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Introduction

It is the Medical College of Wisconsin’s policy to comply with all laws, rules and regulations applicable to the Health Psychology Residency Program. The purpose of this manual is to provide copies of the relevant policies associated with the Health Psychology Residency Program, Medical College of Wisconsin, and Froedtert Hospital set forth herein.

The manual includes policies and procedures adopted specifically for and applicable only to the Health Psychology Residency as well as existing policies and procedures of the Medical College of Wisconsin and of Froedtert Hospital (FMLH) that are also applicable to the Health Psychology Residency.

In addition to the policies and procedures outlined in this manual, Health Psychology Residents are expected to follow all policies and procedures of the Medical College of Wisconsin (available via Intranet webpage, InfoScope, accessible via MCW network computers: https://infoscope.mcw.edu/Corporate-Policies.htm) and Froedtert Hospital (available via the Intranet webpage, Scout, accessible via Froedtert Hospital network computers: https://intranet.froedtert.com/policies).

Any questions related to these policies and procedures may be directed to the Training Director of the Health Psychology Residency Program.
Health Psychology Residency Program
Policies and Procedures
Application and Selection Procedures

Applies To:
Residents of the Health Psychology Residency Program

Purpose:
To ensure equal opportunity compliance for all individuals consistent with applicable State and Federal laws and other pertinent legislation, judicial mandates, and presidential executive orders.

Policy:
Qualified applicants will be students currently enrolled in an APA-accredited graduate program in clinical or counseling psychology. Applicants should have all coursework completed prior to internship year. Preference will be given to applicants who have already proposed or defended their dissertation. Froedtert and the Medical College of Wisconsin encourages applicants from under-represented minority groups, women, and those with disabilities to apply.

Given the health psychology and academic medicine focus of this residency, candidates with relevant training and practicum experience in health settings (e.g., hospitals, academic medical centers, integrated primary care settings) will be most competitive. A balance of psychotherapy, behavioral medicine interventions, and psychological assessment common in health psychology will be present in the most appropriate candidates. Applicants will need to have significant experience working with adults, with experience working with patients with a comorbid medical diagnosis.

This internship seeks to train academic health psychologists; as such, those interested in practicing health psychology and behavioral medicine in a clinic, hospital, or academic medical setting will be preferred. A preferred candidate would have a breadth of experience in general adult mental health (assessment, testing, and therapy) as well as at least one practicum in a health setting. Relevant health psychology research is considered during the selection process, particularly as it pertains to population health; however, clinical experience is more heavily weighed. Applicants who will be reviewed will have a minimum of 400 hours of APPI intervention and 50 APPI assessment hours to be the most competitive candidate.

Required qualifications:
- Enrollment in an APA-accredited doctoral program in clinical or counseling psychology
- Completion of all doctoral coursework prior to internship year
- Strong core clinical/counseling psychology psychotherapy and assessment experience
- Endorsement of doctoral chair for readiness for internship

Preferred qualifications:
- One or more practicum in a health setting (e.g., hospital, academic medical center, integrated primary care)
- Interest in pursuing career in health psychology
- Primary clinical experience/interest with adults
- Experience with empirically validated treatment approaches
- Experience with health psychology behavioral interventions
- Strong assessment background with experience in health psychology assessment
- Dissertation proposed or defended prior to internship year
- Minimum of 400 hours of APPI intervention and 50 hours of APPI assessment hours

Required materials:
- APPIC Application for Psychology Internship (AAPI Online)
- Curriculum vitae illustrating past clinical and relevant research experience
- Graduate transcript
- Three letters of recommendation

Based on the aforementioned qualifications, a select group of applicants will be invited to interview in person. Applicants who do not meet required qualifications will not be considered for an interview and will be provided with proper notice. The Residency Selection Committee will review the other applications and rate them based on the above criteria. Interviews will be offered to applicants based on meeting qualifications and being identified as a good fit for the Residency. Notification of interview status will be given no later than December 3. Interview applicants will be rated based on the criteria above. The Residency Selection Committee will review the rating forms in a final ranking meeting and create the final rankings for the APPIC Match.

