House Staff

Policies & Procedures

2012 - 2013
# House Staff Policies and Procedures
## 2012 – 2013

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Statement of Commitment to Graduate Medical Education

In accordance with its mission, Stanford University Medical Center is dedicated to pursuing the highest quality of patient care and graduate medical education. Stanford University Medical Center recognizes as one of its major responsibilities the provision of organized educational programs. This responsibility includes guidance and supervision of the resident while facilitating the residents’ professional and personal development and ensuring safe and appropriate care for patients. In fulfilling these responsibilities, the administrations, Hospital Boards, and faculty of Stanford University School of Medicine are committed to supporting quality graduate medical education programs and excellence in residency training and research. Furthermore, Stanford University Medical Center commits itself to providing adequate funding of graduate medical education to ensure support of its faculty, residents, ancillary staff, facilities, and educational resources to achieve this important mission.

Stanford University Medical Center will ensure that all of its graduate medical education programs meet or exceed the Institutional, Common Program Requirements and Specific Specialty Program Requirements, promulgated by the Accreditation Council for Graduate Medical Education.

APPLICATION TO STANFORD RESIDENCY PROGRAMS

Information may be obtained from the individual School of Medicine departments to which the application is made. Completed applications should be sent directly to the residency program being considered.

Note: A reference to “Stanford” or “Stanford University Medical Center” usually means all three programs and entities that make up the Stanford University Medical Center – the Stanford University School of Medicine, Stanford Hospital and Clinics (SHC), and Lucile Packard Children’s Hospital (LPCH). The Stanford residency programs are formally a part of Stanford Hospital and Clinics, with their substantive content and conduct provided through the clinical departments of the School of Medicine, whether in SHC or LPCH.

RESIDENT ELIGIBILITY – RECRUITMENT

Applicants with one of the following qualifications are eligible for consideration for appointment to accredited residency programs:

A. Graduates of medical schools in the United States and Canada accredited by the Liaison Committee on Medical Education (LCME).
B. Graduates of colleges of Osteopathic Medicine in the United States accredited by the American Osteopathic Association (AOA).

C. Graduates of medical schools outside the United States and Canada who meet one of the following qualifications.

1. Have received a current valid certificate from the Educational Commission for Foreign Medical Graduates and an applicant status letter (PTAL) from the Medical Board of California confirming completion of pre-residency requirements.
2. Have a full and unrestricted license to practice medicine in a U.S. licensing jurisdiction.

D. Graduates of medical schools outside the United States who have completed a Fifth Pathway program provided by an LCME-accredited medical school.

Stanford Hospital and Clinics/Lucile Packard Children’s Hospital Visa Policy for Graduates of International Medical Schools

An International Medical School Graduate (IMG) is defined as a graduate of a medical school located outside of the United States. SHC/LPCH supports the use of the clinical (ECFMG sponsored) J-1 Visa for all clinical trainees. Exceptions for individuals with pending green cards or individuals unable to obtain the ECFMG J-1 Visa may be granted by a majority vote by the Graduate Medical Education Committee (GMEC).

Stanford uses J-1 visas sponsored by the Educational Commission for Foreign Medical Graduates. Please see www.ecfmg.org for more information. Please allow 120 days for the processing of a J-1 visa. Stanford does not sponsor graduates of international medical schools on H-1B visas.

Under certain circumstances Graduates of United States medical schools may be eligible for the H-1B visa. This is at the discretion of your program. Approval must be granted by both the program and the Graduate Medical Education Committee. The cost of obtaining the HIB visa is the responsibility of the residency program training the resident.

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1 A Fifth Pathway program is an academic year of supervised clinical education provided by an LCME accredited medical school to students who meet the following conditions: (1) have completed in an accredited college or university in the United States, undergraduate premedical education of the quality acceptable for matriculation in an accredited United Stated medical school, (2) have studied at a medical school outside the United States and Canada but listed in the World Health Organization Directory of Medical Schools; (3) have completed all of the formal requirements of the foreign medical school except internship and/or social service; (4) attained a score satisfactory to the sponsoring medical school on a screening examination; and (5) Steps 1 and 2 of the United States Medical Licensing Examination (USMLE).
NATIONAL RESIDENT MATCHING PROGRAM

Stanford University Medical Center participates in the National Resident Matching Program (NRMP) for all PGY I positions. The purpose of the NRMP is to match all medical students and other applicants with hospitals to obtain internships and residencies. Applicants submit a confidential list to the NRMP ranking their desired place of residency. Participating hospitals also enter a confidential list of most desired applicants. On a uniform date (mid-March) all of the applicants and hospitals are informed of the result of the match.

The NRMP sends rank order list information to the individual programs starting in July of each year. Rank order lists are entered by individual programs into the NRMP system.

Lists are subject to the approval of the Director of the Department of Graduate Medical Education.

The results of the match are delivered to Program Directors on the date specified by the NRMP via email. Programs are not allowed contact with successful applicants until the national announcement of the match has taken place. Programs are expected to submit a recommendation of appointment form via the Stanford web-based program for all matched PGY I applicants to the Department of Graduate Medical Education within 48 hours of the match. The Department of Graduate Medical Education will send employment contracts to all matched house staff within fifteen (15) working days of receiving the recommendation of appointment.

Graduates of medical school programs accredited by the LCME may participate in the match. Foreign medical school graduates who have a valid ECFMG certificate and a California applicant status letter (PTAL) may enroll as independent applicants.

Rank order lists are to remain confidential. Any agreement or contact offered by an enrolled hospital or program prior to the Match Date will be superseded by the results of the NRMP match.

RECOMMENDATION OF APPOINTMENT

Recommendations of appointment for continuing residents are due in the Department of Graduate Medical Education no later than January 1st each year for the following July 1st. It is strongly suggested that departments verify home addresses with their house staff prior to completion of the forms via Med Hub, our online web-based Resident Management program. All recommendations of appointments are subject to review and final approval by the Director of the Department of Graduate Medical Education.

House staff contracts are issued with a copy of House Staff Policies and Procedures attached. House Staff Policies and Procedures are part of the resident contract. All house staff are required to read the Policies and Procedures and then return the contract to the Department of Graduate Medical Education. Contracts are issued for each academic year and are limited to 1 year in duration at a time. All residents must complete all required on-line training modules and provide proof of completion of training.
RECOMMENDATION OF APPOINTMENT CONT.

Incoming residents must complete all required Healthstream and EPIC/LINKS modules by June 15th, 2012.

CONTINUING HOUSESTAFF: must complete all required Healthstream modules by June 1st, 2012 or forfeit their educational benefits. Signed contracts for academic year 2012-2013 need to be returned by June 1st, 2012, to the GME office.

CONTINUING HOUSESTAFF: Mandatory, starting this year, SHC/LPCH continuing Residents & Fellows will have until July 1st, 2012, to be compliant with their medical surveillance. To promote compliance, all Housestaff will be TB tested between the months of March and July. OHS is located on the Ground Floor, Main SHC Hospital, Room H0124. Walk-in appointments are available.

Monday & Wednesday 7:00 a.m. – 3:30 p.m.
Tuesday & Thursday 7:00 a.m. – 6:00 p.m.
Friday 7:00 a.m. – 2:30 p.m.

Failure to complete Healthstream, Returning Contracts or Completion of TB screening, Housestaff will not be able to continue in their residencies after July 1st, 2012.

LEVEL OF APPOINTMENT

A house officer’s appointment is determined in accordance with the level recognized by the specialty board in the residency training program. If you have any questions as to your appropriate level, this should be resolved with your department prior to your acceptance of appointment.

PROGRAM CLOSURE/REDUCTION IN RESIDENT NUMBERS

SHC will make reasonable efforts to complete the training of residents actively enrolled in a residency program in the event of program closure or reductions in resident numbers. In the event the residency cannot be finished, SHC will make a reasonable effort to place the affected resident in another training situation which will allow completion or continuation of the residency training. Before making any reductions in a residency program, SHC will consider the effects of such reductions on its other residency programs and its affiliated institutions. Residents will be informed as soon as possible of any decisions regarding program closure or reduction in size. Such decisions are not reviewable under the Dispute Resolution Procedure.
POLICY ON RESIDENCIES IN CASE OF NATURAL DISASTER

If, because of a disaster, an adequate educational experience cannot be provided for each resident/fellow the sponsoring institution will attempt to:

1. Arrange temporary transfers to other programs/institutions until such time as the residency/fellowship program can provide an adequate educational experience for each of its residents/fellows.

2. Cooperate in and facilitate permanent transfers to other programs/institutions. Programs/institutions will make the keep/transfer decision expeditiously so as to maximize the likelihood that each resident will timely complete the resident year.

3. Inform each transferred resident of the minimum duration of his/her temporary transfer, and continue to keep each resident informed of the minimum duration. If and when a program decides that a temporary transfer will continue to and/or through the end of a residency year, it must so inform each such transferred resident.

The Designated Institutional Official (DIO) will call or email the ACGME Institutional Review Committee Executive Director with information and/or requests for information. Similarly the Program Directors will contact the appropriate Review Committee Executive Director with information and/or requests for information.

Residents should call or email the appropriate Review Committee Executive Director with information and/or requests for information. Within ten days after the declaration of a disaster, the DIO will contact ACGME to discuss due dates that ACGME will establish for the programs.

1. To submit program reconfigurations to ACGME and
2. To inform each program’s residents of resident transfer decisions.

The due dates for submission shall be no later than 30 days after the disaster unless other due dates are approved by ACGME.
REGISTRATION

1. You will receive an email with a link to the online application prior to April 1st, 2012. Please complete the checklist by Friday, May 4th, 2012. We cannot guarantee your June/July start date if your online application is received late. Individuals may not start training without completion of all mandatory on-line modules and completion of all required forms.

2. Please check the GME website (gme.stanford.edu) for your scheduled orientation time.

3. If you are leaving an outside Internship/Residency program and are unable to be at one of the orientations, please contact the Department of Graduate Medical Education at (650-723-5948) as soon as possible or email Ann Dohn (adohn1@stanford.edu).

4. Please bring proof of eligibility of employment (e.g., passport or birth certificate/social security card plus a driver’s license with picture) to orientation along with receipt of the online I-9 registration. We will be unable to employ you without this information.

COMPUTER TRAINING

Residents, Fellows, and Visiting Residents will be required to complete computer training (Healthstream, EPIC, LINKS) in order to participate in educational activities at Stanford Hospital and Clinics and affiliate hospitals. Such training is mandatory and failure to complete required training by the dates specified earlier in this manual may lead to a leave of absence from program without pay.

VISITING RESIDENTS

All visiting residents must be approved by the applicable ACGME program director PRIOR to submission to the Department of Graduate Medical Education.

Visiting residents from ACGME accredited programs who comply with California requirements for medical trainees within the state will be considered for rotation to Stanford residency programs. Residents wishing to spend elective time at Stanford Hospital and Clinics or the Lucile Packard Children’s Hospital should apply directly to the department or division in which the training will take place for consideration. The department/division will obtain a letter of good standing from the program director of the visitor’s residency. The letter will also include an affirmation that the visiting resident’s salary and benefits will be covered in full during the stay at Stanford and documentation of current TB surveillance and immunity to measles, rubella, chickenpox, hepatitis B, a copy of medical school diploma and ECFMG certificate (if applicable) and completion of HIPAA training.
The Stanford program will provide the Department of Graduate Medical Education with a copy of the signed Program Letter of Agreement with the visiting resident parent program. All visiting resident rotations are subject to review and final approval by the Department of Graduate Medical Education.

A copy of the Program Director’s letter will be forwarded to the Department of Graduate Medical Education in room HC435 with an explanation from the Stanford department/division accepting the resident. The visiting resident will report to the Department of Graduate Medical Education prior to the start of the rotation. They should bring a copy of their medical school diploma, photo I.D., a California physician’s license (if applicable) or a license to practice medicine in another state (if available) and proof of HIPAA training. Visiting residents must wear a photo I.D. from their home institution at all times while at Stanford. Registration forms (House Staff Information Form and IT form) must be completed before the start of their rotation. The Department of Graduate Medical Education will arrange for issuance of the physician’s number, and access to the on-call quarters, if needed. All visiting residents are covered under Stanford Hospital and Clinics malpractice insurance.

The Department of Graduate Medical Education will also forward the registration information to Finance in order to qualify for Indirect Medical Education (IME) payments.

Visiting residents from Santa Clara Valley Medical Center and Kaiser, Santa Clara do not need a letter of good standing from their program director.

Effective January 1, 2008, a late fee of $350.00 will be charged to the hosting Stanford Department to cover costs incurred by the Department of Graduate Medical Education. The fee applies only if the application is not complete and not given to GME at least 31 days prior to the start of the rotation.

**PHOTO I.D.’S/SECURITY ACCESS CARD**

Photographic I.D. badges will be issued during the orientation process. You are required to wear your I.D. badge at all times when on duty at Stanford University Medical Center. Under no circumstances may your I.D. badge be loaned to anyone. Your I.D. badge functions as your identification badge & security access card. Upon completion of training you will need to turn in your badge & security access card to the Department of Graduate Medical Education Office. The Security Access Card remains Stanford University Medical Center property at all times and must be returned or relinquished upon request of the GME office.
UNIVERSITY COURTESY CARD & PRIVILEGES TO LIBRARIES

Access to University facilities is authorized by obtaining a University Courtesy Card at the Stanford Card Office @ 275 Panama Street, Forsythe Hall, Room 135, Monday through Friday, 8AM to 5PM. Call 498-2273. Fee for Courtesy Card is $20. To obtain access to Stanford University Libraries, go to the Privileges Desk in Green Library (557 Escondido Mall) in order to be entered into their system. You will become eligible for both physical and online access. Privileges Desk hours are Monday – Thursday, 8AM – 12:55AM and Friday 8AM – 5:55PM. Please bring documentation verifying residency status, such as your hospital photo ID badge.

LICENSURE

CALIFORNIA MEDICAL LICENSE: California law provides that medical school graduates in the first postdoctoral year may practice for that year without a California license, but must register with the Medical Board of California, which is accomplished at orientation.

The law further provides that a resident in the second or subsequent postdoctoral year may be appointed and may practice in an approved hospital, provided that such a resident shall qualify for and take the next succeeding examination for physician’s and surgeon’s certificate, or qualify for such a certificate by one of the other methods specified in the California Business and Professional Code (USMLE or reciprocity with another state). Graduates of international medical schools must complete 2 years of U.S. residency prior to receiving a California medical license.

All eligible house staff must obtain a California physician’s license within two months from the date the house officer becomes eligible for licensure. The resident must immediately (within 2 months of eligibility for licensure) apply for a DEA number. Copies of the license and DEA certificate must be provided to the Department of Graduate Medical Education. Failure to promptly obtain a license and DEA certificate will result in a suspension of training until such time as they are obtained. Unreasonable delay in obtaining a medical license or DEA certificate may result in termination of the resident at the discretion of the Program Director and the Director of GME.

If an individual in the third postdoctoral or subsequent years (following completion of “internship” and one year of residency in the USA or Canada) does not have a valid California medical license, written confirmation will be requested from the Director of Residency Training program of the resident’s department certifying that the resident will have no patient contact until the license is received. Continuation in the program is at the discretion of the Director of Graduate Medical Education. The resident will be placed on leave and may be subject to termination. Salary may be continued only in the amount of vacation time not used. Graduates of international medical schools must be licensed by the first day of their fourth year of training.
LICENSURE CONT.

Those who have completed the first postdoctoral year are urged to seek full licensure as soon as possible. (See California Medical License Fees under Other Benefits). It may take 6 months or longer for the processing of an initial California physician’s license application. We expect all interns to file the application no later than March 1st of their internship year. Applications may be obtained via the Medical Board of California website (www.medbd.gov).

Incoming residents requiring a California MD license to start must show proof that an application has been submitted to the Medical Board of California (MBC) with their registration materials. Please allow 9 months for the MBC to process your application.

PRESCRIPTION AUTHORITY

House staff without California licenses are authorized only to prescribe medications for inpatients (chart orders). Outpatient prescriptions and discharge prescriptions written by house staff without California licenses and DEA numbers must be countersigned by a licensed physician. The California license and DEA number of the licensed physician must appear on all outpatient prescriptions. Residents with California licenses should apply immediately for assignment of a DEA number (www.deadiversion.usdoj.gov).

MANDATORY PROCEDURES

Certain specific requirements in the areas of medical records, employee health, and cardiopulmonary resuscitation must be met by all house officers. The details of these requirements are outlined below. Failure to comply may result in the unpaid suspension of the house officer from training, pending satisfactory completion of any given requirement.

Residents are required to promptly complete medical records (including medical records at affiliates). Failure to do so is grounds for suspension without pay (suspension means you cannot work as a resident until the suspension has been lifted). Any resident who feels that a proposed suspension is unfair should contact the Director, Department of Graduate Medial Education or the Medical Director, Education within 24 hours of the notice to suspend.

1. Medical Records:
   All records are the property of SHC or LPCH. Original medical records shall not be removed from SHC or LPCH. Copies of medical records may be released pursuant to contractual arrangement with affiliated hospital, court order, subpoena or other statutory requirements. The records may be inspected for professional purposes only by members of the Medical Staff, Allied Health Care Staff, and authorized hospital employees. Information from the medical record shall not be disclosed to persons not otherwise authorized to receive this information without written permission of the patient or of the patient’s legally authorized representative.
MANDATORY PROCEDURES CONT.

Medical Records cont.:
All medical record entries and documents which are to be completed by house staff must be completed within the guidelines as stated in the Hospital Rules and Regulations.

HIMS SHC – Chart Completion (650-721-7594 or 650-721-7488)
HIMS SHC -Transcription Front Desk (650-721-7591)
LPCH – Chart Completion (650-497-8605)

The Guidelines for document completion are as follows:
• History & Physical within 24 hours of admission
• Operative Report must be dictated or written immediately but in no case later that 24 hours after surgery or procedure
• Discharge Summary within 7 days of patient discharge
• Signature within 14 days of patient discharge
• Verbal orders must be signed within 48 hours

All entries in the medical record are also to be timed, dated and signed. Please clearly dictate your name and beeper number or dictation number. Errors in documentation should be reported to the chart completion desk at (650) 721-7594.

2. Occupational Health Requirements:
The California Hospital Licensing Regulations require that you obtain a physical examination, drug testing, and tuberculosis screening within one week of the commencement of training. TB screening with the Quantiferon blood test is the preferred TB screening test performed by Occupational Health Services (OHS).

• In order to meet regulatory requirements, annual TB screening is required for all healthcare workers regardless of any previous results
• Persons with a positive result are required to have a chest x-ray and provide documentation of physician consultation regarding the positive result and/or history of treatment or prophylaxis
• All persons will be tested for antibodies against Hepatitis B. If you have not already been vaccinated against hepatitis B, you should begin the three dose series of injections as soon as possible. If you choose to refuse vaccination, you are required to sign a declination form

Occupational Health Requirements Cont.:
• Please provide documentation of positive titers for Rubella, Rubeola and Varicella and mumps. Submit documentation of all previously administered vaccines prior to physical; vaccines will be given to persons requiring vaccines in order to meet proof of immunity requirements.

You may make arrangements for a physical examination and tuberculosis surveillance through Occupational Health Services (650-723-5922).
MANDATORY PROCEDURES CONT.

All work-related injuries, including needle sticks, are to be reported to Occupational Health as soon as possible after injury occurs. If Occupational Health is closed, notify the 1 STIX pager (17849) for any blood or body fluid exposures. Residents with injuries requiring immediate first aid and/or medical care must proceed directly to the Emergency Department.

3. **Training or Demonstrated Proficiency in Cardiopulmonary Resuscitation:**
   All house officers are required to complete (or substantiate the completion of) a course, or demonstrate proficiency in Cardiopulmonary Resuscitation within three months of the commencement of training and at least once every two years thereafter. You can make arrangements with the Life Support Training Center before or shortly after you commence training to ensure that this requirement is completed. The Life Support Training Center Office is located at 1451 S. California Avenue, Palo Alto, CA 94304. For questions call: 650-725-9938 or visit their website at www.cecenter.stanfordhospital.com

INFECTION PREVENTION

1. Perform hand hygiene (waterless alcohol gel or soap and water wash) before and after every patient contact.
2. Do not wear artificial fingernails.
3. Wear personal protective equipment (PPE) for contact with blood/body fluids:
   - GLOVES: non-intact skin, mucus membranes
   - GLOVES & GOWN: large draining wounds;
   - GLOVES, GOWNS, EYEWEAR: intubation, irrigating large wounds.
4. If blood exposure occurs, go to Occupational Health Services (OHS) during the day 7:30 to 3:30, (closed for lunch 12:30 – 1:00PM) Room H0121, located on the ground floor of the hospital, Monday through Friday. On holidays, weekends and off-hours notify OHS via the 1 STIX Pager (17849) to speak with the on-call Occupational Health BBP specialist. Available 24 hours a day 7 days a week.
5. Have immunity to hepatitis B, measles, rubella; know your varicella antibody status; have annual tuberculosis screening.
6. Do not report to work if you have a fever, flu symptoms, or skin lesion drainage. Report to Occupational Health for evaluation and clearance.
7. Report “Reportable Diseases” and conditions to the County Health Department (408) 885-4214 or to Infection Control (Adult, 650-725-1106),(Child, 650-497-8447).
8. Before discharging or transferring a patient with verified or suspected active TB, obtain approval from the county TB Controller. Call Infection Control (Adult, 5-1106)
9. Get fit-tested for N-95 respirator and wear N-95 respirator for all patients with verified or suspect pulmonary TB, H1N1, SARS, and other diseases as required. Fit testing is managed by SHC Risk Management Department. Contact: John Champoux at JChampoux@stanfordmed.org
10. Use single dose/use vial for one use and discard immediately after use; multi-dose vial used in a patient room will be used for the patient only and then discarded,

For SHC, call Infection Control and Epidemiology at (650-725-1106) or pager 16167 (Adult).
NON-SMOKING POLICY

Smoking is not permitted anywhere within Stanford University Medical Center, including private offices and internal patios. This policy applies to all hospital-controlled premises and leased hospital offices, including those within the City of Palo Alto. Violations of the policy by house staff are referred to the Department of Graduate Medical Education to handle in accordance with normal policies. The American Cancer Society Quit for Life program is available for employees at no cost. Employees may contact 1-877-210-7848.

