, including scholarly activity.
   c. A listing of program citations, if any, and program responses.
   d. The ACGME resident and faculty survey reports
   e. Financial resident allocations by training site.
   f. Notification of each of its ACGME-accredited programs’ accreditation statuses and self-study visits.

2. Section 2: Data to be provided by the program on an annual basis (See Appendix F)
   a. Board pass rate by resident
   b. In-service scores by resident
   c. USMLE scores by resident
   d. The composition of the program evaluation committee and the process used to conduct the annual review.
   e. The source data used to inform and measure the annual review
   f. A narrative account of the previous year’s goals for improvement, with subsequent results.
   g. The three priority areas for improvement for the coming academic year
   h. A narrative response to all ACGME fallouts (compliance <80%) on the resident and faculty surveys.
   i. A narrative description of the program’s quality improvement project(s) and a listing of residents and faculty who participated in the project.

3. Section 3: Endurable Materials to be on-file in the GME Office, with updates occurring on a pro re nata basis.
   a. The Program’s resident manual.
   b. A copy of the resident-of-faculty, resident-of-rotation, resident-of-resident, patient/nurse-of-resident and faculty-of-resident evaluations
   c. A description of how the program addresses the following curricular components:
      a. Sleep deprivation and fatigue mitigation
      b. Training residents on how to teach
      c. Patient safety/Quality Improvement
      d. Resident wellness, sustainability and burnout mitigation
   d. A sample copy of the mid-year, end-of-year promotion and end-of-training letters to sent to residents, documenting the resident’s interval progress with the core competencies.
   e. Updated Copies of Program Letters of Affiliation (PLA) for each Participating Training Site.
   The PLA should include (See also Chapter XIII)
      i. The faculty responsible for the educational and supervisory responsibilities for residents;
      ii. The responsibilities of faculty for teaching, supervision, and formal evaluation of residents.
      iii. The duration and content of the educational experience
      iv. The policies and procedures that will govern resident education during the assignment.
v. The name of the site director serving as the liaison between the program director and the clinical site.
vi. The number of residents assigned to this site each year, the nature of the rotation (in-house call, no call, home call) and the number of months residents rotates to this facility.

D. The Residency Manual: This should be organized as follows, and posted to the program’s wiki webpage:

1. Section I: The Academic Year Calendar
   a. The Residency Education Committee (REC) Composition and meeting schedule
   c. The Clinical Competency Committee (CCC) Composition and meeting schedule
   e. The Curriculum Calendar and Matrix (by core competency)

2. Section II: Program Expectations
   a. Overview of the Training Program
   b. Overall Goals and Objectives: Core Competencies and Learning Goals
   c. Overall Goals and Objectives by year of training (Progressive Lines of Responsibility)
   d. Block Diagram of a Sample Clinical Curriculum (Rotations)
   e. Scholarly Activity Opportunities
   f. A Description of Conferences and Educational Resources
   g. A Description of Participating Institutions (including rationale for why these sites have been chosen to be a part of the training program), and the local director at each participating site who is accountable for resident education;

3. Section III: Description of Clinical Rotations and Electives with Goals and Objectives (Organized by core competencies)

4. Section IV: Evaluation

5. Section V: Program Policies. These policies should be compatible with the institutional policies, but they must be unique to the training program (i.e., the program cannot simply default to institutional policies).
   a. Moonlighting (Chapter VI)
   b. Interacting with vendors (Chapter VII)
   c. Duty hours (VIII)
   d. Vacation and leave (Chapter XI)
   e. Supervision and evaluation of residents (XIII)

Approved by the GMEC; September 28th, 2011
XXIII. The Special Review Process: Oversight of Underperforming Programs

A. The Special Review Process refers to a systematic review of a residency program, as conducted under the leadership of the Tulane Office of Graduate Medical Education, based upon cause as outlined below.

B. Criteria for identifying under-performing residency programs;
The DIO may select, with the GMEC’s approval, any program for the Special Review Process. Criteria for selection can include any of the following:
1. Adverse reporting on the resident and faculty ACGME survey
2. Failure to achieve minimal compliance with reporting on the resident and faculty ACGME survey
3. ACGME citations
4. Resident or faculty reports of adverse compliance with institutional or program policies, including but not limited to, supervision and duty hours.
5. Failure to respond in a timely fashion to DIO requests for information necessary in ensuring compliance with accreditation and compliance with institutional or program policies.
6. Failure to provide, in a timely fashion, or comply with financial allocation of resident positions.
7. Failure to present an annual review that addresses each of the required components.