AWAY ELECTIVES

All elective rotations outside of SHC, LPCH, the Palo Alto VA Healthcare System, Kaiser, Santa Clara, and Santa Clara Valley Medical Center must be approved by the GME Director and Medical Director, Education of Stanford Hospital and Clinics at least 60 days prior to the start of the away rotation. If you fail to obtain approval you will not be paid for any time worked on such elective rotation. The appropriate form for away rotations is available in each program office or on our website (www.med.stanford.edu/gme/). You must attach competency based goals and objectives for the away rotation as well as a completed and signed Program Letter of Agreement with the elective site. Please send all requests to the GME Department, at HC435, MC:5207. Residents wishing to rotate outside of the state must obtain malpractice coverage from the institution sponsoring the elective.

HARASSMENT

Any resident subject to unwelcome or threatening verbal or physical conduct, telephone calls, mail or attention from patients, co-workers, or others should notify Ann Dohn, Director, Department of Graduate Medical Education at 723-5948, or Office of the Ombudsperson, Stanford University School of Medicine at 650-723-3682 (David Rasch) for immediate assistance.

Stanford is committed to providing a respectful workplace safe from unlawful discrimination and harassment of any kind. A copy of SHC’s harassment policy is attached hereto as Appendix A. Violations of the harassment policy will lead to appropriate disciplinary action up to and including termination. No reprisals against house staff reporting suspected harassment or discrimination in good faith will be tolerated.
**IMPAIRED PHYSICIANS**

It is imperative that house staff in a position of responsibility, whether this is for patient care or other areas, should not have their performance impaired by drugs, alcohol or other circumstances. For those who recognize that they have such a problem or feel they may be developing a problem or need advice concerning substance abuse, there is a Physician Support Panel which functions on a confidential basis. Members are knowledgeable about the subject and act as physician advocates, offering advice on sources of treatment and other aspects. The 2012-2013 Chairman is Dr. William Berquist. Stanford Hospital and Clinics views this issue with the utmost seriousness, and it is the policy of the institution to ensure that a chemically impaired physician be enrolled in an effective program of therapy. Every reasonable encouragement and support is given for this purpose. **Residents are prohibited from being impaired or under the influence of illegal drugs or alcohol while on duty.**

For access to treatment, house staff has the following options:

- Dr. Berquist, Chairman of the Physicians Support Panel at Stanford University Medical Center, 650-498-5603
- The House Staff Well Being Committee (contact Dr. Janet Spraggins, 650-346-3241)
- United Behavioral Health (1-866-374-6060, PRESS 8, if emergency) **Does not include Kaiser participants.**
- Ann Dohn, Director, Department of Graduate Medical Education (650-723-5948)
- Health Connect (contact Lisa Post, Ph.D, 650-724-1395)
- The Stanford University Help Center - To contact the Help Center, call 650-723-4577. In addition to the Faculty Staff Help Center, you can also use the Value Options EAP - which has the same benefit of 10 free and confidential sessions. They can be reached at 855-281-1601.

**SUPERVISION**

Each residency training program is required to maintain a level of faculty supervision of residents which complies with ACGME requirements. Resident supervision should reflect graduated levels of responsibility based on individual skill and level of training.

Each department shall develop a policy regarding residents who request to participate in patient care provided by non-faculty and non-visiting clinical faculty physicians. This policy will include a provision to assess the educational benefits of the participation.
RESIDENT PHYSICIAN RESPONSIBILITIES, REPORTING
SCHEDULING, PROFESSIONAL FEES, AND REAPPOINTMENT
PROCEDURES

STAFF REPORTING PROCEDURES: The faculty of the Stanford University School of Medicine is responsible for the specific content and conduct of the house staff education and training program. You will report through your Chief Resident to the Director of the Residency Training Program for your program in all matters involving education, training, professional care and patient management.

The faculty is responsible for resident supervision. Medical staff concerns over resident competency in performing procedures or writing orders should be addressed with the attending faculty member of the service involved.

Stanford Hospital and Clinics, through the Medical Director, Education and its Department of Graduate Medical Education, is responsible for the administrative aspects of the educational programs. These include: pay, personnel benefits, legal matters, privileges, procedures concerned with admission and discharge of patients, medical records, consents for treatment, use of pharmacy, laboratories, x-ray and similar matters.

The house staff training programs are accredited by the Accreditation Council for Graduate Medical Education (ACGME).

RESIDENT PHYSICIAN RESPONSIBILITIES: The Hospital supports the delineation of resident responsibilities as outlined in the Essentials of Accredited Residencies in Graduate Medical Education, which appears below:

RESIDENT PHYSICIANS ARE EXPECTED TO:

1. DEVELOP A PERSONAL PROGRAM OF SELF STUDY AND PROFESSIONAL GROWTH WITH GUIDANCE FROM THE FACULTY.
2. PARTICIPATE IN SAFE, EFFECTIVE AND COMPASSIONATE PATIENT CARE UNDER SUPERVISION, COMMENSURATE WITH THEIR LEVEL OF ADVANCEMENT AND RESPONSIBILITY.
3. PARTICIPATE FULLY IN THE EDUCATIONAL AND SCHOLARLY ACTIVITIES OF THEIR PROGRAM AND, ASSUME RESPONSIBILITY FOR TEACHING AND SUPERVISING OTHER RESIDENTS AND STUDENTS.
4. PARTICIPATE IN INSTITUTIONAL PROGRAMS AND ACTIVITIES INVOLVING THE MEDICAL STAFF AND ADHERE TO ESTABLISHED PRACTICES, PROCEDURES, AND POLICIES OF THE INSTITUTIONS.
5. PARTICIPATE IN INSTITUTIONAL COMMITTEES AND COUNCILS, ESPECIALLY THOSE THAT RELATE TO PATIENT CARE ACTIVITIES.
6. DEVELOP AN UNDERSTANDING OF ETHICAL, SOCIOECONOMIC, AND MEDICAL/Legal ISSUES THAT AFFECT GRADUATE MEDICAL EDUCATION AND OF HOW TO APPLY COST CONTAINMENT MEASURES IN THE PROVISION OF PATIENT CARE.
7. COOPERATE WITH ANY REPORTING REQUIREMENTS IN CONNECTION WITH THE NATIONAL PRACTITIONER DATA BANK AND APPLICABLE STATE AND FEDERAL REQUESTS FOR INFORMATION PERTAINING TO STANFORD HOSPITAL AND CLINICS AND ITS AFFILIATES.
8. COMPLY WITH THE ETHICAL STANDARDS OF THE AMERICAN MEDICAL ASSOCIATION.
9. PARTICIPATE IN RISK MANAGEMENT, COMPLIANCE AND QUALITY ASSURANCE/IMPROVEMENT ACTIVITIES.
10. PARTICIPATE IN EVALUATION OF THE QUALITY OF EDUCATION PROVIDED BY THE PROGRAM.

Residents should be aware that federal and state agencies, either directly or through affiliates of SHC, may require information concerning residents (such as social security numbers, dates of hire, training participation dates, and other such data) be provided to the requesting agency or other government unit. SHC will comply with such requests and may also provide this information to an affiliate who requires such information. Residents are expected to comply with such reporting requests if they are directed to the resident.

There may be additional responsibilities and expectations of resident physicians specific to the service to which they are assigned.

**THE COMPLIANCE PROGRAM AND CODE OF CONDUCT**

The Compliance Program is established to guide the Board of Directors and Senior Management for SHC and LPCH in effective implementation of policies and procedures, oversight and monitoring processes, and provide effective communication mechanisms to ensure an ethical culture which incorporates the principles of Trust, Responsibility, Ethics and Excellence (TREE) in the way we conduct our business. As such, the “Tree” serves as the Compliance Program’s logo and symbolizes our values and principles. The Compliance Program and related activities are designed and communicated in a manner consistent with and to support the mission and values principles of SHC and LPCH.

The Compliance Program has an overarching umbrella program which is founded upon the principles delineated in the Code of Conduct. Stemming from the umbrella compliance program are the following sub-programs:

- Privacy Assurance Program
- Hospital and Professional Services Billing Integrity Program
- Emergency Medical Treatment Active Labor Act (EMTALA) Compliance Program
- Hotline Reporting Program
THE COMPLIANCE PROGRAM AND CODE OF CONDUCT CONT.

The Chief Compliance and Privacy Officer reports directly to the Audit and Compliance Committee of the Board of Directors and to the CEO’s of both SHC and LPCH. The following three key fundamentals have been drafted to support the organizational goals of SHC and LPCH.

**Purpose**

“Cultivate Compliance Across SHC and LPCH”

**Mission**

Our efforts will support the values and standards of performance of the organization.

**Vision Statement**

SHC/LPCH Compliance Department is committed to cultivating trust, responsibility, ethics, and excellence to support our organization and the communities we serve.

It is the mission of the Compliance Department to “cultivate compliance” across both organizations and the School of Medicine and it is the responsibility of all SHC and LPCH employees, including House Staff, to complete the on-line training, read the Code of Conduct and actively participate in our Compliance Program. Additionally, workforce members (including Residents) must immediately notify the Privacy and compliance Office of any suspected violation of hospital policy or state or federal law by calling 650-724-2572 or emailing ComplianceOfficer@stanfordmed.org or PrivacyOfficer@stanfordmed.org. Concerns may be reported anonymously by calling the Privacy and Compliance Hotline at 1-800-216-1784. SHC/LPCH will not retaliate against any individual who reports potential violations of laws or hospital policy in good faith.

**HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT**

Congress passed the Health Insurance Portability and Accountability Act (HIPAA) in 1996 and subsequently enacted the Administrative Simplification provisions of HIPAA to regulate and standardize electronic transactions and billing codes and establish standards for privacy and security of individually identifiable health information. SHC, LPCH, and the health care components of Stanford University and Health Plans for the Hospitals and University implemented the privacy standards when they became effective on April 14, 2003 and implemented the security standards in April 2005. These regulations reinforce SHC/LPCH’s commitment to maintaining the confidentiality and security of Protected Health Information (“PHI”).

There are a number of information sources to assist House staff in identifying and protecting PHI. One is the online Compliance Manual which is accessible from the SHC/LPCH intranet where you can access SHC and LPCH policies and procedures. ([http://portal.stanfordmed.org/depts/ComplianceDepartment/pages/compliancePolicyManual.aspx](http://portal.stanfordmed.org/depts/ComplianceDepartment/pages/compliancePolicyManual.aspx))
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT CONT.

For SHC:

All House Staff are expected to strictly comply with all policies of SHC and LPCH, including the privacy and compliance policies and procedures. In addition, House Staff are required to complete HIPAA training on-line before starting clinical rotations at SHC and LPCH. HIPAA training is available on-line through the internet at http://healthstream.com/hlc/stanford.

SHC/LPCH Resources

Chief Compliance Officer – Diane Meyer – 650-724-2572 – dmeyer@stanfordmed.org

IT Security Officer – Michael Mucha – 650-796-7462 – mmucha@stanfordmed.org

SCH/LPCH Compliance Hotline – 800-216-1784

HIPAA Information Hotline – 800-216-1784

1. **Protected Health Information (PHI)** – Individually Identifiable Health Information that is created or received by a health care provider, health plan, employer, or health care clearinghouse, relating to the mental or physical health of the individual, the provision of health care to the individuals, or payment for the provision of health care to the individual. Protected Health Information includes but is not limited to the following identifiers:

   ♦ Names
   ♦ Social Security Numbers
   ♦ All geographic subdivisions smaller than a state, including street address, city, county, precinct, zip code
   ♦ All elements of dates (except for year) that directly relate to an individual, including birth date, admission date, discharge date, date of death and all ages over 89
   ♦ Fax numbers
   ♦ Electronic mail addresses
   ♦ Medical record numbers
   ♦ Health plan beneficiary numbers
   ♦ Account numbers
   ♦ Certificate/license numbers
   ♦ Full face photographic images and any comparable images

The identifiers listed above are a partial listing only. For a complete listing of identifiers, please refer to the HIPAA Definitions policy.
2. **Privacy Standards** – Protect the privacy and confidentiality of Individually Identifiable Health Information and define the patient’s rights as they relate to their Protected Health Information, whether that information is maintained in a paper or electronic record.

3. **Security Standards** – Requirements that health plans, health care providers, and clearinghouses which process health claims must include in their operations to assure that protected health information is secure.

4. **Transactions and Code Sets**
   - **Providers**
     *If Providers choose to use electronic transactions*, they must use the designated standard transaction sets, standard code sets, and unique identifiers, and must abide by the Privacy standards.
   - **Health Plans**
     Health Plans must *have the capability* to accept and send electronic transactions via the designated standard transaction sets, using the standard code sets and unique identifiers. Information transactions between health plans must also follow the standards.

5. **Minimum Necessary Standard** – *Workforce* members of SHC and LPCH must make reasonable efforts to limit their use and disclosure of protected health information (PHI). Requests for PHI from an outside party must be limited to the minimum necessary to accomplish the intended purpose of the use, disclosure, or requests typically require the patient’s consent. Please refer to the HIPAA Policy for more information.

**PHYSICIAN ORDER ENTRY/VERBAL ORDER**

The 4th floor House Staff on-call quarters have computers in each call room that have access to the physician order entry system at SHC. Verbal orders are accepted by nurses from the residents who are sleeping in the on-call area. The person receiving the verbal order is required to read the order back to the physician and document that verification. Verbal orders must be signed within 48 hours.

**DUTY HOURS & PROFESSIONAL ACTIVITIES**

**OUTSIDE PROGRAM**

With respect to working hours both on-site and off-site, all house staff must comply with the rules of the department to which they are assigned and will also comply with any applicable ACGME, State or Federal Regulations setting limitation on work hours. All house staff are required to accurately record their work hours and report their work hours on the MedHub system ([stanford.medhub.com](http://stanford.medhub.com)) and will be disciplined if they fail to do so. Access to MedHub will be emailed to the Resident/Fellow upon completion of Orientation.
Residents can report non-compliance with residency work hours to the Department of Graduate Medical Education, Medical Director, of Education or ACGME. Contact Ann Dohn, Department of Graduate Medical Education at (650-723-5948), if you have any questions about work hours or outside commitments. (gme.stanford.edu/anon_report.html)

All residents must accurately report their work hours on a weekly basis using the MedHub system. Failure to do so may result in disciplinary action including termination from the residency program.

- Requirements for entering hours accurately into existing and future time recording systems weekly.
- The need for Faculty Chairs to observe hours worked by residents to check compliance.
- Details of required Whistle Blower protection arrangements; and
- The need to reference the ACGME website on Procedures Addressing Complaints against Residency Programs.

Professional activities in your off-time hours should be arranged so as not to interfere with your house officer obligations and your ability to benefit from the Graduate Medical Education Program.

**MOONLIGHTING**

Residents must not be required to engage in “moonlighting.” All residents engaged in external moonlighting must be licensed for unsupervised medical practice in California or the state in which the moonlighting occurs. Stanford’s malpractice insurance will not cover residents for moonlighting activities. Residents must obtain written acknowledgement that the program director is aware and approves of any moonlighting activities before any moonlighting activity is undertaken. A copy of the written acknowledgement will be kept in the resident’s file. The program director has the discretion to decline to approve moonlighting activities if he/she believes that such activities will interfere with the resident’s training progress or for other legitimate reasons. All external moonlighting must be logged into MedHub as duty hours.

SHC/LPCH does not allow internal moonlighting by an ACGME trainee. You may have the opportunity to receive extra compensation for “on-call coverage” i.e.: extra shifts within the scope of your training program.

**PAGING SYSTEM**

Upon commencement of your training you will be issued a pager by Stanford Hospital and Clinics. You will be asked to sign a “Responsibility Form” which guarantees return of the pager in the same condition as it was when received, with due consideration for normal wear. Warranty for the pager is for one year. If the pager is lost or stolen you are required to reimburse Stanford Hospital and Clinics for the full replacement value (at the time of replacement). The present cost of a pager is approximately $106 and you may wish to find out if your personal property insurance will cover this, or add a rider if it does not. It is an expectation of all house staff that they keep their pager on and with them and respond promptly to pages when in hospital, on duty or on call.
RESEARCH

Interns, residents, and fellows paid by the hospital are not qualified to participate in clinical research as Principal Investigators. They may participate in clinical research under the direction of a faculty member who is a qualified Principal Investigator as long as the participation is disclosed to the School of Medicine prior to commencement of the research project and the terms and conditions of the intern/resident/fellows grant, tuition reimbursement or stipend do not conflict with the research project requirements.

PERFORMANCE EVALUATION

These policies are generally applicable to all house officer training programs. However, since house officer training programs vary from one department or division to another, some programs may wish to add additional policies of their own. Such policies must be approved by the Graduate Medical Education Review Committee and the Medical Director, Education.

1. Recommendation of Residency Review Committee:

As part of the educational mission of Stanford Hospital and Clinics and the School of Medicine’s residency training programs, each resident’s professional qualifications must be periodically evaluated by his or her department. Residents should be made aware of the results of these evaluations. The following policies are intended to assist the resident and the department or division in the evaluation process.

2. Evaluation Procedures:

Each department shall adopt procedures which provide for regular and timely evaluation and regular verbal and written notification of the evaluation to the resident regarding performance. During the residency, evaluation results should be personally presented to the residents no less than every 6 months. A resident whose performance is less than satisfactory should be notified of the conclusion promptly after such determination is made.

An evaluation file should be maintained for each resident. Information in this file shall be accessible to the resident. Supervisory faculty should submit written evaluations of each resident to the file after each rotation, but not less frequently than quarterly during the PGY I year or semiannually during a house officer’s first year in a program above the PGY I level. The program director should review each resident’s file on a routine basis. If a resident disagrees with statements in a written evaluation in the file, the resident has a right to submit a written response which shall become a part of the file.

Residents will participate in evaluation of the faculty and the training program.
3. Consequences of Satisfactory or Unsatisfactory Evaluation:

Upon receipt of satisfactory evaluations and compliance with all other terms of the House Staff Policies and Procedures, each resident should expect to continue to the level of training agreed upon when the resident was recruited, unless given 4 months notice (if possible) from the department that advancement to the next level of training is not to take place at the anticipated time. Reasons for lack of advancement must be given to the resident both verbally and by written notification. While advance written notice is preferable, an unsatisfactory evaluation may result in a decision adversely affecting the resident at any time and without advance notice, such as probation, non-advancement, non-renewal or immediate termination. In such instance, the resident shall be informed of the reasons for that decision both verbally and by written notification by the program director. The program director of any service to which the house staff member will rotate may be notified of the existence of any current probation or other performance-related issue of which the resident has been apprised.

Unless circumstances warrant immediate termination, residents will typically have an opportunity to remediate unsatisfactory performance. Corrective actions can include: (1) repeating one or more rotations; (2) participation in a special remedial program; (3) academic probation; (4) termination. With respect to academic probation, the program will determine the length of the probationary period, and what the resident must accomplish to be removed from the probation. In general, the probationary period will not extend past the end of the current agreement year, unless the agreement ends within three months, in which case the program has the option of extending the probationary period into the next agreement year, but the extension shall not exceed three months. Any house officer agreement that has been issued by a program for a subsequent training year will be considered invalid and withdrawn until the resident has fulfilled the probationary requirements imposed in the current training year and successfully been removed for probation. At the time the house officer completes a period of probation, the program has the following option’s to: (1) allow the resident to complete the remainder of the training year, (2) reappoint the house officer for the next year, where applicable, (3) not reappoint for the next year, (4) immediately terminate the resident’s contract for the current training year.

If a resident disagrees with an evaluation or an adverse decision based on the evaluation, the resident shall have a right to meet with the cognizant program director or committee making the decision, to hear the reasons for the decision, and to respond to them verbally or in writing. If after such meeting the resident wishes to appeal the adverse decision, the resident may do so through the mechanism for resolution of disputes outlined below. Residents may not appeal a negative performance evaluation, beyond discussions with the cognizant program director or committee, unless the negative evaluation also results in some adverse action such as academic probation or the imposition of a remediation program which may be appealed to Level 2 only.
PERFORMANCE EVALUATION CONT.

Except in cases involving termination, the resident may (in the discretion of the program director in consultation with the Medical Director, Education) be permitted to continue in the residency program pending such appeal. If the resident is permitted to continue in the program, the resident may be assigned to a non-patient care rotation, unpaid leave or observation status.

RESOLUTION OF DISPUTES

The procedures set forth below are designed to provide both house officers and Stanford Hospital and Clinics with an orderly means of resolving differences which may arise between them. It is the desire of Stanford Hospital and Clinics that all disputes or other matters of concern to the house staff be fully considered by medical professionals charged with the responsibility for achieving interprofessional resolution of disputes wherever possible.

I. Informal Discussions:

The interests of Stanford University Medical Center and members of its house staff are best served when problems are resolved as part of regular communications between the house officer and the appropriate Department Chair or Division Chief. House officers are also encouraged to utilize other resources available to aid them in addressing difficulties. The Department of Graduate Medical Education and the Office of the Ombudsperson, Stanford University School of Medicine, may provide useful guidance.

If informal discussion is not successful in resolving disputes the following procedures may be followed to appeal adverse decisions other than negative evaluations. The procedures described are available to all house officers.

II. House Staff Dispute Resolution Procedures:

A. Applicability

A house staff member may use these procedures when it is believed an unfair or improper adverse action has occurred, provided that the action complained of involves a claim of a violation of a Hospital or Department policy which has had a direct and adverse effect upon the house officer.

The procedures are not applicable to claims that Stanford Hospital and Clinics or School of Medicine department policy is inadvisable or unfair generally. House staff suggestions for change of such general rules or policies may be submitted to the Department of Graduate Medical Education.
RESOLUTION OF DISPUTES CONT.