C. Protocol for the Special Review
1. The DIO will meet with the residents to assess compliance with institutional and/or program policies. The DIO will continue such meetings throughout the process, at his or her discretion, until the conclusion of the Special Review Process.
2. The DIO will meet with the faculty to assess compliance with institutional and/or program policies. The DIO will continue such meetings throughout the process, at his or her discretion, until the conclusion of the Special Review Process.
3. The DIO will meet with the program director and chair to assess compliance with institutional and/or program policies. The DIO will continue such meetings throughout the process, at his or her discretion, until the conclusion of the Special Review Process.
4. The DIO will then share his or her collective information with the Special Review Committee, as outlined below. The Special Review Committee will then identify areas for immediate corrective action.
5. The DIO will again meet with the program director and chair to share the results of the Special Review Committee’s decisions/assessment.
6. The DIO will request as response from the program director and chair as to the program’s action plan; this will be shared with the Special Review Committee. The plan should include measurable progress outcomes according to a time line.

D. Participants of the Special Review Process
1. The Associate Dean of GME (DIO), or the Assistant Dean of GME in his or her absence, will chair the Special Review process.
2. At least one faculty member from the GMEC, not from the department or program that is being reviewed.
3. At least one resident/fellow member, not from the department or program that is being reviewed, as appointed by the president of the TRFC.
4. Program Participants
   a. The Program Director and the Chair of the program that is being reviewed.
   b. A representation (at least two) of the key clinical faculty of the program that is being reviewed.
   c. A representation (at least two) of peer-elected residents from the program that is being reviewed. At least one representative from each level of training in the program must be present.

E. Components of the Special Review. The DIO and the Special Review committee will review the following
components as it relates to the residency program’s compliance with the following:

1. Compliance with the Common, specialty/subspecialty-specific Program, and Institutional Requirements.
2. Educational objectives and effectiveness in meeting those objectives
3. Educational and financial resources
4. Effectiveness in addressing areas of non-compliance and concerns in previous ACGME accreditation letters of notification and previous internal reviews
5. Effectiveness of educational outcomes in the ACGME general competencies
6. Effectiveness in using evaluation tools and outcome measures to assess a resident’s level of competence in each of the ACGME general competencies
7. Annual program improvement efforts in:
   a. Resident performance using aggregated resident data
   b. Faculty development
   c. Performance of program graduates on the certification examination
   d. Program quality

F. The Special Review Report.
The Special Review committee will produce a report that describes the quality improvement goals, the corrective actions, and the process for GMEC monitoring of outcomes. This report will be shared with the respective program director and chair, and the Dean of the Medical School

*Approved by the GMEC; September 28th, 2011*
XXIII. POLICY ON ACGME COMMUNICATIONS

A. The Office of Graduate Medical Education encourages program directors to interact with their respective specialty-specific RRC for matters of guidance and advice as it pertains to their compliance with the Common and Program-specific ACGME regulations, except as noted in Chapter XXII.

B. The Associate Dean of GME and subsequently, the GMEC, must approve all communications with the ACGME that involve the following, prior to their submission.
   1. All applications for ACGME accreditation of new programs
   2. Changes in resident complement
   3. Major changes in program structure or length of training
   4. Additions and deletions of participating sites
   5. Appointments of new program directors
   6. Progress reports requested by any Review Committee
   7. Responses to all proposed adverse actions
   8. Requests for exceptions of resident duty hours
   9. Voluntary withdrawal of program accreditation
   10. Requests for an appeal of an adverse action
   11. Appeal presentations to a Board of Appeal or the ACGME.
   12. All requests for experimentation/innovation as it regards exceptions to the ACGME Common and Specialty-specific requirements.

C. The Associate Dean of GME must receive all program information forms (PIF’s) one month prior to submission to the ACGME.

*Approved by the GMEC; September 28th, 2011*
APPENDIX A: THE RESIDENT AND FELLOW CONGRESS

A. ARTICLE ONE: NAME, PURPOSE, AND OBJECTIVES

Section 1. Name. The name of this organization shall be: The Tulane Resident and Fellow Congress

Section 2. Purpose. The Resident and Fellow Congress is the residents’ voice to ensure the Office of Graduate Medical Education’s mission of striving for excellence in education. This organization will provide a mechanism by which residents can participate directly in GME activities for the purpose of:
   A. Opening dialog to identify concerns and facilitate resolution
   B. Encouraging resident input into graduate medical education governance and policy
   C. Fostering professionalism, empathy and personal growth and development for our physicians in training
   D. Improving:
      a. The educational experience and opportunities
      b. Representation of the interest of its members in deliberations with affiliated hospitals on issues regarding working conditions and benefits
      c. Communication with other health care providers, program directors, the medical staff and administration
      d. Active membership and participation in constituent societies of organized medicine
      e. Overall quality of patient care
      f. Resident and resident’s significant other’s well-being through social and charitable activities

B. ARTICLE TWO: MEMBERSHIP

Section 1: Membership
The membership shall be comprised of all physicians holding an internship, residency, or fellowship appointment at Tulane University School of Medicine and its affiliated hospitals and clinics.

Section 2: Rights of Membership
Physician members in good standing shall be entitled to all privileges of membership as provided in the constitution and bylaws of the association, including the duty to vote and the right to hold office.

Section 3: Termination of Membership
   Membership shall be terminated upon:
   A. Written resignation
   B. Death
   C. Completion of training program
   D. Transfer or dismissal from training program
   E. A determination by 2/3 majority vote of the Congress that an individual’s actions are contrary to the Constitution, Bylaws, or best interest of the Organization.

C. ARTICLE THREE: MEETINGS
   Section 1. Meetings
All regular and annual meetings of the Resident and Fellow Congress shall be conducted following the guidelines of Robert’s Rules of Order.

Section 2. *Board Meeting*

The executive council shall meet at least six times annually, and other times as deemed necessary by the President.

Section 3. *Quorum*

No meeting of the Congress shall take place nor shall any business of the Congress be conducted in the absence of a quorum as outlined in the Bylaws to this constitution.

D. ARTICLE FOUR: OFFICERS

Section 1. *Election of Officers.*

A. Nominations for all the elected positions, except President-elect, shall be made by the Resident and Fellow Congress membership no less than 30 days prior to the Annual Meeting.

B. Nominations for President-Elect shall take place before November 30. Election by majority shall take place in January.

C. In the event that there are no nominations for an elected position, a special meeting of the Board shall be called and the position filled via appointment.

D. Absentee voting may occur during the 30 days immediately prior to the election.

E. Election will be determined by majority of votes received. Run-off elections will be held if no candidate receives a majority vote.

Section 2. *Officers*

A. GME Liaison: Assistant Dean of Graduate Medical Education
   1. Supervise all operations of the Resident Congress
   2. Avenue for direct interface between the Resident and Fellow Congress and the DIO and GMEC
   3. Assist and advise the President in Operations of the Resident and Fellow Congress
   4. Attend or designate attendee for all Annual and Special Congress meetings

B. President—Duties of the President:
   1. Preside over all Annual and Special meetings; under the supervision of the GME Liaison
   2. Preside over all Board meetings
   3. Shall appoint all committee chairpersons and maintain summary documentation of active committee’s and agenda items. This will be communicated to the GME Liaison at least quarterly
   4. Serve as an ex-officio member of all committees
   5. Within seven days of any meeting submit, in writing to the GME Liaison, all recommendations arising from the Resident and Fellow Congress
   6. Maintain open lines of communication with the GME Liaison on all issues which pertain to and encompass the overall Resident and Fellow Congress goals and objectives
   7. Serve as the Resident and Fellow Congress GMEC representative and report findings to this organization

C. Vice-President (President-Elect)—Duties of the Vice-President:
   1. Preside over all meetings where the President is not in attendance
   2. Will work directly with the president to help supervise the operations of the association
   3. Facilitate communication between committees and departments
   4. Will be a representative to meeting with the chief residents of all departments.
5. May serve as Chairperson of any committee
6. Serve as the Graduate Medical Education Committee representative

D. Secretary—Duties of the Secretary:
   1. Maintains a current roster of membership and Board members
   2. Oversees interdepartmental communications
   3. Ensures the taking of minutes and communications
   4. Chair of Membership Committee.