B. Dispute Resolution Levels:

Level 1 – Discussion with Department Head or Division Chief

House officers who feel that they have been improperly subjected to an adverse action and who have been unable to resolve the problem through informal discussion shall submit the matter in writing to the appropriate Department Head or Division Chief for consideration within fifteen (15) days of the occurrence of the action identifying the matter as a formal dispute. The Department Head or Division Chief consulted will respond in writing to the claim by the house officer within fifteen (15) days.

Level 2 – Review by Medical Director, Education

If the dispute is not resolved by these discussions, a house officer who wishes to continue the matter shall file a written statement of dispute with the Medical Director, Education. The statement must describe the matter in dispute, previous attempts at resolution, and the action that the house officer requests be taken. The statement must specify a particular adverse action or inaction taken by the Hospital or School of Medicine and how that adverse action or inaction directly and adversely affects the individual house officer. TO BE COGNIZABLE UNDER THESE PROCEDURES THE STATEMENT MUST BE PRESENTED TO THE MEDICAL DIRECTOR, EDUCATION WITHIN TEN (10) WORKING DAYS AFTER THE DATE OF LEVEL 1 RESPONSE FROM CHAIR OR CHIEF.

The Medical Director, Education or designee shall discuss the dispute with the house officer and the appropriate individual or individuals in the department of division in an effort to resolve the matter. If the matter is not resolved within fifteen (15) days and involves a decision to terminate or, not to advance the house officer, the Medical Director, Education will notify the house officer in writing that the matter has not been resolved and inform the house officer of his or her right to request review pursuant to Level 3 below. If the Medical Director, Education or designee determines that time beyond fifteen days may be required, the house officer shall be notified accordingly. In no event will there be an extension of time beyond thirty (30) additional days after receipt of the written statement of dispute from the house officer.

In all other disputes that remain unresolved after fifteen (15) days, including decisions to place a house officer on probation, the Medical Director, Education or designee will issue a written determination regarding whether the adverse action by the Program was consistent with Policies and Procedures applicable to the Housestaff officer. The determination of the Medical Director, Education or designee will be final in all such Level 2 disputes, except those involving termination or non-advancement which are subject to review and arbitration at Level 3 and Level 4 as described below.

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2 Calendar days are considered to be Monday through Friday exclusive. All time frames established in this section on dispute resolution refer to calendar days only.
RESOLUTION OF DISPUTES CONT.

Level 3 – Review by House Staff Review Committee

If the dispute involves termination or non-advancement, the house officer may request review by a House Staff Review Committee (HRC). The request from the house officer for a HRC review must be made in writing to the Medical Director, Education within fifteen (15) days after issuance of the Level 2 notice from the Medical Director, Education that no resolution has been reached. In the alternative, by mutual agreement, the house office and Medical Director, Education can agree to skip Level 3 and proceed to Level 4 of this procedure.

In each instance the HRC will be appointed by the Medical Director, Education and will consist of one member of the full-time faculty, one senior resident and one member of the Graduate Medical Education Committee who shall chair the committee. No member of the committee will have been involved in any earlier review of the dispute.

A review meeting will be set by the Chair of the HRC within forty-five (45) days of the receipt of the house officer’s request for review by HRC. At least ten (10) days prior to the meeting the house officer will be provided with a written explanation supporting the department or division’s decision to terminate or not advance the house officer. The house officer will have an opportunity at the review meeting to examine the evidence against him or her and to present evidence. A stenographic record of the review meeting will be made.

The affected department or division will appoint a representative from the medical staff to present its information in support of its decision and to present evidence. The house officer may be represented at the review by a physician or surgeon licensed to practice medicine in the State of California, who preferably is a member in good standing of the medical staff at Stanford University Medical Center. Attorneys may not participate in the review meeting. At the discretion of the HRC chair, the meeting may be opened or closed to witnesses, and may run over the course of more than one session or day.

At the review meeting it will be incumbent on the department or division to initially come forward with evidence to support its decision concerning the house officer. Thereafter the burden will shift to the house officer to come forward with evidence to establish the decision was improper. The HRC will evaluate the evidence presented. The decision of the department or division will be upheld unless the HRC finds upon review of the evidence presented that by clear and convincing proof the action of the department or division was arbitrary or capricious.

The HRC shall reach a decision based upon the record produced at the review meeting within thirty (30) days of the final committee session. The written decision will be forwarded to the Medical Director, Education, the affected house office, and the appropriate Department Head or Division Chief. Such decision will be final unless timely appealed to arbitration at Level 4 as described below.
RESOLUTION OF DISPUTES CONT.

Level 4 – Final Binding Arbitration

Either the house officer or the department or division may appeal the HRC’s decision to final and binding arbitration as described in the Arbitration Provision attached hereto as Appendix B. The decision of the arbitrator will be final.

C. Time Frames:

Level 1: Department or Division. House office submits matter in writing for consideration by the cognizant department chair or division chief within fifteen (15) days of adverse action. Chairman or Chief will respond within fifteen (15) days after receipt of the matter. If not resolved:

Level 2: Written statement must be submitted to Medical Director, Education within 10 days of the date of the Level 1 written response from the Chairman or Chief. In all disputes involving matters other than decisions to terminate, not advance or place the house officer on probation, the Medical Director, Education or designee will issue a written determination which will be a final determination. In cases involving a decision to terminate or to not-advance a house officer, if the Medical Director, Education or designee determines that more than fifteen (15) days are required to consider the dispute, they may continue the Level 2 process for a period of time as necessary, but in no event to exceed more than thirty (30) additional days.

Note: Only disputes involving termination or non-advancement may be reviewed at Level 3.

Level 3: Request for review in writing by House Staff Review Committee (HRC) must be submitted in writing to Medical Director, Education within fifteen (15) days after issuance of the Medical Director, Education decision at Level 2, meeting scheduled within 45 days; final decision within 30 days of final HRC session.

Level 4: HRC decision in cases of termination or failure to advance may be appealed to final and binding arbitration in writing within 7 days after issuance of decision at Level 3.

REAPPOINTMENT PROCEDURE

Until completion of the term of residency required by the appropriate specialty board, a house officer who is performing satisfactorily will be offered reappointment to succeeding residency levels, subject to continuing satisfactory performance and conduct, and continuing satisfaction of other terms and conditions of house officer appointments, unless notified in writing AT LEAST (4) MONTHS, IF POSSIBLE, prior to the termination of an existing appointment.
REAPPOINTMENT PROCEDURE CONT.

A resident who is not performing satisfactorily is subject to probation, non-advancement or immediate termination at any time during residency, including during the period after any notice of reappointment.

FEES FOR PROFESSIONAL SERVICES

Patients may not be billed by a house officer for professional services rendered in the course of a house officer’s training program.

BENEFITS

HEALTH, DENTAL, LEGAL, DISABILITY AND LIFE INSURANCE

Graduate Medical Education values and has an institutional commitment to provide, equal employment opportunities for qualified employees with disabilities in accordance with state and federal laws and regulations, including the California Fair Employment and Housing Act (CFEHA), the Americans with Disabilities Act of 1990 (ADA) and Section 504 of the Rehabilitation Act of 1973.

Disability is defined as any physical or mental impairment that limits one or more of an individual’s major life activities (e.g., caring for oneself, walking, seeing, hearing, speaking, breathing, learning, sitting, standing). To ensure equality of access for employees with disabilities, reasonable accommodations and auxiliary aids shall be provided to enable the employee to perform the essential functions of his/her job and to participate in all University programs and activities.

This section contains benefit highlights only and is subject to change. The specific terms of coverage, exclusions and limitations are contained in the plan documents. If there is any conflict between this summary and the plan documents, the plan documents will govern. SHC/LPCH reserves the right to review, change or end any benefit for any reason. A Summary Plan Description (SPD) is available to you through BenefitsConnect at www.healthysteps4u.org. For benefit questions, please contact the HR Business Center for additional information.

Telephone Number: 650-723-4748
Fax Number: 650-618-2551
E-mail Address: www.HR4Uonline.org
**BENEFITS, HEALTH, DENTAL, LEGAL, DISABILITY AND LIFE INSURANCE CONT.**

**DISABILITY POLICY:**

SHC is committed to enhancing employment opportunities for qualified individuals with disabilities. A disability is defined as any physical or mental impairment that limits one or more of an individual’s major life activities (e.g. caring for oneself, walking, seeing, hearing, speaking, breathing, learning, sitting, standing). To ensure equality of access for employees with disabilities, reasonable accommodations will be provided to Housestaff who require accommodation to perform the essential functions of his/her job. Housestaff who require workplace accommodation for a disability should contact their Program Director or the Office of Graduate Medical Education. If you believe you have been discriminated against because of a disability (including a failure to provide workplace accommodation), contact the Office of Graduate Medical Education.

**INITIAL ENROLLMENT:**

When you enroll, you can also choose coverage for your spouse or eligible domestic partner and/or your dependent children. You must enroll within 31 days of your first date of employment; otherwise, the next opportunity to enroll will be during open enrollment period or when you have a qualified life event, which enables you to adjust your health insurance plans and reimbursement account elections.

**EFFECTIVE DATE:**

Your medical benefits go into effect on your date of hire. All other Basic and Elected under the SHC Group Plan such as dental, legal, disability and life insurance go into effect the first day of the month following your hire date. Please refer to your Summary Plan Description Booklet’s through BenefitsConnect via the HealthySteps website [www.healthysteps4u.org](http://www.healthysteps4u.org) for the detailed information.

**OPEN ENROLLMENT PERIOD:**

There is an open enrollment period once each year typically in the fall. During that time, you may add, drop, or change your health insurance plans, enroll in the legal plan and/or add any eligible dependents at that time. Your new coverage becomes effective January 1st, of the following year.

You will receive communication about the benefits open enrollment in the fall. The HR Business Center can answer any questions concerning your coverage.

**HEALTH CARE:**

Preventive Care is covered at 100%.
All medical plans provide 100% coverage for preventive care from in-network providers, with no deductibles or copays. This means you and your family can receive the important preventive care services you need to manage your health, such as routine physical exams and lab tests, all covered at 100% with no out-of-pocket costs.
HEALTH CARE CONT.: 

You have a choice of three Medical plans: Exclusive Provider Organization (EPO), Preferred Provider Organization (PPO) with a Health Savings Account (HAS) or Kaiser Permanente HMO plan. You have two choices for a Dental plan: PPO or HMO plans for which SHC/LPCH pays most of the cost (and in some cases, SHC/LPCH pays all of the coverage); you pay your part through convenient pre-tax payroll deductions. With a choice of programs, you can be sure to find one that is best for you and your family.

Medical coverage also includes prescription, vision and mental health benefits. Please refer to the HealthySteps website at www.healthysteps4u.org for more detailed information (i.e. Overview of the Plans, Medical Plan Comparison Chart, Premiums for your Health Care Contributions, List of eligible preventive generic and formulary brand name drugs covered at 100% for PPO participants only) or you can link out to BenefitsConnect from the HealthySteps website.

Working Spouse/Eligible Domestic Partner Access Fee:

SHC wants to ensure all employees and eligible family members have access to quality health coverage. In the case where a spouse or eligible domestic partner has access to other coverage but decides not to take it and instead joins an SHC plan, we will ask that family to contribute a “spouse/eligible domestic partner access fee”. This is because we are absorbing costs for health care that would have been paid for by the spouse’s employer.

The $50 monthly fee will be collected on a pre-tax basis using payroll deductions; for eligible domestic partners the fee will be collected after taxes.

The fee will apply if you meet all the following criteria:
- Your spouse/eligible domestic partner is employed
- Your spouse/eligible domestic partner is offered health coverage from his/her employer as part of their benefits package
- Your spouse/eligible domestic partner declines that coverage
- You enroll your spouse/eligible domestic partner in a SHC plan
- You earn $27.51 or more per hour as of August 31, 2011, or your date of hire, whichever is later

HEALTH SAVINGS ACCOUNT (HSA):

A Health Savings Account, or “HSA”, is an employee-owned, tax advantage savings and investment account to pay for health care expenses both now and after retirement. The HSA is only available if you enroll in the PPO medical plan.

In 2012, SHC will contribute quarterly to your account – in January, April, July and October, for a total yearly contribution of either $400 or $800. You own the full value of the account. If you terminate employment before the quarterly contribution is made to your account, you forfeit that contribution and no further contributions from SHC will be made.
BENEFITS, HEALTH, DENTAL, LEGAL, DISABILITY AND LIFE INSURANCE CONT.

HEALTH SAVINGS ACCOUNT (HSA) CONT.:

An HSA can be used to pay for your or your eligible dependents health care services before the annual deductible has been met or for your share of the cost of services after the deductible has been met. Any balance in the account can also be used to pay for eligible health expenses in the future.

By law HSA money can only be used by yourself, your spouse and your tax dependents. If your eligible domestic partner meets IRS qualifications to be considered a tax dependent, you can use your HAS funds for his or her medical expenses. If they do not meet this qualification, they are not eligible.

You are eligible to open an HSA if you meet the following criteria:
- You are enrolled in the PPO medical plan
- You cannot be enrolled in Medicare Part A and/or B
- You cannot be covered by another non-high deductible health plan (Note: your dependents can be double covered by your plan and another health plan, as long as you are not)
- You cannot be claimed as a dependent on another individual’s tax return
- You cannot have access to dollars in a flexible spending account (FSA) – such as a spouse FSA – that can pay for medical expenses.

For more information visit or call Health Equity at:
www.healthequity.com/shclpch - Educational Site
www.myhealthequity.com – Members
877-395-6548 – Phone number 24 hours/day

FLEXIBLE SPENDING ACCOUNTS (FSA)

Flexible Spending Accounts allow you to pay for eligible health care and/or dependent daycare expenses with money you earmark for that use. You can set aside up to $3,000 for health care and up to $5,000 for dependent daycare. The money is deducted automatically from your paychecks pre-tax. During the year, you can draw on your reimbursement account(s) to pay yourself back for eligible expenses.

In addition, you will have the ability to pay eligible health care expenses with a debit card that is linked to your reimbursement account balance. You can use your debit card for many purchases without the initial requirement to pay out of pocket and then be reimbursed at a later date. However, using the card does not eliminate the requirement to submit receipts and documentation within 30 days.

WELLNESS INCENTIVE PROGRAM

SHC is committed to your health and wellbeing – personally, financially and in the workplace. That’s why we launched our HealthySteps wellness program. HealthySteps encourages individuals to make informed health decisions and measures the impact of prevention activities.
WELLNESS INCENTIVE PROGRAM CONT.: 

The first step towards your good health is completing the Stanford Health and Lifestyle Assessment (SHALA). This fully confidential health risk assessment will provide an instant personal health report, which includes an outline of your risk for diseases, and suggest behavior targets for improving your health. It’s also a helpful too you can use as a starting point for conversations with your health professional, family members and wellness providers.

If you complete the SHALA before January 31, 2012, you will earn $100 to use for your health expenses in 2012! SHC will automatically deposit your reward into either your Health Savings Account (if enrolled in the PPO) or a Health Incentive Account (if you enrolled in the EPO or HMO) in January or April depending on when you completed the SHALA.

Health Incentive Account (HIA)  
If you enroll in the EPO or Kaiser HMO, your wellness incentive will be deposited into a Health Incentive Account that will be set up for you. You’re free to use this money any time during the year to help pay for your medical expenses. Similar to an FSA, the funds in this account do not roll over at the end of the year, so you must use all your HIA money by 2012.

VOLUNTARY BENEFITS PROGRAM

This program, which is offered through Marsh U.S. Consumer, is designed to provide you access to quality insurance coverage at group discount rates with the convenience of payroll deductions. Voluntary benefits help you meet your personal needs by providing you access to affordable protection for what’s most valuable to you and your family. You may elect to participate in any of the following plans:

- Legal Insurance
- Homeowners/Renters Insurance
- Auto Insurance
- Identify Theft Services
- Online Discount Market place
- Purchase Program
- Pet Insurance

Details about each of these benefits as well as other Employee Discounts can be found at www.shclpchvoluntarybenefits.com or by calling 1-800-689-9314.
BENEFITS, HEALTH, DENTAL, LEGAL, DISABILITY AND LIFE INSURANCE CONT.

LIFE AND ACCIDENT INSURANCE:

We know financial security is important to you and your family. That is why we offer all employees hospital-paid basic life insurance up to $50,000, as well as the optional, employee-paid personal and dependent life and accident insurance.

DISABILITY INSURANCE:

1. State Disability Insurance (SDI). SDI pays approximately 55% of your weekly salary up to a maximum weekly benefit amount of $1011 in 2012. Benefits begin after you have been continuously disabled for 7 calendar days. To be eligible for SDI benefits, you generally must have contributed to the California SDI plan within the last 18 months. Beginning July 1, 2004, State Disability Insurance also provides benefits for “Paid Family Leave” to eligible employees.

2. Long Term Disability Insurance. You receive hospital–paid LTD coverage that pays a benefit of 60% of your base pay.

Stanford Hospital and Clinics Plan pays the premium for a long-term disability (LTD) plan designed to provide you with income protection during your tenure at Stanford Hospital and Clinics and to ensure that you have the ability to purchase specialty-specific LTD coverage when you leave Stanford Hospital and Clinics.

Group coverage while at Stanford Hospital and Clinics pays 60% of your salary to maximum of $3,000 after a period of disability of 90 days. You will be enrolled in the plan automatically at time of hire.

On leaving Stanford Hospital and Clinics, you may continue the group coverage by purchasing it at group rates, and you may also purchase an individual, specialty-specific policy.

Monthly Benefits: 60% of salary to a maximum benefit of $3,000/mo.

Integration: Policy coverage integrates with CA State Disability, Social Security and Workers Compensation.

Elimination: 90 days

Length of Coverage: To age 65 whether disabled by sickness or accident. Includes a 2 year protection of medical student provision.

Conversion Option: Guaranteed conversion to an individual disability policy for up to $3,000 per month upon completion of residency from Stanford.

Company: The Guardian (A++ rated by A.M. Best)
**BENEFITS, HEALTH, DENTAL, LEGAL, DISABILITY AND LIFE INSURANCE CONT.**

**TAX DEFERRED ANNUITY PLAN:**

Stanford Hospital and Clinics provides an opportunity by which you can begin saving a portion of your own earnings through the Tax Deferred Annuity Plan. When participating in this program you can contribute as much as 75% of your salary up to a $17,000 annual limit for 2012 through payroll deduction. There are two companies to choose from and Diversified can provide you with a summary of the programs on their website, including investment choices. You may review the materials and enroll online by going to www.healthysteps4u.org, clicking on the Financial Health ab and linking out to the Diversified website.

**BENEFIT FORMS:**

Forms are available through BenefitsConnect located on the HealthySteps website at www.healthysteps4u.org

**CONTINUATION OF GROUP COVERAGE:**

Our benefit program complies with the federal COBRA law, which requires that companies continue health coverage under certain circumstances. If your health coverage under our benefit plan ends, you may be able to continue health coverage for a certain period of time. See Appendix C for more information about the Group Health Coverage Continuation Rights under COBRA.

**REIMBURSEMENTS:**

**ACADEMIC YEAR PAYMENT:** All residents will receive a one-time $1,000 payment added to a paycheck in July. The funds are designed to cover cell phone charges, mileage, and meals while on duty. The benefit will be subject to the appropriate taxes.

**CALIFORNIA MEDICAL LICENSE FEES:** Stanford interns are eligible for reimbursement of the initial license application fee of $493, if the application is submitted to the GME office for review by March 1st of the internship year. License applications can be notarized in the Department of Graduate Medical Education by setting up an appointment. License application forms can be found on the Medical Board of California’s website (www.medbd.ca.gov).

Stanford residents in their PGY II year are eligible for a partial reimbursement of their CA medical license application fee in the amount of $895, if the medical license is issued before September 1st. Residents that completed their internship at Stanford and were reimbursed the initial licensing fee of $493, will receive an additional reimbursement of $402, provided they meet the September 1st deadline.
REIMBURSEMENTS CONT.

CALIFORNIA MEDICAL LICENSE FEES CONT.: Stanford residents and fellows that will be starting at Stanford as a PGY III or higher are eligible for a partial reimbursement of their CA medical license application fee in the amount of $895, if the medical license was issued after a formal offer letter from Stanford was sent to the individual and before the individual’s start date at Stanford Hospital.

When you receive your license, please bring it by the Department of Graduate Medical Education for verification and arrangements will be made for reimbursement. A Xerox copy of your license will be maintained in the Department of Graduate Medical Education.

CALIFORNIA MEDICAL LICENSE RENEWAL FEES: Effective 9/1/2007 the Department of Graduate Medical Education will reimburse residents/fellows up to $805 towards the renewal fee for their California medical license. To qualify for renewal reimbursement, the residents’ license must expire during the contract year as a SHC resident/fellow. Residents/Fellows will not be reimbursed if the California medical license has been allowed to lapse or become delinquent. To qualify for reimbursement you must bring a copy of the renewed California medical license to the GME Office. It is your responsibility to renew your license in a timely manner.

DEA CERTIFICATES: Effective 9/1/2007 individuals are eligible to receive $551 for the cost of obtaining a DEA certificate. The certificate must be obtained while employed as a SHC resident/fellow. To qualify for DEA renewal reimbursement your certificate must expire during your contract year. A copy of your DEA certificate must be turned in along with the reimbursement form.

EDUCATIONAL AND OTHER BUSINESS RELATED EXPENSE REIMBURSEMENTS: Full-time, active residents will receive an educational benefit of $2,000 on a January, 2013 paycheck, IF ALL HEALTHSTREAM MODULES ARE COMPLETED BY June 1st, 2012. Receipts are no longer required. Funds should be used for educational materials at the discretion of each resident. Note: These funds will be subject to all appropriate taxes.

USMLE Part III: Effective 9/1/2008 individuals at Stanford Hospital and Clinics in the PGY I category are eligible to receive $655 towards the cost of one sitting of the USMLE Part III examination. Individuals should provide a receipt from their money order or cashier’s check to the Department of Graduate Medical Education for reimbursement. (Eligible to receive during your PGY I year at Stanford Hospital and Clinics) Reimbursement must be submitted to the GME office by the end of internship year.
REIMBURSEMENTS CONT.