E. Treasurer—Duties of Treasurer:
   1. Provide the Association with a proposed balanced budget for the year
   2. Keep the Association informed on monetary issues affecting the Association
   3. Chair of Finance Committee
   4. Investigate mechanism’s for funding

Section 3. Terms
Officers shall be elected or appointed for the term of one academic year at the Annual Meeting, with the exception of the President-Elect who will begin service when elected and become President at the conclusion of the Annual Meeting.

Section 4. Qualifications
Candidates for elected or appointed offices shall be a member in good standing. Candidates for the office of President-Elect must be members in good standing for at least one year before running for office. Exceptions must be approved by the Board.

Section 5. Vacancies
Elected or appointed officers will be considered vacant when an officer ceases to perform their duties secondary to death, resignation, removal and/or disqualification.

Section 6. Removal of Officers.
An officer may be removed during any Annual or Board meeting by a simple majority vote. The officer shall be afforded due process prior to any dismissal proceedings. Any officer who disqualifies from membership immediately ceases to be an officer.

E. ARTICLE FIVE: BOARD OF DIRECTORS

Section 1. Board Membership.
A. The Executive Board shall consist of a minimum of the President, Vice-President, President-Elect, Secretary, Treasurer and six Directors; one shall be from a surgical residency program, one shall be from a non-surgical residency program, two shall be interns from any program, one shall be a fellow, and one shall be from any program.
B. All board member terms expire at the conclusion of the Annual Meeting following their election.

Section 2. Selection of Executive Board Members
A. The Directors of the Board shall be elected by majority vote at the Annual Meeting according to Article Four, Section 1 of the Constitution.
B. Qualifications, vacancies and removal of members from the Executive Board will follow the same
guidelines as other officers.

Section 3.  Meetings of the Board
A. All meetings of the Resident and Fellow Congress Executive Board shall be conducted under the
Robert’s Rules of Order.
B. Special meetings of the Executive Board may be called by either the President or by the majority of
Board members. The GME Liaison will be notified of Board meetings and attends upon formal invitation.
The GME Liaison will attend all Annual and Regular Resident and Fellow Congress meetings.

Section 4.  Duties of the Board of Directors
The duties of the Executive Board members shall be:
  A. Advise the officers on matters brought to the association’s attention
  B. To aid in developing policy that shall guide the affairs of the Resident and Fellow Congress
  C. To assist in the dissemination of information to the members and serve as a voice from their
     represented departments
  D. To assist in the dissemination of information from the Executive Board back to their respective
     departments.

F. ARTICLE SIX: COMMITTEES
The committees of the Association shall be composed of members of the Congress.
Committees will be designated each year according to the concerns and goals of the Congress.

G. ARTICLE SEVEN: DUES, FUNDING AND ASSESSMENT
Funds may be set by annual dues or assessment of the members or on recommendation of the Board as
provided by the bylaws.

H. ARTICLE EIGHT: AMMENDMENT OF THE CONSTITUTION
1. The Resident and Fellow Congress Constitution may be amended at any annual meeting.
2. Proposed amendments to the constitution shall be presented in writing to the Tulane Dean of
   Graduate Medical Education and publicized to the membership at least six months prior to the proposed
   amendment shall be considered
3. Members in good standing may vote in absentee with a signed letter to be opened only at the time
   of counting votes.
4. An amendment to the Constitution must be approved by a $\frac{3}{4}$ majority voting membership in order
to pass.
Bylaws
Tulane University School of Medicine:
Resident and Fellow Congress

Article I. Membership
Section 1. Good standing
A member shall be considered to be in good standing who currently is a resident or a fellow with Tulane University and is not on probation or serving any disciplinary sanctions.

Section 2. Privileges
A member in good standing shall have the:
- Right to vote
- Right to hold office
- Right to serve on the committees
- Right to participate and attend all meetings

Section 3. GME Liaison
The GME Liaison shall be the Assistant Dean of GME and he shall serve as the interface between the Resident Congress and the DIO and GMEC. The GME Liaison will provide direct supervision and function in an advisory role. The GME Liaison will attend all Regular, Special and Annual Resident Congress Meetings.

Article II. Meetings
Section 1. Board meetings
A. Any member of the resident congress may attend any general meeting. Any person other than resident congress members, who wish to participate in discussions of an agenda item pertinent to their responsibility, must be invited by either a member of the Board or one of the officers.
B. The TRFC reserves the right to meet without the DIO, faculty members, or other administrators present.
C. Board meeting may be called into executive session restricted to Officers and Directors upon 2/3 majority vote of the Board members present at a Board meeting.

Section 2. Special meetings
Special or executive board meeting may be called at any time by the President or upon written request of a majority of the Board.

Section 3. Annual Meetings
Annual Meetings shall be held each May according to the Constitution. The GME Liaison will attend both Annual and Regular Congress Meetings.

Section 4. Regular Meetings
Regular Meetings shall be held quarterly.

Section 5. Quorum
An assembly of 1/3 of the membership shall constitute a quorum for the conduction of business of all Annual and Special meeting of the Congress.
An assembly of 50% of the Board of Directors shall constitute a quorum for the conduction of business at all Board meetings. Board members on scheduled vacation, leave of absence or rotations more than 30 miles from Tulane’s downtown medical campus are excused from Board meetings and shall not count for or against a quorum.

Article III. Officers
Section 1. Voting
Absentee voting may occur during seven days immediately prior to the election by submitting ballots to the Resident Congress Secretary or designee.
Each member voting absentee shall initial the roster signifying that the member has voted. The roster and ballots shall be submitted to the Assistant Dean of GME’s office the day prior to the election.
The GME Liaison shall be a non-voting member.

Section 2. Due process
An officer or executive board member may be removed from office at any Annual, Special, or Board meeting of the Congress.

The officer or Board member shall be given notice of the intent to remove one week prior to the meeting. The officer shall have the right to speak on his/her behalf to the general assembly prior to any removal vote.

Article IV. Vacancies
A vacancy of any elected office shall be filled by a member nominated by the President and confirmed by simple majority vote of the Board at any Board meeting. A vacancy in the office of President shall be filled by the Vice-President.

Article V. Board
The board shall be comprised of intern, resident and fellow members.

Article VI. Committees
Committee Chairpersons shall be appointed by the President. All committee members shall be selected at the discretion of the Chairperson.
Any person other than committee members that should attend a committee meeting must be invited by one of the committee members.
Any person denied participation on any committee shall have the right to petition the Congress for review. The Board shall have the power by majority vote to assign additional committee members.

Article VIII. Amendments
The Resident Congress Bylaws may be amended at any Annual, Special, or Board meeting.
Proposed amendments to the bylaws shall be presented in writing at least one meeting before the proposed amendment shall be considered. The two meetings must be at least fourteen days apart.
Members in good standing may vote in absentee with a signed letter to be opened only at the time of counting the votes.
An amendment to the Bylaws must be approved by a 2/3 majority of the voting membership in order to pass.
Bylaws changes shall be forwarded to the Tulane Dean of Graduate Medical Education upon their passage.

Article VIII. Reporting
The President of the Resident Congress shall report, to the GME Liaison, within seven days and in writing, the minutes and recommendations from all meetings. The President in consultation with the GME Liaison shall regularly report to the GMEC. The GME Liaison is responsible to directly oversee operations of the Resident Congress.
Appendix B: Written Statement of Institutional Commitment

September 5th, 2017

Tulane University School of Medicine, and in particular, Tulane University Hospital and Clinic, is committed to providing an organized educational program with guidance and supervision of residents and fellows, facilitating their professional and personal development while ensuring safe and appropriate care for patients. Tulane University Hospital and Clinic will support graduate medical education programs in principal and financially with facilities, equipment, personnel and other resources. This commitment is supported by the Hospital Board, the administration, and the teaching staff.