HOUSING ALLOWANCE: Each resident commencing training in a Stanford house staff program for the first time will be eligible for up to $3,000 in housing allowance. Individuals transferring from the University to Stanford Hospital and Clinics while remaining within residency/fellowship programs are not eligible for the reimbursement. Individuals failing to complete at least six (6) months of internship/residency is expected to re-pay the $3,000 in full. The housing allowance will be added to a paycheck in August. You do not need to apply or save receipts for this benefit.

Note: The $3,000 will be subject to all appropriate taxes. All reimbursements appear on your paycheck.

FAMILY AND MEDICAL LEAVE ACT OF 1993: The FMLA and CFRA (California Family Rights Act) entitlements shall run concurrently with medical leaves with the exception that CFRA and Pregnancy Disability Leave do not run concurrently. The criteria for eligibility are one year of service, and 1250 hours during the 12 months preceding the leave and that the leave entitlement has not been used within the last year.

FMLA will not be provided beyond the end date of a fixed term appointment. See appendix D for a more detailed description of FMLA and CFRA leave.

Reasons for Taking Leave: Unpaid FMLA/CFRA leave will be granted for any of the following reasons:

- The birth of your child, or placement for a child with you through adoption or foster care;
- To care for your spouse, domestic partner, child or parent who has a serious health condition;
- For a serious health condition that makes you unable to perform you job; or
- Leave is for a qualifying exigent circumstance relating to the active duty or deployment of a qualifying service member; or
- Leave is to provide for the care of a family member who is an ill or injured military service member

Certain kinds of paid disability benefits may be used to provide salary replacement during unpaid leave.

Advance Notice and Medical Certification: You may be required to provide advance leave notice and/or medical certification. Taking of leave may be denied until requirements are met.

- Ordinarily you must provide 30 days advance notice when the leave is “foreseeable”.
- SHC requires medical certification to support a request for leave because of a serious health condition, and may require second opinions (at SHC’s expense) and a fitness-for-duty report prior to your return to work.
FAMILY AND MEDICAL LEAVE ACT OF 1993 CONT.:

Job Benefits and Protection:

- For the duration of authorized FMLA/CFRA/PDL leave, SHC will maintain your health coverage under its group health plan for a period not to exceed six months, provided you continue to pay any premiums you were paying prior to the leave.
- Upon return from authorized leave, consistent with applicable law, you will be restored to your original or equivalent positions with equivalent pay, benefits, and other employment terms.
- The use of leave will not result in the loss of any employment benefit that accrued prior to the start of your leave.

PREGNANCY LEAVE: In accordance with California law, a female employee must be granted an unpaid Pregnancy Disability Leave of up to four months if the employee is incapable of performing her job duties because of medical disability resulting from pregnancy, delivery, or post-childbirth recovery, as verified by a physician. In addition, under the California Family Rights Act (CFRA), eligible employees have a right to unpaid family care/baby bonding leave of up to 12 weeks in the 12-month period following the birth, adoption or foster care placement of a child. During these periods of unpaid leave, qualifying medical residents will receive up to 6 weeks pay per annum less any applicable state disability benefits. Failure to file for disability will not result in Stanford paying the disability benefit available from the state. Moreover, ineligibility for state disability benefits will not result in SHC paying the equivalent of the benefit. In addition, the resident has the option of using available personal time off to maintain her salary for an additional three (3) weeks at the end of the paid 6-week period, and in coordination with any applicable state disability benefits. California Pregnancy Disability Leave and any applicable periods of CFRA or FMLA leave run concurrently with the paid periods noted above. See Appendix D for a more detail description of these and other FMLA and CFRA entitlements. Any other arrangement should be negotiated with your department/division and cleared with the Department of Graduate Medical Education. Any pregnant house staff member should notify her Program Director as soon as possible after discovery of pregnancy so that scheduling changes can be made to accommodate any leave. The sick leave policy will apply during the extended period of disability.

The Graduate Medical Education Office must be notified within 24 hours of any leave.
For CA State Disability Forms - http://www.edd.ca.gov/disability

PATERNITY LEAVE: One week with pay (Five days). Additional unpaid time off will be provided in accordance with FMLA & CFRA (see Appendix D for more information regarding these policies).

PERSONAL TIME-OFF: Housestaff do not accrue vacation. House staff is permitted to take up to three weeks of personal time off with pay during each one-year period. Personal time off must be scheduled in advance with the approval of the Director of the Residency Training Program in each department or division. Stanford University Medical Center believes that personal time away from the residency program is important to the welfare of house staff, so unused personal time off does not accumulate from year to year and there is no provision to pay in lieu of time off.
PERSONAL TIME-OFF CONT.

A leave of absence for professional reasons will be considered on a case by case basis. Written consent must be obtained from the Program Director and Medical Director, Education. Continuation of salary is at the discretion of the Medical Director, Education. Benefits, however, will not continue for more than six months.

SICK LEAVE: House officers will not accumulate sick leave credit, and no additional compensation will be paid for unused sick leave. They will be granted 20 days of sick leave (4 weeks) per annum, if needed. Salary will continue, offset by state disability or worker’s compensation benefits.

If a house staff member becomes ill (or is injured) and is unable to continue in the training program, he or she may be eligible for continuance of all salary, to be offset by any Stanford Hospital and Clinics or State Disability Insurance or any Worker’s Compensation payments for which the house staff member may be eligible. Stanford Hospital and Clinics maintains the prerogative in either work-related or non-work-related situations to have a complete physical examination done in order to assess the duration of the stated disability.

In order to qualify for disability benefits under these policies, house officers are responsible for notifying the Department of Graduate Medical Education of any illness lasting more than seven (7) days resulting in hospitalization. Disability forms can be found online at http://www.edd.ca.gov

NOTE: Residents are advised that absences of longer than 4 weeks per year may require additional training in order to comply with board regulations. Please contact your program director for more information. In cases where a leave of absence has been approved by the Department Chair and the Medical Director, Education, residents will be paid in full during the additional weeks of residency required to be board eligible.

MEDICAL MALPRACTICE INSURANCE (TAIL COVERAGE): Professional liability and general liability insurance coverage or self-insurance will be provided for you without charge for patient care related activities that are part of your official duties at Stanford Hospital and Clinics and at any other institutions to which you are assigned during the term of your appointment. Insurance coverage off site is not automatic. The Risk Management Office must be contacted for coverage to be in effect for off campus assignments, volunteer activities or training opportunities.

Stanford Hospital and Clinics currently maintains a program of self-insurance through a licensed captive insurance company, SUMIT. Tail coverage, or coverage that allows for claims to be covered outside the policy year of their occurrence, is provided for individual physicians leaving the Stanford program. Specific information regarding the availability of tail coverage can be obtained from the Risk Management Office.

House staff are cautioned that SUMIT will not cover activities which have not been assigned as part of your Stanford postdoctoral training program, e.g., moonlighting at other institutions.

3 Calendar days are considered to be Monday through Friday exclusive.
MEDICAL MALPRACTICE INSURANCE (TAIL COVERAGE) CONT.

The professional conduct of house officers is a very important element in Stanford University Medical Center’s exposure to medical malpractice claims. Maintaining good rapport with your patients reduces the risk of being sued.

Any patient care complaint against a house officer will be fully investigated by either Risk Management, Quality Management or the Department of Graduate Medical Education. When applicable and appropriate, the resident will be notified of the outcome of the investigation and any action taken. If the resident wished to appeal any decision made in such cases, the resident may go through the mechanism for resolution of disputes described in RESOLUTION OF DISPUTES, above.

Any unusual occurrence or accident involving the care of a patient should be reported immediately using the on-line incident reporting system available at each nursing station. Incidents involving the possibility of serious consequences to a patient, or those situations in which a patient and/or family has threatened legal action or requested compensation, should be reported immediately by you or the Unit/Clinic/Department to the Risk Management department at (650-723-6824) or by paging the on call Risk Manager.

The Risk Management Office investigates adverse events, patient complaints/claims, and lawsuits involving the Hospitals, Clinics and physicians and arranges for assignment of outside defense counsel needed for the defense of these matters. If you are involved in an adverse event, or named in a claim or as a defendant in a suit, you will be contacted by a member of the Risk Management Office who will advise you of your role in the investigation as well as the details of the legal process for the matter in which you are involved.

It is also possible that you may be subpoenaed as a witness in a matter where you were the patient’s treating physician but where they are not suing the hospital or providers for malpractice (for example, an auto accident, where the patient was treated in the emergency room). Should you receive any legal papers please call the Risk Management Office immediately.

For questions regarding certificates and medical malpractice claims history:
https://shcintranet.stanfordmed.org/depts/riskmanagementpages/insurancemanagement.aspx

Acceptance of Documents:
You may be personally served with various legal documents, including summons and complaints (lawsuits) or personal subpoenas which are related to your house staff activities. If you receive such documents, please contact the Risk Management Office (650-723-6824) for advice. Your clinic staff may also contact you directly about accepting such documents. You or your clinic can contact Risk Management about how to handle such documents.

ON-CALL MEALS: Each house officer required to be on call at Stanford hospital overnight (24 hours) will be eligible to receive $12.50 per night in food credit. A bar code behind your security access card will serve as your meal card. Your monthly food credit is automatically entered at the beginning of each month. Please notify the GME office if you obtain a new bar code at anytime or contact Debbie Valdez at 723-5948 (email: dvaldez@stanfordmed.org).

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ON-CALL QUARTERS: Sleep quarters are provided for house officers who are required to take call at Stanford Hospital & Clinics. Residents taking call from home should check with their residency program director regarding any response time requirements. Security access cards are distributed at orientation. To replace a lost security access card notify Security Dispatch in Room H0258C.

All of the sleep rooms are single occupancy. A number of rooms are designated as hotel. They are open to all housestaff needing to sleep. For assistance call the GME office at (650-723-5948), located on the 4th floor of SHC in the “C” wing.

STIPEND DEDUCTIONS

In addition to deductions for such optimal items as spousal dental insurance, the following deductions are required:

INCOME TAX WITHHOLDING: Stanford Hospital and Clinics is required by Internal Revenue Service regulations to withhold income tax on the entire stipend paid to house officers. If you wish to change the number of exemptions for withholding purposes, use the Benefits Office website www.econnect.stanfordmed.org


CALIFORNIA STATE DISABILITY INSURANCE: House officers on the Stanford Hospital and Clinics’ payroll are covered by California State Disability Insurance. The coverage is mandatory under California law and is solely contributory by the covered individual.

MISCELLANEOUS

CHANGE OF ADDRESS: Please keep your address updated in eConnect and in Med Hub (Med Hub contact your coordinator or the GME office). This will ensure that you receive all mailings such as your Contract, Benefits information, Reimbursements and receive your W2 in a timely manner. Log onto: www.econnect.stanfordmed.org

DIRECT DEPOSIT: All residents should use direct deposit for automatic deposit of their paycheck into their personal checking and/or saving account(s). Log into eConnect (www.econnect.stanfordmed.org) to setup or make changes to your account. You are allowed to have up to three accounts at any one time. Direct deposit is the safest way to get your money in your account(s) and prevents lost or stolen live checks. House staff is paid 26 times annually or every other Friday. Direct Deposit receipts are sent to your home address. “Go Green” and waive paper copies of your direct deposit on eConnect.

If you do not sign up for direct deposit you will receive and be paid through the Visa Aline Pay Card. We strongly suggest you sign up for direct deposit asap!
**COMPLETION OF TRAINING**

An appropriate certificate will be issued to each individual upon successful completion of residency. Issuance of the certificate will require the following prior clearance:

- Return of photo ID & Security Access Card
- Return of pager
- Return of lab coats
- Return of access key FOB
- Return of University Access Card
- Medical Records (chart completion)
- Lane Medical Library (return books and journals and clear any fines)
- Operating Rooms (return of locker key, if applicable)
- Department of Graduate Medical Education (delivery of clearance form)

A checkout list must be completed prior to departure. You can print the form from the web (www.med.stanford.edu/gme/).

**RESTRICTIVE COVENANT**

Stanford does not require residents to sign noncompetition guarantees or agreements.

**OMBUDSPERSON’S OFFICE**

The Office of the Ombudsperson’s for Stanford University School of Medicine is available to all residents and fellows. The Ombudsperson is a neutral and confidential resource for assistance with any workplace related issue. Further information about the office is available at www.med.stanford.edu/ombuds or by calling the office at 650/498-5744.

**OMBUDSPERSON:** DAVID RASCH  
**ADDRESS:** Mariposa House  
585 Capistrano Way  
2nd floor, Room 210  
Stanford, CA 94305-8200  

**PHONE:** 723-3682  
**FAX:** 725-7288  
**Email:** rasch@stanford.edu
The Department of Graduate Medical Education is located on the fourth floor of Stanford Hospital and Clinics. Access is via the stairwell located adjacent to the Hospital Gift shop or you can take the escalators by the Gift shop up to the third floor, as you enter the hallway take a right then another right around the corner and on your immediate left is the stairwell. Take the stairwell up to the 4th floor and knock on the door to your left. Office hours are 8:00 a.m. to 5:00 p.m. or by appointment.

The office responsibilities include payroll, verification of training for student loans, employment and licensure. The office is available to assist house officers with questions on physician licensure, housing and general questions on relocating/living in the Palo Alto area.

HOUSE STAFF WELL BEING PANEL

Established in 1983, the panel sponsors Psychiatry Services. Residents and their spouses/significant others may obtain up to 12 hours of free psychiatric counseling through a panel of community psychiatrists and psychologists. For referral to the services contact Janet Spragins, M.D. at 650-346-3241 (from inside the hospital, dial *82 first). Please identify yourself as a Stanford resident or resident’s dependent. This service is entirely confidential. There is no reporting to either the hospital or the department regarding individuals seeking care.

Health Connect, Lisa Post, PhD, (650-724-1395), Clinical Associate Professor and Clinical Psychologist, is Director of this confidential consultation and referral service jointly sponsored by the Department of Psychiatry and Stanford Hospital & Clinics to facilitate timely access to mental health services.
GRADUATE MEDICAL EDUCATION
REVIEW COMMITTEE

The Graduate Medical Education Review Committee was formed in 1989 to coordinate and review all aspects of residency education. It is chaired by the Medical Director, for Graduate Medical Education. The committee is composed of:

- Program Directors who are not Department Chairs
- Department Chairs who are not Program Directors
- 5 resident representatives elected by their peers
- The Associate Chief of Staff for Education at the VA
- The Medical Director, SCVMC
- The Director, Staff Education, Kaiser Northern California Region
- The Medical Director at Children’s Hospital at Stanford
- A University lawyer (ex-officio, non-voting)
- Director, Department of Graduate Medical Education/Designed Institutional Official

All ACGME program information forms and any/all documents must be reviewed and signed by the DIO. In the absence of the DIO the chair of the GMEC can review and sign the documents. Please allow a minimum of 2 weeks for review of all program information forms.

Residents are encouraged to bring issues or topics for discussion to the committee’s monthly meetings.

STANFORD UNIVERSITY PROGRAMS

RESIDENT REPRESENTATION ON THE GRADUATE MEDICAL EDUCATION
REVIEW COMMITTEE

Five resident representatives will be elected by their peers to serve one-year terms on the Graduate Medical Education Committee. Of the five representatives, no more than one resident from each program will serve per year, and at least one representative will be a Chief Resident.

Process: A call for nominations/interest will be sent to all house staff via email in May/June of each academic year. The nominations will be placed on a ballot. Voting will be via email.

WELCH ROAD APARTMENTS

72 apartments located adjacent to Stanford Hospital are available for house staff. They are configured as studios, one and two bedroom units. The application for the Welch Road Apartments is available on the GME Website: www.gme.stanford.edu. If you are interested in applying, print out the application and submit it to the GME Office by May 4th, 2012. (Fax # 650-723-3045) Assignments are made via lottery in early May 7th, 2012. Tenancy is limited to the term of your initial Stanford residency. There is a strict no pet policy.
APPENDIX A

Harassment

SHC Human Resources

Related Policies, Procedures or Guidelines

Code of Conduct and Principles of Compliance

Employment

Termination Procedures

Policy Statement

A basic value of Stanford Hospital and Clinics (SHC) and Lucile Packard Children’s Hospital (LPCH) is the respect for each individual and for individual differences. In keeping with that principle, we are committed to maintaining an environment which is free of harassment or intimidation based on race, creed, color, sex, religion, national origin, age, sexual orientation, physical/mental disability or veteran status. Harassment includes any behavior or conduct that unreasonably interferes with an individual's work performance or creates an intimidating, hostile or offensive work environment. Such behavior is in violation of policy and will not be tolerated. While all forms of harassment are prohibited, this policy also separately emphasizes sexual harassment. The policy defines harassment and explains the procedures for responding to harassing behavior by members of the hospital community.

Questions about this policy should be addressed to the employee's immediate supervisor. Further questions can be addressed to the Risk Management Office.

Definition

A. Harassment (General)
1. Harassment is verbal, visual, or physical conduct that denigrates or shows hostility or aversion toward an individual because of his/her race, creed, color, sex, religion, national origin, age, sexual orientation, physical/mental disability or veteran status, or that of his/her relatives, friends, or associates, and that:

Has the purpose or effect of creating an intimidating, hostile, offensive working environment;
APPENDIX A (CONT.)

Has the purpose or effect of unreasonably interfering with an individual's work performance; or otherwise adversely affects an individual's employment opportunities.

2. Harassing conduct includes, but is not limited to, the following:
   Epithets, slurs, negative stereotyping, or threatening, intimidating or hostile acts that relate to race, creed, color, sex, religion, national origin, age, sexual orientation, physical/mental disability or veteran status; and

   Written or graphic material that denigrates or shows hostility or aversion toward an individual group because of race, creed, color, sex, religion, national origin, physical/mental disability or veteran status and that is placed on walls, bulletin boards, or elsewhere on SHC or LPCH premises, or circulated in the workplace; and

   Retaliation for having reported or threatened to report harassment.

B. Harassment (Sexual)

1. The determination of what constitutes sexual harassment will vary with the particular circumstances. However, in general, unwelcome sexual advances, requests for sexual favors and other verbal, visual or physical conduct of a sexual nature may constitute sexual harassment when:

   Submission to such conduct or rejection of such conduct is used as a basis for employment decisions affecting an individual; or

   Such conduct unreasonably interferes with an individual's work performance or creates an intimidating, hostile or offensive working environment. Examples of conduct which may create an offensive work environment include, but are not limited to, repeated and unwanted sexual advances or requests for sexual favors, displays of sexually suggestive objects, cartoons, or pictures; suggestive or derogatory comments, insults or jokes; gestures or physical contact which are sexual in nature.

2. Prohibited acts of sexual harassment can take a variety of forms ranging from subtle words or actions to physical assault. Sexual harassment can be male to female, female to male, female to female, or male to male. Examples of conduct which may create an offensive work environment include, but are not limited to:

   Verbal conduct such as using epithets, derogatory comments, slurs, or making unwanted sexual advances, invitations, comments or noises:

   Visual conduct such as displaying derogatory posters, photographs, cartoons, drawings, or gestures;

   Unwelcome physical conduct such as touching, blocking normal movement, or interfering with work directed at an individual because of his/her sex;
APPENDIX A (CONT.)

Insinuations, threats and demands of an individual to submit to sexual requests in order to keep his/her job or avoid some other adverse impact on his/her job, and offers of job benefits in return for sexual favors. An adverse impact on an individual's job need not amount to loss of his/her job or a advancement or promotion, assigned duties, shifts or any other condition of employment or career development; and

Retaliation for having reported or threatened to report harassment

Procedure

A. All employees and supervisors should be aware that SHC and LPCH will take appropriate action to prevent and correct any behavior which constitutes harassment or sexual harassment as defined above, and that individuals who are found to be engaged in such behavior are subject to discipline up to and including termination.

B. Each Department Manager has a responsibility to maintain the workplace free of any form of harassment, whether by a manager, supervisor, employee, or other person (including a patient or vendor).

C. Discussing and Reporting Incidents or Problems
   1. We urge anyone who believes he or she had been subjected to discrimination, harassment offensive sexual behavior to immediately contact one of the resources listed in F. below to discuss the situation

   2. All complaints of discrimination, harassment or offensive sexual behavior will be investigated promptly and in an impartial manner by a staff member of Employee/Labor Relations.

   3. Because the subject of sexual harassment may be particularly sensitive to some, you are encouraged to choose the resource you feel most comfortable with in order to resolve the situation as quickly as possible. These discussions will be kept confidential to the extend possible and every reasonable effort shall be made to protect the privacy of all parties. However, please keep in mind that reporting of the situation and cooperation in the inquiry is important in order to prevent it in the future.

   4. In addition, employees may call an Employee/Labor Relations representative on an anonymous basis to explore, discuss or gain clarification about sexual harassment.

D. Investigation
   An Employee/Labor Relations representative will promptly conduct a thorough
APPENDIX A (CONT.)

And objective investigation of the alleged incident, and will make a determination as to whether the harassment occurred, whether it did not occur, or whether the evidence is inconclusive.

1. The investigation will include, but may not be limited to, a meeting or meetings with the individual accused of harassment ("individual accused"), the complaining employee ("complainant"), potential witnesses, including other employees or non-employees who have frequent contact with the individual accused.

2. An Employee/Labor Relations representative will meet with the individual accused and
   a. Inform the individual that an investigation is being conducted;
   b. Summarize the procedure that will be followed in conducting an investigation;
   c. Inform the individual that the hospital will treat the complaint and its investigation confidentially to the extend possible and that it expects the individual accused to do the same; and
   d. Advise the individual of the hospital's strict policy against harassment and retaliation against or intimidation of any individual who has made a complaint or who has cooperated in connection with an underlying harassment charge will not be tolerated.

3. The complainant will be informed:
   a. That he or she should contact any of the available resources identified below immediately if he or she believes that any further violation of this policy against harassment or retaliation occurs, and
   b. That SHC and LPCH will treat the complaint and its investigation confidentially to the extent possible and that it expects the individual accused and the complainant to do the same; and
   c. That intentionally submitting a complaint of sexual or other harassment which contains material false facts may be grounds for disciplinary action, but that no disciplinary action will be taken against an employee who submits a complaint which, although accurate, does not qualify as harassment under the definition contained in this policy. Further, that a finding that a complaint is not supported by the evidence, or is inconclusive, is not in itself evidence that material false facts were made as part of the complaint.

E. Resolution
   1. If it is determined that harassment or retaliation has occurred, prompt and effective measures will be taken to remedy the harassment.
APPENDIX A (CONT.)

2. The Employee Relations representative will inform the complainant of the results of the investigation, and any action that will be taken to remedy the harassment.

3. Any employee, supervisor, or department manager who is found, after appropriate investigation, to have engaged in harassment of another employee will be subject to appropriate disciplinary action, depending on the circumstances, up to and including termination.

F. Available Resources
Your immediate supervisor or the next level supervisor.

Staff member of Employee/Labor Relations (650) 724-0958.

Any member of SHC or LPCH management.

Compliance Office (650) 724-2572

Employee Assistance Program (EAP) 866-248-4094 or at www.liveandworkwell.com (access code: EAP4U)

Author/Original Date July 1999 by Vice President of Human Resources

Gatekeeper Stanford Hospital & Clinics Administrative Manual Coordinator and Editor

Distribution and Training Requirements

1. This policy resides in the Stanford Hospital & Clinics and the LPCH Administrative Manual located in Administration and in each department/unit/clinic.

2. New documents or any revised documents will be distributed to Stanford Hospital & Clinics and LPCH Administrative Manual holders. The department/unit/clinic manager will be responsible for communicating this information to the applicable staff.

Review and Renewal Requirements: This procedure will be reviewed every three years and as required by change of law or practice. Any changes to this procedure must be approved by the same entities or persons who provided initial approval.

Reviewed/Revision History January 22, 2001 by Carol Ann Bergman, Project Manager

Approvals January 2001 by Felix Barthelemy, Vice President of Human Resources
APPENDIX B

AGREEMENT TO ARBITRATE DISPUTES

1. As a condition of appointment as a house officer, each house officer agrees that all disputes relating to or arising out of his/her residency training program and employment with SHC, including the termination of his/her appointment, or the terms of his/her appointment, shall be resolved through final and binding arbitration under the terms and conditions set forth below.

2. In the event that any dispute arises between the house officer and SHC concerning or related to the house officer’s training program and employment with SHC, the house officer and SHC agree to make a good faith effort to resolve such dispute informally pursuant to the Dispute Resolution Procedures contained in these House Staff Policies and Procedures. However, if they are unable to resolve such dispute, either party shall have the right to demand that the dispute be resolved by final and binding arbitration.

3. This arbitration agreement is made pursuant to a transaction involving interstate commerce and shall be governed by the Federal Arbitration Act, 9 U.S.C. ss 1-16.

4. This agreement to arbitrate all disputes includes but is not limited to claims of discrimination, harassment or retaliation under Title VII of the 1964 Civil Rights Act, as amended, the Civil Rights Act of 1991, the California Fair Employment & Housing Act, the Americans with Disabilities Act, the Age Discrimination in Employment Act, the Family and Medical Leave Act, the California Family Rights Act, the California Pregnancy Disability Leave Act, or any other state, federal or municipal statute, rule, regulation or ordinance governing employment-related claims, as well as other claims related to or arising out of the house officer’s training and employment, including claims for wrongful termination, fraud, misrepresentation, defamation, tort, or breach of contract. The only claims not covered by this agreement to arbitrate workplace disputes are claims for unemployment insurance benefits under any state law and claims for workers’ compensation benefits under SHC’s workers’ compensation insurance policy or fund.

5. The parties agree that in order to preserve the status quo pending arbitration, either party reserves the right to seek injunctive or other equitable relief in court where appropriate.

6. Any arbitration under this agreement shall be administered by the Judicial Arbitration and Mediation Services (“JAMS”), conducted by a single, neutral arbitrator mutually selected by the parties and in accordance with the then applicable Rules for the Resolution of Employment Disputes of JAMS. The arbitrator shall have all the powers available to a court of law or equity. The opinion and award shall be final and binding to the fullest extent permitted by law and be enforceable in any court of competent jurisdiction.
7. Each party to the arbitration shall bear his/her own attorney's fees and costs, including witness fees and the cost of exhibits or transcripts. If the house officer initiates arbitration, he/she shall be required to pay an arbitration fee equivalent to the cost of filing a civil complaint in the superior court in the county in which the arbitration will be conducted. SHC shall be responsible to pay all costs that are unique to arbitration as required by law. However, nothing herein shall prevent the arbitrator from awarding fees and costs at the conclusion of the arbitration in accordance with law or contract.

8. THE PARTIES UNDERSTAND AND AGREE THAT UNDER THIS AGREEMENT TO ARBITRATE, SHC AND THE HOUSE OFFICER ARE KNOWINGLY AND VOLUNTARILY WAIVING THEIR RESPECTIVE RIGHTS TO A TRIAL BEFORE A JUDGE AND/OR JURY REGARDING ANY DISPUTE BETWEEN THEM WITHIN THE SCOPE OF THE AGREEMENT.

9. The parties agree that should a court determine that any aspect of this agreement is unconscionable, unenforceable, or otherwise invalid, such provision may be severed so that the remainder of this agreement to arbitrate may be enforced.
APPENDIX C

VERY IMPORTANT NOTICE OF GROUP HEALTH COVERAGE
CONTINUATION RIGHTS UNDER COBRA

Our benefit program complies with the federal COBRA law, which requires that companies continue health coverage under certain circumstances explained in this notice. If you have health coverage under our benefit plan, and if that coverage ends for a reason listed below, you may be able to continue your health coverage for a certain period of time. It is important that you, your covered spouse, and any covered child(ren) over the age of 18 read this notice carefully as it outlines both your rights and your responsibilities under the law.

What is a Qualifying Event?

A qualifying event is an event that causes you or your dependents to lost health benefits. The law defines qualifying events as:

- termination of employment (voluntary or involuntary except for gross misconduct)
- reduction in work hours
- death of employee
- divorce or legal separation
- a child no longer satisfying eligibility requirements of a plan (for example a child no longer qualifying as a dependent because of age or student status).

When Does Continued Coverage Apply?

If you are an employee or the dependent of an employee you may elect up to 18 months of continued health coverage if you lose coverage due to the employee’s:

- termination of employment (voluntary or involuntary except for gross misconduct); or
- reduction in work hours less than the minimum needed to remain covered by the plan.

If you are an employee’s spouse or dependent child, you may elect up to 36 months of continued health coverage if you lose coverage due to:

- death of the employee; or
- divorce or legal separation; or
APPENDIX C (CONT.)

If you are a dependent child, you may elect up to 36 months of continued health coverage if you lose coverage due to:

- No longer satisfying the dependent eligibility requirements of a plan.

If you are a retiree and your employer commences a bankruptcy proceeding, you and your dependents who lose a substantial portion of coverage within one year before or after the bankruptcy filing is also entitled to continuation coverage. Coverage may be continued for the lifetime of retiree, or surviving spouse of a retiree who was deceased at the time of the filing. If the retiree is living at the time of the filing, dependents are entitled to up to 36 months of coverage from the date of the retiree’s death.

What Coverage is Continued?

COBRA continuation rights apply only to health coverage as defined by the law (typically medical, dental, vision, employee assistance programs and health care spending accounts). Other coverages provided by your employee benefit plan are not included in these continuation rights.

Your continued health coverage will be the same as the health coverage provided for similarly situated employees or dependents who have not had a Qualifying Event. Any future plan or rate changes affecting the benefit plans for current employees will affect your continued coverage as well.

Continuation is available only for coverage’s that you or your dependents were enrolled in at the time of the Qualifying Event. However, you may enroll new dependents acquired while you are covered under COBRA in the same manner as similarly situated employees. A child born to or placed under adoption with an employee covered under COBRA is considered a qualified beneficiary, provided the child is enrolled under COBRA, and may have additional COBRA extension rights. The covered employee or family member must notify the plan administrator within 30 days of the birth or adoption, in order to enroll the child on COBRA.

How Long Can Coverage Continue?

There are three potential durations of COBRA coverage, depending on the type of qualifying event.

18 Months: Termination of the employee’s employment or a reduction in the employee’s work hours.

36 Months: Death of the employee, divorce or legal separation of the employee, losing dependent status. In addition, if you become entitled to Medicare and, within 18 months, experience a termination of employment or reduction in hours resulting in a loss of coverage, your covered dependents may elect to continue coverage for the period ending 36 months after the date you became entitled to Medicare.

Extension beyond 18 months: There are three additional circumstances when you can potentially continue COBRA beyond 18 months.
If you or your dependents have a subsequent qualifying event during the initial 18 months of continuation coverage, dependents of the original employee may continue their coverage for up to 36 months total, from the date of the initial qualifying event.

If you or any family member are determined to have been disabled (for Social Security disability purposes) on the date of the original qualifying event (termination of employment or reduction of hours) or within the first 60 days of COBRA coverage, all qualified beneficiaries may extend COBRA coverage for up to 29 months total, from the date of the qualifying event. Non-disabled family members of COBRA coverage may also be eligible for this extension. To receive such an extension, you must notify the plan administrator of your disability determination before the end of the initial 18-month period and within 60 days of the Social Security determination date. If Social Security makes a determination of disability prior to the date of the qualifying event, then you must notify the plan administrator within 60 days of the date of the qualifying event.

The Cal-COBRA extension provides up to 36 months of medical coverage from the date federal COBRA coverage began, provided you were entitled to less than 36 months of federal COBRA, your former employer’s insurance contract is issued in California and you are enrolled in a fully-insured medical plan. The premium charged under this Cal-COBRA extension may be up to 110% of the employer cost. Please contact your medical insurance carrier directly, 30 days prior to the termination date of your federal COBRA coverage, to inquire about the availability of this option.

**When Does Coverage End?**

COBRA coverage can be terminated before the maximum coverage period expires. Continuation coverage will terminate on the earliest of the following dates. In no event can coverage continue beyond 36 months from the original qualifying event date.

a. when no health coverage is provided by your employer for any employees; or  
b. when premium payment for your continued coverage is not made on time; or  
c. after electing COBRA coverage, when you become covered under another group health plan. Exceptions to this rule include if the new group plan contains any exclusion or limitation with respect to any pre-existing condition that applies to you; or  
d. after electing COBRA coverage, when you first become entitled to Medicare; or  
e. after electing COBRA coverage, the date you or your dependent is no longer disabled if you have extended coverage for up to 29 months due to your disability and Social Security has made a final determination that you or your dependent is no longer disabled. (You must notify the plan administrator within 30 days of this Social Security determination).
APPENDIX C (CONT.)

What Does It Cost?

You are required to pay the entire cost of your continued health coverage to the COBRA Representative plus a 2% administration fee. The cost of coverage during the 19th through the 29th month extension period for individuals under the Social Security disability extension may be up to 150% of the total cost.

You have 45 days from the day you elect COBRA to pay all current and retroactive premiums back to the day you lost coverage. Thereafter, you have a grace period of 30 days for regularly scheduled premium payments.

What Do You Have To Do?

In the event of a divorce, legal separation or dependent child who is no longer eligible as a dependent, you or a family member must formally advise your employer of the qualifying event. Such notification must be received on a COBRA Employee Notice of Qualifying Event Form. This form may be obtained in your human resources department.

The form must be received by your employer within 60 days of the date of the Qualifying Event or loss of coverage, whichever is later. No exceptions can be made.

In the event of a termination of employment, reduction of hours or death, you need not take any action to request election materials. You should automatically receive a COBRA Election Kit at your home via the U.S. Postal Service. This COBRA Election Kit will outline coverage costs and options available to you and your dependents. If you wish to elect coverage, you must follow the guidelines detailed in the COBRA Election Kit.

If you decide to elect continued coverage, you must return your Universal Election Form (UEF) to the COBRA Representative within 60 days from the later of:

(a) the date your coverage would terminate due to the Qualifying Event; or
(b) the date on which the COBRA Election Kit is provided.

You then have 45 days to pay all current and retroactive premiums. Your coverage will be retroactively reinstated once the premium(s) and all required re-enrollment forms are received.

Is There Continuation Beyond COBRA?

You may be eligible to continue health coverage beyond COBRA by converting to an individual plan. A conversion privilege must be exercised within 30 days of termination of coverage. Individual conversion plans offer different plan designs at higher costs. The coverage and cost will not be the same as under COBRA.
What About Life Insurance?

Group life insurance benefits are not subject to the COBRA continuation provisions. However, your life insurance policy may offer a conversion privilege. This must be exercised within 30 days following the date of termination. If you wish to exercise this conversion, please refer to your certificate of coverage for specific requirements.

NOTE: Questions regarding continuation of benefits should be referred to our COBRA Administrator, Vita Administration Company, at (650) 966-1492.
APPENDIX D

FAMILY CARE AND MEDICAL LEAVE (CFRA LEAVE)

AND

PREGNANCY DISABILITY LEAVE

Under the California Family Rights Act of 1993 (CFRA), if you have more than 12 months of service with us and have worked at least 1,250 hours in the 12-month period before the date you want to begin your leave, you may have a right to an unpaid family care or medical leave (CFRA leave). This leave may be up to 12 work weeks in a 12-month period for the birth, adoption, or foster care placement of your child or for your own serious health condition or that of your child, parent or spouse. Corresponding federal leave under the Family Medical Leave Act also provides for leave to care for family members who are members of armed services and injured and for exigent circumstances in connection with a family member’s deployment to service or active service. An eligible employee may take up to 12 workweeks of leave during any 12-month period when leave is for a qualifying exigency. When leave is to care for an injured or ill service member, an eligible employee may take up to 26 workweeks of leave during a single 12-month period.

Even if you are not eligible for CFRA leave, if disabled by pregnancy, childbirth or related medical conditions, you are entitled to take a pregnancy disability leave of up to four months, depending on your period (d) of actual disability. If you are CFRA-eligible, you have certain rights to take BOTH a pregnancy disability leave and a CFRA leave for reasons of the birth of your child. Both leaves contain a guarantee of reinstatements to the same or to a comparable position at the end of the leave, subject to any defense allowed under law.

If possible, you must provide at least 30 days advance notice for foreseeable events (such as the expected birth of a child or a planned medical treatment for yourself or of a family member). For events, which are unforeseeable, we need you to notify us, at least verbally as soon as you learn of the need for the leave.

Failure to comply with these notice rights is grounds for, and may result in, deferral of the requested leave until you comply with this notice policy.

We may require certification from your health care provider before allowing you to leave for pregnancy or your own serious health condition or certification from the health care provider of your child, parent, or spouse who has a serious health condition before allowing you a leave to take care of the family member. When medically necessary, leave may be taken on an intermittent or a reduced work schedule.

If you are taking a leave for birth, adoption or foster care placement of a child, the basic minimum duration of the leave is two weeks; however, leave may be granted for less than two weeks on any two occasions. The leave must be taken and conclude within one year of the birth or placement for adoption or foster care.
Taking a family care pregnancy disability leave may impact certain of your benefits and your adjusted hire date. If you want information regarding your eligibility for a leave and/or the impact of the leave on your seniority and benefits, please contact the Benefits Office at (650) 723-4748 or www.HR4Uonline.org.
Appendix E
(Vendor Policy)

Policy and Guidelines for Interactions between the Stanford University School of Medicine, the Stanford Hospital and Clinics, and Lucile Packard Children’s Hospital with the Pharmaceutical, Biotech, Medical Device, and Hospital and Research Equipment and Supplies Industries (“Industry”)

Purpose of Policy:
The purpose of this policy is to establish guidelines for interactions with industry representatives for medical staff, faculty, staff, students, and trainees of the Stanford School of Medicine, Stanford Hospital and Clinics and the Lucile Packard Children’s Hospital. Interactions with industry occur in a variety of contexts, including marketing of new pharmaceutical products, medical devices, and research equipment and supplies onsite, on-site training of newly purchased devices, the development of new devices, educational support of medical students and trainees, and continuing medical education. Faculty and trainees also participate in interactions with industry off campus and in scholarly publications. Many aspects of these interactions are positive and important for promoting the educational, clinical and research missions of the Medical Center. However, these interactions must be ethical and cannot create conflicts of interest that could endanger patient safety, data integrity, the integrity of our education and training programs, or the reputation of either the faculty member or the institution.

Statement of Policy:
It is the policy of the Stanford School of Medicine, Stanford Hospital and Clinics and the Lucile Packard Children’s Hospital that interactions with industry should be conducted so as to avoid or minimize conflicts of interest. When conflicts of interest do arise they must be addressed appropriately, as described herein.

Scope of Policy:
This policy incorporates the following types of interactions with industry. It does not include faculty research and related activities, which are included in the Stanford University Faculty Policy on Conflict of Commitment and Interest (http://www.stanford.edu/dept/DoR/ehh/4-1.html).

I. Gifts and compensation
II. Site access by sales and marketing representatives
III. Provision of scholarships and other educational funds to students and trainees
IV. Support for educational and other professional activities
V. Disclosure of relationships with industry
VI. Training of students, trainees, and staff regarding potential conflict of interest in industry interactions
Appendix E  
(Vendor Policy)  
(Cont.)

I. Gifts and Compensation
A. Personal gifts from industry may not be accepted anywhere at the Stanford School of Medicine, Stanford Hospital and Clinics, the Lucile Packard Children’s Hospital, the Menlo Clinic or off site clinical facilities such as other hospitals at which Stanford faculty practice, outreach clinics and the like.

1. It is strongly advised that no form of personal gift from industry be accepted under any circumstances. Individuals should be aware of other applicable policies, such as the AMA Statement on Gifts to Physicians from Industry (http://www.amaassn.org/ama/pub/category/4001.html) and the Accrediting Council for Continuing Medical Education Standards for Commercial Support (http://www.accme.org/).

B. Individuals may not accept gifts or compensation for listening to a sales talk by an industry representative.

C. Individuals may not accept gifts or compensation for prescribing or changing a patient’s prescription.

D. Individuals must consciously and actively divorce clinical care decisions from any perceived or actual benefits expected from any company. It is unacceptable for patient care decisions to be influenced by the possibility of personal financial gain.

E. Individuals may not accept compensation, including the defraying of costs, for simply attending a CME or other activity or conference (that is, if the individual is not speaking or otherwise actively participating or presenting at the event).

II. Site Access by Sales and Marketing Representatives
A. Sales and marketing representatives are not permitted in any patient care areas except to provide in-service training on devices and other equipment and then only by appointment. (Note: Vendor policies are already in place in the hospitals and will need to be made consonant with this policy.)

B. Sales and marketing representatives are permitted in non-patient care areas by appointment only. Appointments will normally be made for such purposes as:

1. In-service training of Stanford Hospital and Clinic or Lucile Packard Children’s Hospital personnel for research or clinical equipment or devices already purchased.
2. Evaluation of new purchases of equipment, devices, or related items.

C. Appointments to obtain information about new drugs in the formulary will normally be issued by the hospital pharmacy or by Pharmaceutical and Therapeutics Committees.

D. Appointments may be made on a per visit basis or as a standing appointment for a specified period of time, at the discretion of the faculty member, his or her division or department, or designated hospital personnel issuing the invitation and with the approval of appropriate hospital management.

III. Provision of Scholarships and Other Educational Funds to Students and Trainees
A. Industry support of students and trainees should be free of any actual or perceived conflict of interest, must be specifically for the purpose of education and must comply with all of the following provisions:
Appendix E
(Vendor Policy)

1. The School of Medicine department, program or division selects the student or trainee.
2. The funds are provided to the department, program, or division and not directly to student or trainee.
3. The department, program or division has determined that the funded conference or program has educational merit.
4. The recipient is not subject to any implicit or explicit expectation of providing something in return for the support, i.e., a “quid pro quo.”

B. This provision may not apply to national or regional merit-based awards, which are considered on a case-by-case basis.

IV. Support for Educational and Other Professional Activities

A. Individuals should be aware of the ACCME Standards for Commercial Support. They provide useful guidelines for evaluating all forms of industry interaction, both on and off campus and including both Stanford-sponsored and other events. The Standards are appended to this policy and may be found at http://www.accme.org/.

B. All education events sponsored by the Stanford School of Medicine, Stanford Hospital and Clinics or the Lucile Packard Children’s Hospital must be compliant with ACCME Standards for Commercial Support whether or not CME credit is awarded.

C. Meals or other types of food directly funded by industry may not be provided at Stanford School of Medicine, Stanford Hospital and Clinics, the Lucile Packard Children’s Hospital, or the Menlo Clinic.

D. Faculty and medical staff should evaluate very carefully their own participation in meetings and conferences that are fully or partially sponsored or run by industry because of the high potential for perceived or real conflict of interest. This provision does not apply to meetings of professional societies that may receive partial industry support, meetings governed by ACCME Standards, and the like.

E. Individuals who actively participate in meetings and conferences supported in part or in whole by industry (e.g., by giving a lecture, organizing the meeting) should follow these guidelines:

1. Financial support by industry is fully disclosed by the meeting sponsor.
2. The meeting or lecture content is determined by the speaker and not the industrial sponsor.
3. The lecturer is expected to provide a fair and balanced assessment of therapeutic options and to promote objective scientific and educational activities and discourse.
4. The Stanford participant is not required by an industry sponsor to accept advice or services concerning speakers, content, etc., as a condition of the sponsor’s contribution of funds or services.
5. The lecturer makes clear that content reflects individual views and not the views of Stanford School of Medicine, Stanford Hospital and Clinics or the Lucile Packard Children’s Hospital.
6. The use of the Stanford name in non-Stanford event is limited to the identification of the individual by his or her title and affiliation.
Appendix E
(Vendor Policy)
(Cont.)