Graduate Medical Education is an integral part of providing the academic atmosphere necessary to accomplish the mission of the University, the Hospital and the School of Medicine. The postgraduate medical education programs will be conducted in compliance with the general and special requirements of the ACGME. As the Sponsoring Institution for all Tulane University graduate education programs, Tulane University is committed to GME by providing the necessary financial support for administrative, educational, and clinical resources, including personnel. The institutional support of these goals will be monitored through existing reporting mechanisms by the Hospital Board, the Dean of the School of Medicine, the Senior Associate Dean for Graduate Medical Education (DIO), the Hospital Executive Committee, the Chairs of the Clinical Departments and the Graduate Medical Education Committee.

Tulane University School of Medicine

Michael A. Fitts
President, Tulane University

Lee Hamm, MD
Dean, Tulane School of Medicine

Tulane University Hospital and Clinic

William Lunn, MD
Chief Executive Officer, Tulane Hospital and Clinics

Jeff Wiese, MD
Senior Associate Dean and DIO
TULANE UNIVERSITY SCHOOL OF MEDICINE RESIDENT AGREEMENT
1430 Tulane Avenue, New Orleans, Louisiana 70112

THIS AGREEMENT between The Administrators of the Tulane Educational Fund, on behalf of the Tulane University School of Medicine (hereinafter “Medical Center”) and __________ (hereinafter “Resident”) is entered into for the period from __/__/____ through __/__/____. Under the sponsorship of the Medical Center and supervision by faculty members of the Medical Center, Resident will serve as a # (PGY) year resident in the __________ Residency/Fellowship Program.

1. Policies and Procedures Resident Handbook. The Resident and Staff Graduate Medical Education Policies and Procedures 2018-2019 (hereinafter “the Manual”) contains the institutional guidelines, policies and procedures governing the selection, appointment, evaluation, and retention of residents at the Medical Center. The Resident will receive a copy of the Manual during orientation and it is posted on the GME website http://tulane.edu/som/gme/; however, the Manual is subject to revision. The provisions of the Manual referred to in this Agreement, in their most recent version, are hereby incorporated into this document by reference. It is the responsibility of the Resident to familiarize him/herself with the information contained in the Manual, including any revisions, and to assure that he/she is in compliance with all policies and procedures contained therein at all times during the term of this agreement.

2. Stipend. Commencing __/__/____ through __/__/____, the Resident will receive an annualized stipend of $__________. This amount will be subject to the appropriate federal and state income tax, social security tax, and any other applicable deductions.

3. Leaves. The Medical Center provides for vacation/sick leave, parental leave, personal leave, leave of absence, and professional leave as set forth in Sections V. and XI of the Manual. The use of leave exceeding the limits established by the Medical Center or Program may require extension of the resident’s training as described in Section XI of the Manual.

4. Additional Benefits.
   a. Support Services. It is understood that counseling, medical and psychological supportive services will be made available on an as needed basis.
   b. Insurance. Health, life and disability insurance will be provided and are effective on the first day of Residency program unless specifically refused. Dental, as well as family medical insurance coverage may be purchased for eligible dependents through payroll deduction as described in Section V of the Manual.
   c. Professional Insurance. Liability insurance will be provided through the Tulane Self-Insurance Trust Program: $1,000,000; and the Louisiana Patient Compensation Fund—Act 817 Qualification, or by the State or Federal plans when rotating through their supported facilities. These are occurrence-based coverages providing that any claim or action arising out of an event that occurred while the person was a resident acting on behalf of Medical Center, regardless of when the action is filed, is covered under the respective insurance programs or plans.
d. **Educational Resources.** Resident shall have access to information related to eligibility for specialty-based examinations as described in Section V of the Manual.

e. **Other Benefits.** Free parking will be available while on rotation in the Tulane University Medical Center area (TMC, VA, MCLNO). Sleeping quarters and meals will be provided while on-call. Lab coats and beepers will be available at no charge.

5. **Duration of Appointment / Termination.**
   a. **One-Year Term.** The term of this agreement is for one year only (as stated in the opening paragraph of this agreement), and no guarantee of a subsequent contract(s) is expressed or implied even though the Resident may be participating in a multi-year residency program.
   b. **Condition for Reappointment.** Conditions for the offer of any subsequent training agreement following an initial appointment and for promotion within the program are described in Section XIV of the Manual.
   c. **Termination with Cause.** During the term of this agreement, the Medical Center may terminate this agreement with cause according to the conditions described in Section XIV of the Manual.