V. Disclosure of Relationships with Industry
A. Individuals are prohibited from publishing articles under their own names that are written in whole or material part by industry employees.
B. In scholarly publications, individuals must disclose their related financial interests in accordance with the International Committee of Medical Journal Editors (http://www.icmje.org/).
C. Faculty with supervisory responsibilities for students, residents, trainees or staff should ensure that the faculty’s conflict or potential conflict of interest does not affect or appear to affect his or her supervision of the student, resident, trainee, or staff member.
D. Individuals having a direct role making institutional decisions on equipment or drug procurement must disclose to the purchasing unit, prior to making any such decision, any financial interest they or their immediate family have in companies that might substantially benefit from the decision. Such financial interests could include equity ownership, compensated positions on advisory boards, a paid consultancy, or other forms of compensated relationship. They must also disclose any research or educational interest they or their department have that might substantially benefit from the decision. The purchasing unit will decide whether the individual must recuse him/herself from the purchasing decision.

1. This provision excludes indirect ownership such as stock held through mutual funds.
2. The term “immediate family” includes the individual’s spouse or domestic partner or dependent children.
E. For disclosure requirements related to educational activities, see the ACCME Standards for Commercial Support (http://www.accme.org/).

VI. Training of Students, Trainees, and Staff Regarding Potential Conflict of Interest in Interactions with Industry
A. All students, residents, trainees, and staff shall receive training regarding potential conflicts of interest in interactions with industry.
I. PURPOSE

The purpose of this policy is to comply with the requirements in Section 6032 of the Deficit Reduction Act of 2005 (the “DRA”), which amends Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)). Under the DRA, any entity that receives or pays five million dollars ($5,000,000) or more in Medicaid payments each year is required to implement specific policies that provide detailed information about the following: (a) the federal False Claims Act; (b) federal administrative remedies for false claims and statements; (c) the California False Claims Act; (d) the civil or criminal penalties for false claims and statements under the California Act; (e) whistleblower protections under the federal False Claims Act and California law; (f) the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs; and (g) detailed provisions regarding the entity’s policies and procedures for detecting and preventing fraud, waste, and abuse. The information in this policy must also be included in entity’s Employee Handbook. Effective January 1, 2007, the existence of such policies will be a condition for any such entity’s participation in the Medicaid program. In addition, the policy must apply to all of the entity’s employees, including management, and any contractors or agents of the entity. Stanford Hospital and Clinics (“SHC”) is subject to these requirements of the DRA and must adopt policies as described above.

II. DEFINITIONS

A. Under the federal False Claims Act, a “claim” is any request or demand, whether under a contract or otherwise, for money or property which is made to a contractor, grantee, or other recipient if the Government provides any portion of the money or property requested or demanded, or if the Government will reimburse such contractor, grantee or recipient for any portion of the money or property.

B. Under the California False Claims Act, a “claim” is any request or demand for money, property, or services made to any employee, officer, or agent of the state or of any political subdivision, or to any contractor, grantee, or other recipient, whether under contract or not, if any portion of the money, property, or services requested or demanded issued from, or was provided by, the state or by any political subdivision thereof.

C. Under both the federal False Claims Act and the California False Claims Act, “knowing” or knowingly” means that a person, with respect to information, has (1) actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.
D. Under the California False Claims Act, a “political subdivision” includes any city, city and county, county, tax or assessment district, or other legally authorized local governmental entity with jurisdictional boundaries.

E. Under the California False Claims Act, a “person” includes any natural person, corporation, firm, association, organization, partnership, limited liability company, business or trust.

III. POLICY STATEMENT

SHC shall provide this policy to all SHC employees, including management, and any contractors or agents of SHC, to educate them about the federal false claims statute, administrative remedies for false claims and statements under federal law, state laws pertaining to civil or criminal penalties for false claims and statements, whistleblower protections under such laws, and the role of such laws in preventing and detecting fraud, waste and abuse in federal health care programs. SHC shall also include detailed provisions regarding any policies and procedures for detecting and preventing fraud, waste and abuse.

IV. PRINCIPLES

A. OVERVIEW

False claims statutes play an important role in preventing fraud and abuse in government health care programs by enabling the Government to bring civil actions to recover damages and civil penalties when false claims are submitted to the Government. The federal False Claims Act (the “FCA”) prompted many states to implement similar statutes that address fraud and abuse in state and local government programs. Some false claims statutes, including the FCA, also allow certain individuals, usually employees or former employees, to file a qui tam suit against the entity that submitted the false claims.

B. FEDERAL FALSE CLAIMS ACT

1. Background

Generally, the FCA applies to any federally funded program with the exception of tax fraud issues. See 31 U.S.C. § 3729. Under the FCA, any person or entity who knowingly submits or causes to be submitted, a false or fraudulent claim for payment of United States Government funds, is liable for the following: (a) three times the Government’s damages, (b) civil penalties ranging from $5,500 to $11,000 per false claim, and (c) the costs of the civil action to recover the penalty or damages from the false claims. However, the
court may assess a minimum of two times the amount of the Government’s damages in lieu of the full amount of penalties above if all of the following criteria are satisfied:

a. the individual provided the Government all information known to the individual within thirty days after he/she first obtained the information;

b. the individual fully cooperated with any government investigation of the violation; and

c. when the individual furnished the information, there was no criminal prosecution, civil or administrative action with respect to the violation and the individual did not have actual knowledge of an investigation into the violation.

In this situation, the person would still be responsible for the costs of the civil action brought to recover any penalty or damages.

The FCA is also implicated when a person or entity does any of the following:

a. knowingly makes, uses, or causes to be used a false record or statement to get a false or fraudulent claim paid by the Government;

b. conspires to defraud the Government by getting a false claim paid;

c. has possession, custody, or control of property or money to be used by the Government, and intending to defraud or willfully conceal the property, delivers less property than the amount for which the person receives a receipt;

d. certifies receipt of property on a document without completely knowing whether the information on the receipt is true;

e. knowingly buys government property from an unauthorized officer or employee of the Government; or

f. knowingly makes, uses, or causes to be used or made, a false record or statement to avoid, conceal, or decrease an obligation to pay or transmit money or property to the Government.
When the Attorney General has reason to believe that a person (or entity) may have material or information related to a false claims investigation, he/she can initiate an investigation. The Attorney General can issue a civil investigative demand, which requires the person (who is the subject of the investigation) to do any of the following: (a) produce the relevant materials for inspection and copying, (b) answer written questions, (c) provide oral testimony regarding the information; or (d) furnish any combination of the information described in (a), (b) and (c). See 31 U.S.C. § 3733.

2. **Qui Tam Suits.**

The “qui tam” provision, more commonly referred to as the whistleblower provision, permits a private person, (the “relator”, also known as a “whistleblower”), to bring a civil action on behalf of the Government, when he or she has information that the defendant knowingly submitted, or caused to be submitted, to the Government false or fraudulent claims. The purpose of a qui tam suit is to recover the funds received as a result of the false claims. If the suit is successful, the relator may receive a percentage of the funds recovered.

Generally, filing a qui tam suit and participating in the corresponding court procedure is a complicated process with many specific requirements. Initially, the relator must provide a copy of the complaint and written disclosure of substantially all material evidence and information in his or her possession to the Government. Once the qui tam suit is filed, the suit remains under seal for a minimum of sixty days, during which time the Department of Justice decides whether to intervene in the relator’s suit.

If the Government joins the suit, the relator may receive between fifteen and twenty-five percent of the proceeds of the action or settlement of the claim, depending upon the extent to which the relator substantially contributed to the prosecution of the action. If the Government declines to intervene in the suit, the relator can proceed on behalf of the Government. Although the Government is not an actual party to the case when the relator proceeds independently, the Government is still entitled to any recovery obtained from the relator’s suit. Generally, the relator may receive between twenty-five and thirty percent of the proceeds, depending
upon what amount the court determines is reasonable for collecting the civil penalty and damages.

There are two limitations on the relator’s recovery of proceeds:

a. regardless of whether the Government participates in the action, if the relator planned and initiated the false claims violation, the court may reduce the relator’s share of the proceeds based on his/her role in advancing the case to litigation and other relevant circumstances; and

b. if the relator is convicted of criminal conduct related to his/her role in the false claims, the relator will be dismissed from the civil action without receiving any portion of the proceeds. See 31 U.S.C. § 3730.

In addition, the FCA has a statute of limitations that restricts the period of time during which a person can file a qui tam action. A civil action under the FCA must be filed (a) within six years from the date of the false claims violation, or (b) within three years of when the Government knows, or reasonably should have known, about facts material to the illegal conduct, but in no event more than ten years after the violation occurred, whichever occurs last. See 31 U.S.C. § 3731.

3. **Whistleblower Protections**

   Under the FCA, a relator/whistleblower is protected from retaliation by his or her employer when he or she files a qui tam case. Any employee who is discharged, demoted, suspended, threatened, harassed, or discriminated against in his or her employment as a result of the employee’s lawful acts in furtherance of a false claims action, including, initiation of, investigation for, testimony for, or assistance in an action filed or to be filed, is entitled to all relief necessary to make the employee whole. The employee may bring an action based on the employer’s retaliation in the appropriate federal district court. If the action is successful, the employee/whistleblower is entitled to:

   a. reinstatement with the same seniority status the employee would have had without the discrimination,
   b. two times the amount of back pay,
   c. interest on the back pay, and
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d. compensation for any special damages incurred as a result of the discrimination, including litigation costs and reasonable attorneys’ fees. See 31 U.S.C. § 3730(h).

C. ADMINISTRATIVE REMEDIES FOR FALSE CLAIMS AND STATEMENTS

The Program Fraud Civil Remedies Act of 1986 (the “PFCRA”) is similar to the FCA and sets forth the administrative remedies for false claims and statements. A person violates the PFCRA by making, presenting or submitting (or causes to be made, presented or submitted), a claim that he or she knows, or has reason to know, is one of the following:

1. false, fraudulent, or fictitious (collectively, “false”);
2. for payment for the provision of property or services that the person did not provide as claimed; or
3. includes or is supported by a written statement that either:
   a. asserts a material fact that is false, or
   b. omits a material fact, is false as a result of the omission, and is a statement in which the person making, presenting or submitting such statement has a duty to include such material fact.

A violation of this section of the PFCRA results in a maximum civil penalty of $5,000 for each claim and an assessment of up to twice the amount of each claim (or the relevant portion of the claim.) However, an assessment will not be made on claims that the Government has not paid.

A person also violates the PFCRA by submitting a written statement that he/she knows or has reason to know:
1. (a) asserts a material fact that is false, or (b) omits a material fact, is false as a result of the omission, and the person has a duty to include the material fact in the statement; and
2. includes or is accompanied by an express certification of affirmation of the truthfulness and accuracy of the statement’s contents.

A person is subject to a maximum civil penalty of $5,000 for each statement that violates this section of the PFCRA. See 31 U.S.C. § 3802.

D. CALIFORNIA FALSE CLAIMS ACT

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1. **Criminal/Civil Penalties**

Under the California False Claims Act (the “CFCA”), any person or entity who knowingly presents, or causes to be presented, a false claim for payment or approval to an officer or employee of the state, or of any political subdivision of the state (hereinafter, the “state”), or knowingly makes, uses, or causes to be made or used a false record or statement to get a false claim paid or approved by the state, is liable for (a) three times the amount of the damages to the state, and (b) the costs of the civil action to recover the penalties or damages. In addition to the penalties above, the person or entity may be liable to the state for civil penalties of up to $10,000 for each false claim. See Ca Govt. Code § 12651(a).

The other actions that result in civil and criminal penalties under the CFCA mirror those of the federal FCA (described above in Section D(1)); however, the CFCA has an additional component under which a person or entity may be liable if (a) he or she is a beneficiary of an inadvertent submission of a false claim to the state, (b) subsequently discovers the falsity of the claim, and (c) fails to disclose the false claim to the state within a reasonable time after discovery of the claim.

A person who violates the CFCA may be liable for a lesser amount, (between two and three times the amount of the state’s damages and no civil penalty), if the court makes the following findings: (a) the person committing the violation provided the state with all information known about the violation within 30 days of when the person first obtained the information; and (b) the person fully cooperated with any state investigation; and (c) when the person furnished the state with information, no criminal prosecution, civil action, or administrative action had commenced with respect to the violation, and the person did not have actual knowledge of an investigation into the violation. See Ca Govt. Code § 12651(b).

The CFCA does not apply to a controversy involving less than $500 in value, nor does it apply to claims involving workers’ compensation, claims against public entities and employees, or claims, records or statements made under the Revenue and Taxation Code. See Ca Govt. Code § 12651.
A civil action under the CFCA must be filed within three years from the date of the state’s discovery of the violation, or within ten years after the date the violation occurred. However, unlike the federal FCA, the CFCA can be applied retroactively if the limitations period has not lapsed. See Ca Govt. Code § 12654.

2. **Qui Tam Suits**

Under the CFCA, a person (the “qui tam plaintiff”) may bring an action for a false claims violation on behalf of either the state or a political subdivision, depending on which funds are involved. Similar to the federal FCA, the complaint may remain under seal for sixty days until the Attorney General decides whether to intervene in the action. On the day the complaint is filed, the qui tam plaintiff must provide (by mail, return receipt requested) to the Attorney General a copy of the complaint and written disclosure of substantially all material evidence and information that the qui tam plaintiff has. Within sixty days of receipt of the complaint and written disclosure, the Attorney General may intervene in the action if the alleged violations involve state funds. See Ca Govt. Code § 12652(e).

Under the CFCA, a qui tam plaintiff is entitled to a greater share of the proceeds from a false claims action than under the federal FCA. If the state proceeds with the action, the qui tam plaintiff receives between fifteen and thirty-three percent of the proceeds of the action or settlement of the claim, depending upon the extent to which the qui tam plaintiff substantially contributed to the prosecution of the action. When the state declines to intervene, the qui tam plaintiff is entitled an amount that the court determines is reasonable for collecting the civil penalty and damages on the Government’s behalf, which is at least twenty-five percent, but not more than fifty percent, of the proceeds.
In the event the qui tam plaintiff actively participated in the fraudulent activity, he or she is not guaranteed any minimum amount of recovery from the proceeds. The court considers the significance of the information, the qui tam plaintiff’s role in moving the case to litigation, the scope of the employee’s past or present involvement in the fraudulent activity, the employee’s attempts to avoid or resist the activity, and any other circumstances surrounding the activity. If the court does allow recovery to the qui tam plaintiff, the amount may not exceed thirty-three percent of the proceeds if the state intervened or fifty percent if the state did not intervene. See Ca Govt. Code § 12652(g).

3. **Whistleblower Protections**
Under the CFCA, an employer is prohibited from making, adopting, or enforcing any rule, regulation or policy that prevents employees from disclosing information to a government/law enforcement agency or from acting in furtherance of a false claims action, including investigating, initiating, testifying, or assisting in an action filed under the CFCA. In addition, an employer may not discharge, demote, suspend, threaten, harass, deny promotion to, or discriminate against an employee in his/her employment because of the employee’s lawful actions to further a false claims action. An employer that violates this section is liable for all relief necessary to make the employee whole which includes the following:

a. reinstatement of the employee with the same seniority status that he or she would have had without the discrimination;
b. two times the amount of back pay;
c. interest on the back pay;
d. compensation for any special damages incurred as a result of the discrimination;
e. litigation costs and reasonable attorneys’ fees; and
f. punitive damages where appropriate, (a remedy that is not provided under the federal FCA.)

When the employee is discharged, demoted, suspended, harassed, denied promotion or discriminated against by his or her employer because of the employee’s participation in conduct that directly or indirectly resulted the submission of a false claim to the state, the employee is entitled the remedies above, only if: (a) the employee
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All Departments

voluntarily disclosed information to the Government or acted in furtherance of a false claims action; and (b) the employee was harassed, threatened with termination or demotion, or coerced by the employer or its management to engage in the fraudulent activity. See Ca Govt. Code § 12653.

V. PROCEDURES

A. SHC shall establish a procedure for implementing this policy. Accordingly, SHC shall be responsible for the following:

1. Ensuring that all SHC employees, including management, and any contractors or agents of SHC, are provided with this policy by making the policy available on the SHC Intranet effective January 1, 2007 and including the policy in the SHC Employee Handbook and/or code of conduct, as appropriate.

2. Implementing training for all SHC employees, management, contractors, and agents regarding the state and federal laws discussed in this policy (including whistleblower protections for employees) and any SHC policies and procedures for detecting and preventing fraud, waste, and abuse.

3. Confirming that all SHC employee, management, contractor and agents received sufficient training regarding this policy and any SHC policies and procedures for detecting and preventing fraud, waste and abuse.

4. Revising this policy when necessary to comply with changes in the laws or regulations and documenting and implementing any such changes.

5. Ensuring that all SHC employees, management, contractors, and agents have access to SHC policies involving the detection and prevention of fraud, waste, and abuse.

VI. PROCEDURES

A. SHC shall establish a procedure for implementing this policy. Accordingly, SHC shall be responsible for the following:
This policy applies to:
☑ Stanford Hospital and Clinics
☐ Lucile Packard Children’s Hospital

Last Approval Date:
May 2008

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1. A copy of this policy will be posted in the SHC Employee Handbook and on the SHC Intranet and referenced in the Code of Conduct training.

2. A copy of the policy will be distributed to employees, agents, and contractors in accordance with the requirements of the DRA.

3. SHC employees, agents, and contractors are aware of their responsibility to report potential or suspected incidents of fraud and/or abuse, and other wrongdoing directly to their supervisor or use one of the reporting methods described in the SHC/LPCH Code of Conduct.

4. The Chief Compliance and Privacy Officer or the Executive Director of Internal Audit, in consultation with the Office of General Counsel, is responsible for receiving and acting upon all information suggesting the existence of possible fraud, abuse, or other wrongdoing; and for directing all investigations arising from this information.

5. This policy will be revised when necessary to comply with changes in the laws or regulations and any such changes will be documented and implemented.

VII. RELATED DOCUMENTS

A. SHC/LPCH Code of Conduct
B. SHC/LPCH Employee Handbook

VIII. DOCUMENT INFORMATION

A. Legal Authority/References
   1. Ca Govt. Code § 12650-12656
   2. 31 U.S.C. § 3801-3812
   3. 31 U.S.C. § 3729-3733

B. Author/Original Date
   November 2006, Erin Leigh, Office of the General Counsel

C. Gatekeeper of Original Document
   Stanford Hospital and Clinics Human Resources Compliance Officer

D. Distribution and Training Requirements
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1. This policy resides on the Intranet of Stanford Hospital and Clinics
2. New versions of the policy will be posted on the Intranet and communicated to applicable staff.

E. Review and Renewal Requirements
   This policy will be reviewed every three (3) years and/or as required by change of law or practice.

F. Review and Revision History
   This is a new policy March 2007.
   Revised May 2008 by Erin Leigh, Office of the General Counsel

G. Approvals
   November 2006, Sarah DiBoise, Chief Hospital Counsel
   November 2006, Lori Curry, Vice President of Human Resources
   September 2008 by Lori Curry, Vice President of Human Resources – SHC

This document is intended for use by staff of Stanford Hospital & Clinics and/or Lucile Packard Children’s Hospital.

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I. PURPOSE

The purpose of this policy is to define under which conditions, residents and fellows may be paid extra funds for services within and without their training program at SHC and LPCH. The policy is written to ensure compliance with the Accreditation Council for Graduate Medical Education (ACGME) work hours regulations, maximize patient safety and address possible resident fatigue.

II. POLICY

This policy covers three subjects:

A. The conditions under which SHC or LPCH may pay ACGME residents and fellows extra funds for duties within the scope of their training (“On-Call Coverage”) at SHC or LPCH. FOR PURPOSES OF THIS POLICY, INDIVIDUALS PROVIDING THESE SERVICES WILL BE REFERRED TO AS “ACGME ON-CALL COVERAGE PROVIDERS”.

B. The conditions under which SHC or LPCH may pay Non-ACGME trainees extra funds for duties within the scope of their training (“On-Call Coverage”) at SHC or LPCH. FOR PURPOSES OF THIS POLICY, INDIVIDUALS PROVIDING THESE SERVICES WILL BE REFERRED TO AS “NON-ACGME ON-CALL COVERAGE PROVIDERS”.

C. The conditions under which SHC or LPCH may pay Non-ACGME trainees extra funds for duties outside of the scope of their training (“Moonlighting Services”) at SHC or LPCH. FOR PURPOSES OF THIS POLICY, INDIVIDUALS PROVIDING THESE SERVICES WILL BE REFERRED TO AS “NON-ACGME MOONLIGHTING PROVIDERS”.

IT IS NOT PERMISSIBLE FOR ANY OF THE INDIVIDUALS DESCRIBED ABOVE TO PROVIDE MOONLIGHTING SERVICES AS AN ATTENDING PHYSICIAN IF THE PHYSICIAN’S SERVICES ARE WITHIN THE SCOPE OF HIS/HER FELLOWSHIP.

ACGME RESIDENTS/FELLOWS MAY NOT PROVIDE MOONLIGHTING SERVICES AT OR ON BEHALF OF SHC OR LPCH BUT MAY PROVIDE ON-CALL COVERAGE AT SHC OR LPCH.

III. DEFINITIONS

Resident: A physician at any level of GME in a program accredited by the ACGME. Participants in accredited subspecialty programs are specifically included.

Fellow: A physician enrolled in a fellowship program approved by the ACGME. Also included in this group are fellowships approved by the American Board of Medical Specialties, e.g. Reproductive Endocrinology, Gynecologic Oncology, and Maternal-Fetal Medicine.
IV. PROCEDURES

A. REQUIREMENTS FOR ACGME ON-CALL COVERAGE PROVIDERS

1. Time spent by ACGME On-Call Coverage Providers must be recorded in MedHub and clearly marked as “On-Call Coverage” in the comments section of the duty hours reporting system. These hours are subject to the ACGME 80 hour work week limits as are all research and clinical hours.
2. Programs must obtain approval from Stanford’s Graduate Medical Education Review Committee prior to engaging ACGME On-Call Coverage Providers.
3. ACGME On-Call Coverage Provider supervision must be at the same level as the regular training program.
4. ACGME On-Call Coverage Providers may not provide attending teaching physician supervision.
5. ACGME On-Call Coverage Providers may not bill for services performed. Attending physicians may bill for professional services that they personally perform while they are supervising ACGME On-Call Coverage Providers, if the teaching physician guidelines are met.
6. On-Call Services must be within the general scope of the training program of the ACGME On-Call Coverage Provider.
7. ACGME On-Call Coverage Providers on J-1 visas must have approval from ECFMG (“Education Commission for Foreign Medical Graduates”) to receive On-Call Coverage payments.
8. Time spent by ACGME On-Call Coverage Providers is includable in the SHC or LPCH Medicare cost report, so no exclusion of such hours from the FTE count is required.
9. House Staff contracts state the residents/fellows may have the opportunity to perform on-call coverage for extra money.
   a. Program Director will determine the fair market value payment after conducting appropriate analysis and submit it to the GMEC for approval.
   b. Payments will be processed by individual departments, approved by the GME office and paid via SHC payroll (for ACGME On-Call Coverage Providers who are SHC employees).

B. REQUIREMENTS FOR NON-ACGME ON-CALL COVERAGE PROVIDERS

1. Time spent by non-ACGME On-Call Coverage Providers must be recorded in MedHub and clearly marked as “On-Call Coverage” in the comments section of the duty hours reporting system. These hours are subject to the ACGME 80 hour work week limits as are all research and clinical hours.
This policy applies to:
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- Lucile Packard Children’s Hospital

| Date Written or Last Revision: | February 24, 2009 |
| Name of Policy: | Payment for extra services by residents and fellows |
| Policy Number: | 7.01.01 |
| Departments Affected: | All Departments |

2. Programs must obtain approval from Stanford’s Graduate Medical Education Review Committee prior to engaging Non-ACGME On-Call Coverage Providers.

3. Non-ACGME On-Call Coverage Provider supervision must be at the same level as the regular training program.

4. Non-ACGME On-Call Coverage Providers may not provide attending teaching physician supervision.

5. Non-ACGME On-Call Coverage Providers may not bill for services performed. Attending physicians may bill for professional services that they personally perform while they are supervising Non-ACGME On-Call Coverage Providers, if the teaching physician guidelines are met.

6. On-Call Services must be within the general scope of the training program of the Non-ACGME On-Call Coverage Provider.

7. Non-ACGME On-Call Coverage Providers on J-1 visas must have approval from ECFMG (“Education Commission for Foreign Medical Graduates”) to receive On-Call Coverage payments.

8. Written agreements must be signed and in place with SHC or LPCH for each Non-ACGME On-Call Coverage Provider, before any services are performed and before any payment is made for such services.

   a. Program Director will determine the fair market value payment after conducting appropriate analysis and submit it to the GMEC for approval.
   b. Payments will be processed by individual departments, approved by the GME Office, and paid via SHC payroll (for Non-ACGME On-Call Coverage Providers who are SHC employees) or SHC Accounts Payable (for Non-ACGME On-Call Coverage Providers who are University employees.)

C. REQUIREMENTS FOR NON-ACGME MOONLIGHTING PROVIDERS

1. Programs must obtain approval from Stanford’s Graduate Medical Education Review Committee prior to engaging Non-ACGME Moonlighting Providers.

2. Non-ACGME Moonlighting Providers must have a valid CA MD license.

3. Persons holding J-1 visas are prohibited from being Non-ACGME Moonlighting Providers.

4. Non-ACGME Moonlighting Providers must have the appropriate Clinician Educator appointment from the School of Medicine.

5. Non-ACGME Moonlighting Providers must have the appropriate Medical staff appointment from SHC/LPCH Medical Staff Office.

6. Non-ACGME Moonlighting Providers must obtain approval from SHC Medical Director of Education prior to moonlighting.

7. Billing For Services Provided by Non-ACGME Moonlighting Providers in Inpatient, Outpatient and ED Setting.
a. Non-ACGME Moonlighting Providers may provide and bill for services provided in the inpatient, outpatient and ED settings if the following criteria are met:
   i. The services are identifiable physician services, and meet the conditions for payment in 42 C.F.R § 415.102a.
   ii. The services can be separately identified from those that are required as part of the fellowship program. This means the services provided by the Non-ACGME Moonlighting Provider must be outside the scope of his/her fellowship as certified by the Program Director.
   iii. Such certification must be submitted to the Compliance Office in writing at least annually, or at such time as the services change.
   iv. Non-ACGME Moonlighting Providers must obtain a billing number from the Professional Services Operations after all approvals required by this policy have been received.
   v. All billable services provided by Non-ACGME Moonlighting Providers must be appropriately indicated in the medical record as moonlighting services.
   vi. Because Non-ACGME Moonlighting Providers are acting as attendings, no other physician may bill for the services provided by the Non-ACGME Moonlighting Provider. Further, other physicians may not duplicate the services previously performed by the Non-ACGME Moonlighting Providers and bill for these services, as such services are not medically necessary.

8. Non-ACGME Moonlighting Providers may act as teaching physicians and supervise residents while moonlighting in the inpatient, outpatient and ED setting. Further, Non-ACGME Moonlighting Providers may bill for professional services that they personally perform while they are supervising residents or fellows in the inpatient, outpatient and ED setting as long as the teaching physician guidelines are met.

9. Written agreements must be signed and in place with SHC or LPCH for each Non-ACGME Moonlighting Provider before the services are performed and before any payment is made for such services.

   a. Program Director will determine the fair market value payment after conducting appropriate analysis and submit it to the GMEC for approval.
   b. Payments will be processed by individual departments, approved by the GME office and paid via SHC payroll (for Non-ACGME Moonlighting Providers who are SHC employees) or SHC/LPCH Accounts Payable (for Non-ACGME Moonlighting Providers who are University employees.)
D. PROCESSES

1. On-Call Coverage Process
   a. Each Department will provide a description of the on-call duties and the prevailing wage to be paid for the services of the resident/fellow. The description will include how the prevailing wage was determined and correlate the on-call coverage duties to program curriculum.
   b. The description will be forwarded to the GME Office in HC435 no later than 60 days before the start of each academic year. The description for on-call coverage will be approved by the SHC/LPCH Graduate Medical Education Committee annually. Departments wishing to institute on-call coverage mid-year should allow 60 days for approval by the GMEC. A copy of all approved descriptions will be returned to the program. Description must be renewed annually.
   c. Invoices for on-call coverage will be submitted to the GME Office, approved by the GME Director, and submitted to Payroll for processing.
   d. All on-call coverage hours will be tracked using the MedHub system. Residents/fellows will clearly mark the on call coverage hours as “on-call coverage” in the comments section of the works hours reporting tool.
   e. Department will monitor on call coverage hours weekly.
   f. The GME Office will monitor on call coverage hours on a monthly basis.
   g. The GME Office will maintain a file of on call coverage payments and establish a computerized log of all invoices.
   h. The Compliance Department will periodically review the invoice files.

2. Internal Moonlighting Process
   a. Each Department will provide a description of the moonlighting duties, the prevailing wage, and how the wage was determined.
   b. The description will be forwarded to the GME Office in HC435. All descriptions will be approved by the SHC/LPCH GME Committee. Departments should allow 60 days for such approval. The description must include an explanation of how the duties are not part of the fellow’s current educational program. A copy of all approved descriptions will be returned to the department. Description must be approved annually.
   c. Departments requesting physician billing numbers for internal moonlighting must arrange for medical staff privileges at SHC or LPCH and for a Clinical Instructor appointment at the School of Medicine.
This policy applies to:

☑ Stanford Hospital and Clinics
☑ Lucile Packard Children’s Hospital

Name of Policy: Payment for extra services by residents and fellows
Policy Number: 7.01.01
Departments Affected:
All Departments

Date Written or Last Revision: February 24, 2009

Page 6 of 7

d. Requests for moonlighting approval by a non ACGME fellow should be sent to the GME Office in HC435. They should include:
   i. Application for moonlighting services by a non ACGME fellow
   ii. Copy of the fellows’ offer letter
   iii. Copy of the contract for services outside the fellowship.
   iv. Copy of the approval description of the moonlighting duty.

e. GME will review application materials:
   i. Verify via email with the Medical Staff Office that privileges have been granted at SHC/LPCH
   ii. Verify via email with Faculty Affairs at Stanford School of Medicine that Instructor/clinical educator appointment is in place.
   iii. Verify that the applicant for moonlighting permission has a valid CA MD License.
   iv. Verify that the applicant for moonlighting permission has no visa issues barring him/her from such activities.
   v. Obtain written approval from the Medical Director for Education at SHC/LCPH for the moonlighting.
   vi. Forward a copy of the above materials to Provide Enrollment.

f. Maintain a file copy of all materials in the GME Office.

g. Compliance will periodically review the moonlighting files in GME.

V. COMPLIANCE

A. The Compliance Department and/or Internal Audit will conduct periodic reviews and/or audits of moonlighting and on-call coverage services provided at SHC and LPCH to ensure that the above requirements are met.
B. Violations of this policy will be reported to the GME Office and to the Compliance Office. Violations will be investigated to determine the nature, extent and potential risk to the hospital. Violations of this policy will be subject to appropriate disciplinary action.

VI. RELATED DOCUMENTS

VII. APPENDICES

VIII. DOCUMENT INFORMATION

A. Legal Authority/References
B. Author/Original Date
   March 1999 by the Compliance Director and the Office of General Counsel
C. Gatekeeper of Original Document
This policy applies to:
- Stanford Hospital and Clinics
- Lucile Packard Children’s Hospital

Date Written or Last Revision:
February 24, 2009

Name of Policy: Payment for extra services by residents and fellows
Policy Number: 7.01.01

Departments Affected:
All Departments

<table>
<thead>
<tr>
<th>SHC/LPCH Compliance Department</th>
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<tbody>
<tr>
<td>D. Distribution and Training Requirements</td>
</tr>
<tr>
<td>1. This policy resides in the Compliance Manual</td>
</tr>
<tr>
<td>2. No revisions to this policy may be made without approval from the Compliance Department and the GME Office</td>
</tr>
<tr>
<td>3. The GME Office is responsible for communicating this policy to applicable faculty and staff.</td>
</tr>
<tr>
<td>E. Review and Renewal Requirements</td>
</tr>
<tr>
<td>This policy will be reviewed and/or revised by the Compliance Department every three years or as required by change of law or practice.</td>
</tr>
<tr>
<td>F. Review and Revision History</td>
</tr>
<tr>
<td>February 2003 by the Compliance Auditor and the Office of General Counsel</td>
</tr>
<tr>
<td>January 2004 by the Chief Compliance Officer and the Senior Compliance Auditor</td>
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<tr>
<td>February 2009 by the Chief Compliance Officer, the Office of General Counsel and the GME Committee</td>
</tr>
<tr>
<td>G. Approvals</td>
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<tr>
<td>November 2004 by the Chief Compliance Officer</td>
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<td>February 2009 by the Chief Compliance Officer, the Office of General Counsel and the GME Committee</td>
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</table>

This document is intended for use by staff of Stanford Hospital & Clinics and/or Lucile Packard Children’s Hospital. No representations or warranties are made for outside use. Not for outside reproduction or publication without permission.
I. Purpose

A. To comply with the legal requirements of the California Penal Code Sections 11164-11174.3, which mandates health care practitioners to report any reasonable suspicion of child abuse or neglect to a child protection or law enforcement agency.

B. To comply with the legal requirements of the California penal code Title 6, sections 13823.9 and 13823.11 and California Health and Safety Code Section 1281 regarding hospital standards and protocols for the medical examination of suspected victims of sexual abuse/assault.

C. To act as an advocate for patient health and safety.

D. To specify the procedures for reporting and managing cases of suspected child sexual abuse/assault of LPCH patients.

II. Policy Statement

A. In accordance with the California Penal Code, LPCH requires that all mandated health care practitioners maintain knowledge of indicators for suspected child sexual abuse, and report any reasonable suspicion of sexual abuse of an LPCH minor patient to child protective services (CPS) or law enforcement agency in the patient's county of residence. (See general child abuse policy for details of reporting requirements and procedure)

III. Definitions

A. See General Child Abuse policy for complete list of definitions.

B. "Child Sexual Abuse/Assault": Any activity with or in the presence of a child for sexual gratification. This includes, but is not limited to:

1. rape
2. incest
3. sodomy
4. lewd or lascivious acts
5. oral copulation
6. penetration of anal or genital opening with a foreign object
7. photographing, filming or depicting a child engaged in an act or simulation of obscene sexual conduct
8. exhibitionism or voyeurism involving children
9. child sexual exploitation, such as child prostitution
10. fondling of a child's genitals, breasts or buttocks
11. adult masturbation of a child or adult masturbation in the presence of a child
12. any other means of molestation or sexual exploitation of a child by an adult or age discrepant minor

And does not include:
1. age and developmentally appropriate sexual play
2. consensual sexual activity between age and developmentally similar minor adolescents age 14 to 17

C. "Minor" or "Child"—any LPCH patient under the age of 18 years old.

D. "Adult"—any individual age 18 years or older.

IV. Procedures

A. Suspected Child Sexual Abuse Management Procedure

1. Sexual abuse may be suspected on the basis of behavioral indicators, medical indicators, or patient or family disclosure (see http://childabuse.stanford.edu/ for indicators). Regardless of the type of initial indicator(s), any child suspected of being sexually abused should have a thorough general medical examination by the treating MD or pediatric nurse practitioner (PNP), and a patient/family interview with an LPCH social worker. The combined medical and interview findings will determine whether there is enough reason to suspect sexual abuse to make a report to child protective services.
2. The medical evaluation and social worker interview are not intended to be a comprehensive collection of evidence and details of any suspected abuse, but only to determine whether or not there is sufficient information to reasonably suspect sexual abuse. If it is determined that reasonable suspicion for sexual abuse exists, child protective services should be notified immediately. CPS will then determine the next steps for evaluation.

3. There are very specific protocols for conducting medical-legal examinations in cases of suspected child sexual abuse that must be adhered to in order to preserve the validity of any forensic medical evidence. Also, child sexual abuse medical-legal examinations have become very specialized, and require professional diagnostic expertise and specialized diagnostic equipment. Likewise, forensic interviewing of suspected victims of sexual abuse has become an area of specialization. Most counties now have specialized sexual abuse medical examination centers, as well as multidisciplinary forensic interview centers. When an LPCH minor patient presents with suspected sexual abuse and a CPS report is made, CPS may authorize a referral to a specialized center for child protection for further assessment and evidence collection.

In general, child protective services or law enforcement may authorize a referral for a forensic medical-legal examination if the last incident of suspected sexual abuse occurred within the 72 hours prior to presentation of the child to LPCH, or if the sexual abuse was otherwise likely to result in physical evidence.

The local child sexual abuse specialty examination centers are:

**San Mateo County:**
Keller Center for Family Violence
San Mateo County General Hospital
222 West 39th Avenue
San Mateo, CA. 94403
(650) 573-2623

**Santa Clara County:**
Center for Child Protection
Santa Clara County Valley Medical Center Building H-12
This policy applies to:

☐ Stanford Hospital and Clinics
☑ Lucile Packard Children’s Hospital
☐ Stanford University

LPCH Approval Date: November 2010

Name of the Policy:
Abuse: Sexual Abuse (Minor Patient Victim)

Departments Affected:
All Departments

751 South Bascom Avenue
San Jose, CA 94110
(408) 885-6460

Alameda County:
Center for Child Protection
Children’s Hospital, Oakland
747 52nd Street
Oakland, CA

San Francisco County:
Child and Adolescent Sexual Abuse Resource Center (CASARC)
San Francisco General Hospital
995 Potrero Avenue, Building 80
San Francisco, CA
(415) 206-8386

NOTE: these centers only will accept referrals from child protective services or law enforcement agencies, not directly from hospitals or families

4. In some instances, it is not possible to refer a suspected victim of sexual abuse to a specialty examination center, and child protective services or law enforcement will authorize the examination to be conducted at LPCH. (For example, if the most recent incident of suspected abuse occurred within the past 72 hours, and the child is an inpatient and not expected to be discharged within 72 hours from the last incident.) Because evidence erodes beyond 72 hours, CPS or law enforcement may request that the forensic exam be conducted at LPCH. If CPS or law enforcement authorizes a forensic sexual abuse exam to take place at LPCH, contact the LPCH SCAN team immediately (pager #2-SCAN). The SCAN team will coordinate with the Santa Clara County Valley Medical Center, Center for Child Protection to conduct a sexual assault examination at LPCH.

B. Staff Responsibilities

See Abuse: Suspected Child Abuse Reporting and Management policy for detailed listing of
responsibilities for physician, nurse, and social worker.

C. Suspected Child Sexual Abuse Reporting Procedure

1. Immediate Telephone Report

The California child abuse reporting laws require all mandated reporting personnel to make a telephone report immediately or as soon as practically possible to the child protective services or law enforcement agency in which the patient is a resident when there is reasonable suspicion of sexual abuse/assault. The call may be made by any member of the health care team and will satisfy the reporting requirement for all other team members. The reporter should be prepared to provide his or her name, the name of the alleged victim, the location of the alleged victim, the nature and extent of the abuse, and any other information that led the team to suspect sexual abuse/assault. All counties have 24 hour emergency numbers for making telephone reports. The numbers for child protective services in counties surrounding LPCH are:

San Mateo County
(650) 595-7922

Santa Clara County
(408) 299-2071

Alameda County
(510) 483-9300

San Francisco County
(415) 558-2650

Santa Cruz County
(408) 454-2273

2. All telephone reports must be followed up with a written report within 36 hours of the initial call. This is the responsibility of the team member who made the initial call. The form that must be files for all cases of suspected child abuse is Department of Justice Form SS 8572, “Suspected Child Abuse Report.” This form may be found at
www.caag.state.ca.us/childabuse/forms.htm. The form should be completed in detail, and all copies sent to the protective services agency. Copies of this completed form should also be sent to HIMS office to become part of the patients medical record, and to LPCH Social Services for SCAN Committee review and data purposes.

3. When the child patient has been examined medically by an MD, PA, or NP for indications of sexual abuse/assault, another form is required that documents findings of the medical exam. This is either form CalEMA 2-925 or CalEMA form 2-930. These forms may be found at http://www.ccfmtc.org/forensic.asp. These forms must be filled out by the medical practitioner who conducted the examination. Any relevant lab finding should be included with this form. All copies should be sent to the child protective services agency along with the general reporting form. Copies of this completed form should also be sent to HIMS office to become part of the patients medical record, and to LPCH Social Services for SCAN Committee review and data purposes.

4. All of the above forms are available at http://www.ccfmtc.org/forensic.asp

Mailing addresses for surrounding counties are:

a. San Mateo County: CPS
   400 Harbor Boulevard
   Belmont, CA 94002
   (650) 595-7922

b. Santa Clara County: CPS
   1725 Technology Drive
   San Jose, CA 95110
   (408) 299-2071

c. Alameda County: CPS
   Las Vista 22300 Fairmont Drive
   San Leandro, CA 94578
   (510) 483-9300
d. San Francisco County: Unit N 550
Post Office Box 7988
San Francisco, California
94120
(415) 558-2650

A complete listing of child protective service addresses for all California counties can be found at http://www.childsworld.ca.gov/res/pdf/EmergencyR_315.pdf

Even when patients are referred to specialty centers, appropriate reports must be filed by LPCH mandated reporters according to above guidelines.

E. Special Considerations:

1. Consent Issues

Whether a child is accompanied by parent/guardian or alone (as is sometimes the case in Adolescent Clinic and OB Clinic), parent/guardian consent is not required for any examination or diagnostic procedures to diagnose suspected child sexual abuse.

2. Sexually-Transmitted Diseases

Some diseases are almost exclusively transmitted sexually, and if present in laboratory findings of preadolescent patients, are strong indicators of child sexual abuse (e.g., syphilis, neisseria gonorrhea in children other than neonates) while others may most often be transmitted sexually but not exclusively, and if present in laboratory findings are suggestive of child sexual abuse (e.g., chlamydia, trichomonas vaginalis). The LPCH SCAN team may be consulted regarding sexually transmitted diseases as indicators of sexual abuse (pager # 2-SCAN).

3. Adult/Adolescent and Adolescent/Adolescent Sexual Contact

This is an ambiguous and controversial area of the law. The following is a list of
some situations which may occur:

a. Statutory Rape-- Penal Code Section 261.5(d) it is unlawful for a person age 21 or older to engage in sexual intercourse with a partner who is under the age of 16 unless they are legally married. This is considered child sexual abuse, and must be reported under current law. Partner consent is considered irrelevant. The gender of each partner also is considered irrelevant.

b. Lewd and Lascivious Conduct with a Child 14 or 15 Years of Age and Adult at least 10 Years Older -- Penal Code section 288(c)

The law defines lewd and lascivious conduct as "touching of the child by the perpetrator, or touching by the child at the direction of the perpetrator, for the purpose of arousing, appealing to, or gratifying the lust, passions, or sexual desires of the perpetrator or of the child." Sexual acts meeting this definition between a 14 or 15 year old minor and an adult at least 10 years older (measuring from the birth date of the minor to the birth date of the adult) are considered unlawful sexual assault, and must be reported as child sexual abuse under the current mandated reporting laws. Minor consent is considered irrelevant.

c. Lewd and Lascivious Conduct with a Minor Under Age 14 Years --

Penal Code Section 228(a)

Between two minors, both under age 14 years--The current child abuse reporting law does not mandate reporting of voluntary sexual conduct between minors when both are under age 14, when "both of whom are of similar age", but case law does not define what constitutes "similar age". Clinicians must use their own best professional judgment in determining whether the relative ages of the children and nature of the conduct make the activity a violation of the penal code, and thus reportable. When in doubt, call the LPCH SCAN team (pager # 2-SCAN) or child protective services reporting hotline for consultation and guidance.

d. A useful resource for determining reporting responsibilities regarding sexual activity with and between minors can be found at http://www.cacsc.org/council/reportminors.html
4. Pregnancy

Pregnancy in an unmarried minor does not in itself constitute reasonable suspicion for a CPS report. However, it should be considered a risk indicator for sexual abuse, and a social work consultation should be ordered for a complete psychosocial assessment.

F. LPCH Staff may consult a child protective services agency or the LPCH SCAN Committee for clarification of any issues related to suspected child sexual abuse.