6. **Grievances and Fair Hearing.** The policies relating to resident grievances and the appeal and fair hearing process are presented in Section XIV of the Manual.

7. **Resident Responsibilities.** Resident physicians are expected to:

   a. Meet the qualifications for resident eligibility outlined in Section I of the Manual.

   b. Comply with Tulane’s verification procedures, which includes:
      
      i) Documentation of identity and right to work.
      
      ii) Proof of compliance with immunization policy.
      
      iii) Accurate completion of the Tulane application for appointment to the housestaff, listing all information requested and returning the document in a timely manner prior to the hiring date so all information can be verified including medical school and previous residency training prior to beginning patient responsibilities.

   c. Obtain a valid, unrestricted Louisiana State Medical license or a training permit from the Louisiana State Board of Medical Examiners.

   d. Develop a personal program of self-study and professional growth under the general supervision of appropriately credentialed attending teaching staff.

   e. Participate in safe, effective and compassionate patient care under supervision, commensurate with level of advancement and responsibility.

   f. Participate fully in the educational activities of your program and, as required, assume responsibility for teaching and supervising medical students, and other residents and participate fully in institutional orientation and at least 50% in education programs and other activities involving the clinical staff.

   g. Participate in institutional programs and activities involving the medical staff and adhere to established practices, procedures, and policies of the Institution.
h. Develop an understanding of ethical, socioeconomic and medical/legal issues that affect graduate medical education and participate in institutional committees and councils, especially those that relate to patient care review activities, quality assurance, and apply cost containment measures in the provision of patient care.

i. Charts, records, and/or reports will by kept up to date and signed at all times. Failure to complete outstanding paperwork will result in discipline, including, but not limited to, suspension without pay.

j. Follow the rules, regulations, policies and procedures of Tulane University School of Medicine, Tulane University and its affiliated institutions that relate to graduate medical education.

k. Act in a professional and ethical manner.

Failure to meet any of the responsibilities listed in Section 7 may result in discipline, up to and including termination.

8. Resident Review. It is understood that as the position of housestaff physician involves a combination of supervised, progressively more complex and independent patient evaluation and management functions and formal educational activities, the competence of the housestaff physician is evaluated on a regular basis. The program maintains a confidential record of the evaluations.

9. Closures or Reduction in Funding. Should any affiliated hospital close or reduce their funding of residency slots during a residency training program, every attempt will be made to replace those training slots at another affiliated institution and to locate funds for completion of the academic year as set forth in Section III of the Manual. Should that not be available and it is necessary to reduce the number of residency positions in a given department, the affected house officers will be informed as early as possible. Assistance will be provided in finding a training position at another hospital, as outlined in Section III of the Manual. Additionally, if a residency-training program is closed or reduced in size, the affected house officers will be notified as soon as possible and assistance will be provided to locate another training program for them.

10. Counseling Services, Disability, and Impairment. The Medical Center provides access and/or referral to medical, psychological and/or financial counseling, and support services as described in Sections V, XIV and XV of the Manual. Section II of the Manual describes the policies pertaining to residents with disabilities. Section XV of the Manual includes policies relating to physician impairment and substance abuse.

11. Duty Hours. It is understood that training, research, teaching and clinical assignments will be approved by the Chairman of the Department of _____________. Duty hours will be consistent with institutional and program requirements based on educational rationale and patient need, including continuity of care with supervision available at all times and are discussed in Section VIII of the Manual.
12. **Moonlighting.** The Medical Center has incorporated policies covering professional activities outside of the residency program (moonlighting) in Section VI of the Manual and Resident agrees to abide by such policy.

13. **Harassment/Discrimination.** Concerns related to harassment, discrimination, or unwelcome conduct of a sexual nature will be handled as described in Tulane University’s EO/Anti-Discrimination Policy. A copy of Tulane’s EO/Anti-Discrimination Policy can be found at: [http://tulane.edu/equity/reporting-policies.cfm](http://tulane.edu/equity/reporting-policies.cfm). All concerns related to harassment, discrimination, or unwelcome conduct of a sexual nature must be directed to the Office of Institutional Equity (504-862-8083).

14. **Severability.** If any provision of this agreement is held invalid, such invalidity shall not affect any other provision of this agreement not held so invalid, and each such other provision shall, to the full extent consistent with law, continue in full force and effect.