V. Document Information

A. Legal Authority/References

B. Author/Original Date
   Jack Komejan, LCSW/LPCH SCAN Committee; 2/25/98

C. Distribution and Training Requirements
   1. This policy resides in the Patient Care Manual of Lucile Packard Children’s Hospital.
   2. New documents or any revised documents will be distributed to Patient Care Manual holders. The department/unit/clinic manager will be responsible for communicating this information to the applicable staff.

D. Review and Renewal Requirements
   This policy will be reviewed and/or revised every three years or as required by change of law or practice.

E. Review and Revision History
   Jack Komejan, LCSW; 10/00
   Jack Komejan, LCSW; 5/03
   Chuck Norek, J.D., CPHRM, Esq.; 8/07
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<td>November 2010</td>
</tr>
<tr>
<td>Lucile Packard Children’s Hospital</td>
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<td>Stanford University</td>
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<tr>
<th>Name of the Policy:</th>
<th>Departments Affected:</th>
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<tbody>
<tr>
<td>Abuse: Sexual Abuse (Minor Patient Victim)</td>
<td>All Departments</td>
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Jack Komejan, LCSW; 7/2010

F. Approvals
Risks Management; 8/07
Clinical Practice Council; 8/07, 11/2010

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I. Purpose

A. To comply with the legal requirements of the California Penal Code, Section 11164-11174.3, which mandates health care practitioners to report any reasonable suspicion of child abuse or neglect to a child protection or law enforcement agency.

B. To act as an advocate for minor patient's health and safety.

C. To specify the requirements and procedures for reporting and managing cases of suspected child abuse or neglect at LPCH.

II. Policy Statement

A. In accordance with California penal code, Lucile Salter Packard Children's Hospital at Stanford requires that all mandated health care practitioners must report to a child protective or law enforcement agency in the county in which the child is a resident any reasonable suspicion that a child patient has been abused or neglected.

B. In circumstances where multiple practitioners are involved in the child's care, the determination of suspicion of abuse will be a team assessment. If it is determined among the team that there is reasonable suspicion for abuse, the reporting responsibility may be assigned to one member of the health care team (usually the clinical social worker). This serves the reporting requirement for all other involved team members. If the team cannot reach agreement on whether or not reasonable suspicion for abuse exists, the LPCH SCAN (suspected child abuse and neglect) team should be consulted for guidance (pager # 2-SCAN). Also, a telephone consultation may be requested from the child protective services agency in the county in which the child is a resident.

C. No supervisor or administrator may impede or inhibit mandated reporting personnel from reporting suspected abuse, and no person making such report shall be subject to any sanction for making a report. To the extent that any person mandated to report believes there is an impediment to reporting, he or she should bring the issue to the immediate attention of their direct supervisor and the LPCH Quality Assurance Director.

D. All newly hired mandated reporting personnel will be oriented to the child abuse reporting requirements and trained in child abuse recognition and risk factors as part of new hire orientation at LPCH. All affected employees will sign a statement to the effect that he or she
has knowledge of, and will comply with the provisions of Section 11166 of the California penal code regarding reporting of suspected child abuse.

E. All reports submitted pursuant to this policy shall be confidential.

F. Any mandatory reporting personnel who violate the reporting requirement may be charged with a misdemeanor, punishable by six months in jail or $1000 fine or both.

G. No mandated reporter shall be civilly or criminally liable for reporting a suspected instance of child abuse, as required and authorized by law.

III. Definitions

A. "Child" is defined as any patient under the age of 18 years.

B. Mandated reporters include any health care practitioner providing care to patients of LPCH, whether or not employed by LPCH, including, but not limited to, all physicians, dentists, podiatrists, clinical psychologists, chaplains, psychological assistants, marriage family and child counselors, interns residents or trainees, nurses, nursing assistants, emergency medical technicians, paramedics, social workers, and other allied health providers.

C. Child abuse is defined as any act of omission or commission that endangers or impairs a child's physical, emotional, or mental health and development. This includes:

1. Physical injury inflicted by other than accidental means. (See specific physical abuse policy) 

2. Sexual assault including rape, incest, sodomy, lewd or lascivious acts, oral copulation, penetration of genital or anal opening with a foreign object, photographing or depicting a minor engaged in an act of obscene sexual conduct, and other means of molestation of a minor child by an adult or age discrepant minor. (See sexual abuse policy)

3. Willful cruelty or unjustifiable punishment including permitting the health of a child to be endangered and/or making emotionally damaging threats or statements to a child. (See physical abuse policy).
4. Cruel or inhuman corporal punishment or injury. (See physical abuse policy)

5. Negligent treatment or maltreatment of a child by a person responsible for the child’s welfare under circumstances indicating harm or threatened harm to the child's health or welfare. This neglect includes severe caloric deprivation resulting in malnutrition, neglect in providing necessary medical care, and medically diagnosed non-organic failure-to-thrive. (See Neglect and Failure-to-Thrive policy)

6. Suspected Pediatric Falsification Disorder (Also known as Factitious Disorder by Proxy or Munchausen's Disorder by Proxy.) (See Pediatric Falsification Disorder Policy)

7. A positive toxicology for illegal substances in a newborn, if other risk factors for abuse are also present. (See Infant Positive Toxicology Policy)

8. Caretaker absence, abandonment, or incapacity. (See Neglect Policy)

9. Suspected abuse must be reported even if the child has died, regardless of whether or not the possible abuse was a factor in the child's death and even if the suspected abuse is discovered during an autopsy.

D. "Reasonable suspicion" means that it is objectively reasonable for a person to entertain such a suspicion, based upon the facts that could cause a reasonable person in a like situation, drawing on his or her training and experience, to suspect child abuse.

IV. Procedures

A. Suspected Child Abuse Reporting Procedure

1. Immediate Telephone Report

The California child abuse reporting law requires all mandated reporting personnel to make a telephone report immediately or as soon as practically possible to the child protection or law enforcement agency of the county in which the child is a resident, as soon as child abuse is suspected. The call may be made by one
member of the health care team and will satisfy the reporting requirement for all other team members. The reporter should be prepared to provide his or her name, the name of the child, the location of the child, the nature and extent of any injuries, and any information that led the team to suspect child abuse. All counties have 24 hour emergency response numbers for making telephone reports. This number also may be called for consultation on questionable reporting cases. The numbers for surrounding local counties are:

a. San Mateo County
   (650) 595-7922

b. Santa Clara County
   (408) 299-2071

c. Alameda County
   (510) 483-9300

d. San Francisco County
   (800) 856-5553 or
   (415) 558-2650

e. Reporting addresses for all other California counties can be found at

2. All telephone reports must be followed up with written reports within 36 hours. This is the responsibility of the health care team member who made the telephone report. There are official state Department of Justice forms that must be used in making the written report. These are available from LPCH Social Services and available for download from on the Stanford Hospitals and Clinics internet site http://childabuse.stanford.edu/ or http://www.caag.state.ca.us/childabuse/forms.htm

a. For suspected child abuse cases of all types, a written report must be filed using Department of Justice form SS 8572, "Suspected Child Abuse Report". The form may be found at http://www.caag.state.ca.us/childabuse/forms.htm. This form should be completed in detail and mailed within 36 hours of the telephone report. Copies also should be sent to HIMS as part of the patient's medical record and to the Social Services office at LPCH for SCAN Committee
b. In cases of suspected physical abuse or neglect in which a child has been examined medically, another form must be completed in addition to form DOJ SS 8572. This form, CalEMA 2-900 “Child Physical Abuse and Neglect Medical/Evidentiary Examination” must be filled out by the examining physician. It should be completed in as much detail as possible, as it has been designed to elicit and record the most relevant facts concerning the suspected child abuse. It should include any relevant lab or radiologic findings, as well as photographs of any visible physical findings. One copy of this form should be mailed along with form DOJ SS 8572 within 36 hours of the telephone report to the appropriate child protective service agency. Another copy should become part of the patient's medical record, and yet another copy sent to Social Services for SCAN Committee review and data purposes. The CalEMA 2-900 form may be found at http://www.ccfmtc.org/forensic.asp.

c. In cases of suspected sexual abuse or assault where a child has been examined medically, another form must be completed in addition to form SS 8572. This will either be form CalEMA 2-925 “Non-Acute (>72 hours) Child/Adolescent Medical/Evidentiary Sexual Assault Examination” or form CalEMA 2-930 “Acute (<72 hours) Child/Adolescent Medical/Evidentiary Sexual Assault Examination”. This form must be completed by the physician who examined the child. It should be completed in as much detail as possible and include any relevant lab findings or photographs of physical findings. Two copies of this form should be mailed along with form DOJ SS 8572 within 36 hours of the telephone report to the appropriate child protective service agency. Copies also should be sent to HIMS to become a part of the patient's medical record and to Social Services for SCAN Committee review and data purposes. Both CalEMA 2-925 and CalEMA 2-930 forms are available for download at http://www.ccfmtc.org/forensic.asp (See Sexual Abuse policy for details) Mailing addresses for surrounding county child protective services are:

(1) **San Mateo County:**
   
   Children's Protective Services
   
   400 Harbor Boulevard
   
   Belmont, California 94002
   
   (650) 595-7922
(2) **Santa Clara County:**
Child Abuse and Neglect Screening Center
373 West Julian
San Jose, California 95110
(408) 299-2071

(3) **Alameda County:**
Children's Protective Services
Las Vista 2
24100 Amador St.
Hayward, California 94578
(510) 259-1800

(4) **San Francisco County:**
San Francisco Department of Social Services
Unit H 110
Post Office Box 7988
San Francisco, California 94120
(415) 558-2650

Mailing addresses for all other California counties can be found at http://www.childsworld.ca.gov/res/pdf/EmergencyR_315.pdf

There are specific protocols for conducting medical-legal examinations in cases of suspected child sexual abuse. See Sexual Abuse policy for details.

**B. Suspected Child Abuse Management Procedures**

Assessment and management of suspected child abuse is a team responsibility at LPCH, and will be carried out by the physician (resident or attending), nursing staff, and clinical social worker assigned to the unit or clinic where the patient's care is being provided.
1. Physician's Responsibilities

   a. Obtain a clinical social work consultation immediately upon suspicion of child abuse. The clinical social worker will act as the team coordinator for the abuse evaluation. (If after hours or on weekend or holiday, contact the LPCH nursing supervisor to notify the on-call social worker.)

   b. Obtain a detailed history from the child, parent(s) or caretaker(s): interview the child separately from parent(s)/caretaker(s) when age and developmentally appropriate. Ideally, the complete history should be obtained by one physician, with another team member present to witness statements of both physician and parent(s) or guardian(s). Detail should be obtained regarding how the injury allegedly occurred, including place, exact time, sequence of events, and lag time before seeking medical attention. Any inconsistencies in report should be noted and documented, as should any discrepancies between the extent of injuries and how they allegedly occurred.

   c. Thoroughly examine the child.

   d. Document carefully, accurately, and legibly the following:

      (1) location and description of all injuries.

      (2) pertinent details concerning the injury, neglect, or sexual abuse such as time, place, sequence of events, people present.

   e. Order laboratory tests and radiological procedures as indicated, including but not limited to: skeletal X-rays and bone and head scans, coagulation tests, blood and urine specimens for toxicology, GC cultures, VDRL, RPR, Chlamydia, and LFTs. Photograph injuries if appropriate. Skeletal X-rays may be taken without the consent of the child’s parent or guardian but only for the purpose of diagnosing the case as one of possible child abuse or neglect and determining the extent of such child abuse or neglect. The non-accidental trauma order set may be used as a guide for medical evaluation. https://intranet.lpch.org/pdf/formsManualsReferences/preprinted OrderForms/pediatricsGeneral/lpchNonAccidentalTraumaEval.pdf
f. Inform parent(s) or caretaker(s) of the medical examination findings and treatments required. Obtain consents for treatment when possible. Advise parent(s) regarding the need to report to child protective services and prepare them for any follow up contacts that might occur. Document that parents have been informed.

In informing parent(s) or caretaker(s) state, "Your child's injuries concern us because there is an inadequate explanation for them. I am obligated by California law to report all unexplained injuries to children to a child protection agency." The physician should do this, accompanied by the clinical social worker, if the case is reported on the basis of medical findings.

In fact, after all diagnostic studies are completed, the physician should review the actual likely cause of each specific injury. This convinces the parent(s) or caretaker(s) that we are aware of what actually happened and permits them to turn their attention to the issue of receiving assistance.

g. Treat any injuries as needed.

h. For suspected Pediatric Falsification Disorder cases (Also known as Factitious Disorder by Proxy or Munchausen's Disorder by Proxy), do not inform caretakers of the child protection report. (See Pediatric Falsification Disorder Policy for details).

i. When injuries are believed to have been caused by physical abuse or neglect and a physical examination is conducted, complete form CalEMA 2-900, "Child Physical Abuse and Neglect Medical/Evidentiary Examination and give to the team clinical social worker for mailing to child protective services within 36 hours.

j. When sexual abuse is believed to have occurred, complete form CalEMA 2-925 or CalEMA form 2-930 and give to the team clinical social worker for mailing to child protective services along with the reporting form. (See Child Sexual Abuse Policy for details)

k. Do not discharge the child from care until a child protective service report has been made and the CPS emergency response worker
determines disposition of the child. Notify LPCH Security if there is any concern that parents may leave with the child AMA, or before CPS has cleared them to go.

i. Arrange for medical follow-up at LPCH or elsewhere.

Child abuse risk factors and indicators can be found on the Stanford Hospitals and Clinics Child Abuse website at http://childabuse.stanford.edu/

2. Nursing Staff Responsibilities

a. See the patient as soon as possible after abuse is a concern.

b. Notify the attending physician, resident physician, clinical social worker, charge nurse, and nursing supervisor immediately upon suspicion of child abuse. These health care personnel will comprise the abuse assessment team. The clinical social worker will act as the team coordinator and notify the child protective service agency if there is reasonable suspicion to report.

c. Refer to LPCH nursing supervisor to notify the on-call clinical social worker after hours or on weekends and holidays.

d. In the event of suspected physical abuse, neglect, or sexual abuse, assist the physician with the physical exams. If physician orders X-ray, lab studies, or radiology diagnostics, accompany the child, parent, or caretaker to these departments. If warranted, the nursing staff should oversee that the child is not left alone with the parent or caretaker.

e. Note the condition of the patient's general hygiene, grooming, and clothing worn upon arrival. Note tears, rips, foreign material, and soiling. Carefully document all observations.

4. General Guidelines for All Team Members
a. Interview the patient and family using a fact-finding approach. Feeling angry with possible perpetrators of child abuse is natural, but expressing this anger can be very damaging to parental cooperation. Avoid repeated interrogation, confrontation and accusation.

b. Avoid moralistic or judgmental remarks as well as incriminating terms such as "battering". Keep in mind that some injuries that at first may appear to be abuse related end up being the result of accidental trauma or illness.

c. Insure confidentiality of patient by containing information to the treatment team. Assure family members that their privacy will be protected, and that everyone's goal is to make sure their child is safe.

d. All statements in the medical record should be objective, accurate, legible and all signatures should include pager number or, for physicians, dictation number.

e. Document all pertinent observations such as statements made by the parent(s) or child, family interactions, etc. Use direct quotations whenever possible. Especially note any discrepancies in reports of how injuries occurred.

V. Related Documents or Policies


B. To arrange education or training, contact LPCH SCAN (suspected child abuse and neglect) Committee at pager # 2-SCAN.

C. http://childabuse.stanford.edu/

VI. Document Information

A. Legal Authority/References

B. Author/Original Date
Jack Komejan, LCSW, 5/8/95

C. Distribution and Training Requirements
1. This policy resides in the Patient Care Manual of Lucile Packard Children’s Hospital.
2. New documents or any revised documents will be distributed to Patient Care Manual holders. The department/unit/clinic manager will be responsible for communicating this information to the applicable staff.

D. Review and Renewal Requirements
This policy will be reviewed and/or revised every three years or as required by change of law or practice.

E. Review and Revision History
Jack Komejan, LCSW, 1/98
Jack Komejan, LCSW, 10/00
Jack Komejan, LCSW, 8/04
Chuck Norek, J.D., CPHRM, Esq.; 8/07
Jack Komejan, LCSW 7/2010

F. Approvals
Risk Management; 8/07
Clinical Practice Council; 08/07, 11/2010
This policy applies to:
☑ Stanford Hospital and Clinics
☑ Lucile Packard Children’s Hospital
☑ Stanford Medical Outpatient Clinics

Last Revision:
October 2011

Name of Policy:
Post-Offer Pre-Hire Medical Evaluation Policy

Departments Affected:
All Departments

I. PURPOSE:

All new applicants selected for employment must be cleared for work by Occupational Health Services prior to commencing employment or attending orientation. Successful completion of the medical evaluation is a condition of employment. The purpose of this requirement is to protect both employees and patients against preventable health hazards, and to ensure that employees are placed in work which they have the ability to perform safely. Pre-employment medical evaluation is conducted in a manner consistent with the Americans with Disabilities Act (ADA), which prohibits discrimination on the basis of physical or mental disability.

II. POLICY:

It is the policy of SHC and LPCH to provide a process for screening applicants for employment while adhering to all Federal, State, and Local employment regulations.

III. PRINCIPLES:

A. Initial medical evaluation.

B. Identification of personal and occupational health risk factors.

C. Ability to perform the essential job duties of the job for which they are applying.

D. Rehire to same position.

E. Rehire or transfer to a different position.
IV. PROCEDURE:

A. Initial medical evaluation will include: a post-offer pre-hire health history questionnaire, focused physical examination, laboratory tests, immunizations (as required for hospital employees according to policies established by the Infection Control Committees), and any other procedures which Occupational Health Services may deem necessary.

1. Screening for infectious diseases and immunization status of the applicant will be initiated. Laboratory testing will be done as necessary. Any applicant found to be non-immune will be vaccinated. Any applicant with a communicable disease will be put on medical hold until medically cleared.

2. All applicants will be assessed for risk of exposure to blood or other potentially infectious materials. Hepatitis B vaccine will be recommended for applicants whose job may involve exposure to blood or other potentially infectious material.

3. Tuberculosis (TB) surveillance will be initiated according to the Tuberculosis Policy. A QuantiFERON Gold Assay or a two-step TB skin test (TST) will be required for all new hires.

   a. The QuantiFERON Gold Assay may be used for TB screening.

   b. Applicants with valid documentation of TST screening within the last 365 days will only require a one-step TST.

   c. A chest x-ray may be required for history of positive tuberculosis testing.

4. Drug and alcohol screening will be completed.

5. Additional baseline health screening for applicants hired into jobs whose essential duties involve chemical, audio, or laser-related hazards must be completed within 30 days of start of regular employment.
6. The physical examination will be completed with special attention to occupational risk factors related to essential job duties. The applicant’s ability to safely perform the essential job duties will be assessed.

B. Personal and occupational health risk factors will be identified. Discussion of reduction of risk factors with education individualized to each employee will be performed. Referrals for further clinical evaluation will be made when appropriate.

C. If an applicant is unable to perform the essential job duties with or without reasonable accommodations, Human Resources will be notified.

1. The applicant will be placed on a medical hold by Occupational Health Services. The applicant will be on medical hold until he/she is cleared to work with or without reasonable accommodations, or it is determined that the applicant cannot safely perform the essential job duties even with reasonable accommodations.

D. If a former employee applies to be rehired to the same position within three months of termination, a full pre-placement evaluation may not be required. However, all pre-placement requirements for infectious disease screening and immunizations must be completed. (See A.1, 2, and 3 above) If a former employee is rehired after three months, a full pre-placement evaluation will be required.

E. If a former employee is rehiring into a different position, a full pre-placement evaluation will be required. For current employees transferring into a different position, an evaluation may be required.

V. RELATED DOCUMENTS:

A. Infectious Disease Surveillance and Immunizations

B. Tuberculosis Surveillance, Exposure, and Control Policy

C. Hearing Conservation Policy
This policy applies to:
☑ Stanford Hospital and Clinics
☑ Lucile Packard Children’s Hospital
☑ Stanford Medical Outpatient Clinics

Name of Policy:
Post-Offer Pre-Hire Medical Evaluation Policy

Departments Affected:
All Departments

D. Occupational Exposure to Lasers Policy

VI. DOCUMENT INFORMATION:

A. Legal Authority/References
   1. Americans with Disability Act
   2. The Joint Commission
   3. Title 22, State of California

B. Author/Original Date
   March 2001

C. Gatekeeper of Original Document
   Stanford Hospital and Clinics Human Resources Compliance Officer

D. Distribution and Training Requirements
   1. This policy resides on the Intranet of both hospitals.
   2. New versions of the policy will be posted on the Intranet and communicated to applicable staff.

E. Review and Renewal Requirements
   This policy will be reviewed every three (3) years and/or as required by change of law or practice.

F. Review and Revision History
   July 2004 by Bernadette Burnes, Director of Occupational Health Services
   July 2006 by Beverley Tobias, Director of Occupational Health Services
   April 2007 by Kelly Murphy, MD, Medical Director of Occupational Health Services
   February 2010 by Kelly Murphy, MD, Medical Director of Occupational Health Services
   August 2011 by Mary Spangler, Director of Occupational Health Services
   September 2011 by the Human Resources Policy Committee – SHC/LPCH

G. Approvals
   April 2007 by Beverley Tobias, Director of Occupational Health Services
| This policy applies to: | Last Revision:  
| Stanford Hospital and Clinics  
| Lucile Packard Children’s Hospital  
| Stanford Medical Outpatient Clinics | October 2011 |

| Name of Policy: | Page 5 of 5 |
| Post-Offer Pre-Hire Medical Evaluation Policy |

| Departments Affected: |
| All Departments |

April 2007 by Kelly Murphy, MD, Medical Director of Occupational Health Services
April 2007 by Cindy Day, Vice President of Patient Care Services – SHC
April 2007 by Pam Wells, Vice President of Patient Care Services – LPCH
February 2010 by Kelly Murphy, MD, Medical Director of Occupational Health Services
August 2010 by the Human Resources Policy Committee – SHC/LPCH
October 2011 by the Human Resources Steering Team – SHC/LPCH

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