15. **Modification and Waiver.** This agreement may not be modified or amended except by an instrument in writing signed by the parties hereto. No term or condition of this agreement shall be deemed to have been waived, nor shall there be any estoppel against the enforcement of any provision of this agreement, except by written instrument of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than that specifically waived.

16. **Governing Law.** This agreement is made in the state of Louisiana and shall be controlled by the laws of the state of Louisiana in all matters or interpretations of this agreement.

_I accept the appointment outlined above and agree to all rules and regulations of Tulane University and affiliated institutions to which I am assigned. I agree to discharge all the duties of a resident as determined jointly by the affiliated institutions and the respective directors of training programs at Tulane University School of Medicine, and I acknowledge that I have read and understand the Institutional Policies referred to in Paragraph 1._

**ACCEPTED:**

__________________________  _______________________________, M.D.
Date     Resident/Fellow Signature

__________________________  _______________________________, M.D.
Resident/Fellow Printed Name

__________________________  _______________________________, M.D.
Date     Residency/Fellowship Program Director Signature
Residency/Fellowship Program Director Printed Name

Date

Program Department Chair Signature

Program Department Chair Printed Name

Date

Jeffery G. Wiese, M.D.
Associate Dean for Graduate Medical Education
Appendix D: Organizational Chart.
Appendix E: Code Cloud and Code Grey Army Coverage Assignments

### CODE CLOUD - TULANE

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<th>Intern Pre-Call</th>
<th>Faculty On-Call</th>
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<td>b. Intensive Care Medicine</td>
<td>Resident Pre-Call</td>
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### Precautionary Services

- Ophthalmology: Faculty
- Urology: Faculty
- Orthopedics: Faculty
- Otolaryngology: Faculty
- Neurology: Faculty
- Gastroenterology: Faculty
- Internal Medicine: Faculty
- Cardiology: Faculty
- Nephrology: Faculty
- Radiology: Faculty
- Anesthesiology: Faculty

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Appendix F: List of Affiliated Sites

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APPENDIX G: ANNUAL EVALUATION AND SELF-STUDY TEMPLATE

Annual Program Evaluation Template
Academic Year (AY) ______

Use this template for aggregating information from a single year's Annual Program Evaluation. The template is suggested, and you may adapt it in any way you find useful to facilitate program improvement. You may also use attachments or appendices if additional detail is relevant to tracking a given issue.

Program: _______________________________________ Date: _______________

A. Membership: Program Evaluation Committee (Include PGY level for peer-elected residents participating) and a narrative account of the process used to conduct the annual review
   1. 
   2. 
   3. 
   4. 
   5. 
   6. 
   7. 
   8. 
   9. 
   10.

B. Mandatory Source Data to be used in the annual review, and to be provided directly to the GME Office.
   a. Board Pass Rate by resident
   b. In-Service scores by resident
   c. USMLE scores by resident

C. Additional Source Data used in the review of the training program
   Resident of Rotation Evaluations
   Resident of Program Evaluations
   Resident of Faculty Evaluations
   Resident of Institution Evaluations
   Faculty of Program Evaluations
   Duty Hour Reports
Evaluation compliance
ACGME survey data
Internal survey data
Summary results of resident focus groups/retreats
In-service Scores
Board Pass Rate/Scores
Procedure/Case Log Reports
Scholarly activity
Fellowship/Career Placement results
Recruitment/Match results/scores
Other_______________________

D. Program Goals for Improvement from the Previous Year and Interval Progress Reports

1. Goal
   Result

2. Goal
   Result

3. Goal
   Result
E. The Three Areas of Greatest Improvement for the Coming Year. Goals should be operationalized as SMART Goals (Specific, Measurable, Aggressive but Realistic, Time-Limited)

1. Goal
   Narrative description of the action plan

2. Goal
   Narrative description of the action plan

3. Goal
   Narrative description of the action plan

F. Narrative response to all Faculty and Resident ACGME survey responses that were below 80% compliance (identify the source/cause of the fallout, and planned corrective action).

G. A descriptive account of the quality improvement project(s) conducted by the residents over the previous year. Include resident and faculty participants, the topic, source data used to inform the project, and project results.