Effective Date: July 1, 2018
Authorization to Exchange Information with Resident's Doctoral Program

I, __________________________, release the Froedtert and the Medical College of Wisconsin Health Psychology Residency to communicate with my doctoral institution training director regarding information about my:

- Progress in the doctoral program
- Progress in the psychology residency/internship
- Past academic and clinical performance
- Current academic and clinical performance
- Job duties and performance
- Formal residency evaluations
- Professionalism including but not limited to professional and interpersonal interactions/behaviors

I understand that the Health Psychology Residency (Froedtert/MCW) Director of Clinical Training will regularly communicate information relevant to the items listed above to clarify progress in the program and successfully completion of the health psychology residency/internship. I understand and agree to regular communication between the Health Psychology Director of Clinical Training and the Director of Clinical Training from my doctoral program to address routine development and progress as well as remediation or problematic competence.

<table>
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<tr>
<th>Resident Name (print)</th>
<th>Resident Signature</th>
<th>Date</th>
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<tbody>
<tr>
<td>Training Director (print)</td>
<td>Training Director Signature</td>
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Effective:  July 1, 2018
**Didactics Attendance Policy**

**Applies To:**
Residents of the Health Psychology Residency Program

**Purpose:**
This policy sets forth the standards necessary for attendance at didactics.

**Policy:**
Didactics are an integral part of the Health Psychology Residency, providing didactic training on multiple levels of entry level practice for health service psychology. As such, attendance and active engagement in didactics is essential to meeting the competency requirements for successful completion of residency/internship.

Didactics are scheduled on Friday mornings, typically at the Tosa Health Center location. However, occasionally, didactics will be scheduled at Froedtert Memorial Lutheran Hospital and/or presented by a presenter using Polycom Video Conferencing technology. A didactics schedule will be provided to the residents at the beginning of the academic year. Revisions made to the schedule will be communicated to the residents via the Educational Coordinator.

Residents are required to attend all didactics in person. Exceptions to in person didactic attendance includes vacation, illness, or family emergency. In these cases, it is the responsibility of the resident to inform the Director of Clinical Training and Program Coordinator 7 days prior to the absence, unless in the case of an emergency. It is the responsibility of the resident to obtain the readings, PowerPoint presentations, and information presented in the didactic.

In the event a resident misses 4 didactics outside of excused absences from the office, a plan will be created with the training director to improve didactic attendance. Should this occur, the resident will also be responsible for a content paper on the topics missed in the didactics presentations to ensure adequate competence.

**Effective Date:** July 1, 2018
Dissertation and Professional Development Leave Policy

Applies To:
Residents of the Health Psychology Residency Program

Purpose:
This policy sets forth the standards for requesting dissertation and professional development release time.

Policy:
Froedtert and the Medical College of Wisconsin Health Psychology Residency values resident engagement with research, as well as successful completion of the resident’s doctoral studies, and professional development. As such, dissertation release time, professional development leave time, and/or conference release time is available, typically not to exceed 5 business days per academic year, but up to the discretion of the training director. Dissertation release time, professional development leave time, and conference release time (up to 5 days) does not count against resident vacation and/or sick time.

To qualify for dissertation release time, a resident must be traveling to his/her home institution for a defense hearing. Time to meet with faculty regarding dissertation and time to work on dissertation do not constitute dissertation release time. The resident should request dissertation release time in writing via the Time Off Request Form that will be submitted to the Director of Clinical Training and Program Coordinator at least 30 days in advance when possible. Time will be authorized by the Director of Clinical Training commensurate with the scheduling and travel requirements of the dissertation defense. Residents will be provided with notice via signed Time Off Request Forms if their request has been approved or denied.

In accordance with APPIC Policy, residents may also use professional development leave time for post-doctoral and job interviews. To qualify for professional development leave time, the resident must be traveling to or attending a job (post-doctoral fellowship or post-graduate job) interview. Residents will be provided with notice via signed Time Off Request Forms if their request has been approved or denied.

To qualify for conference release time, the resident must be presenting at the conference. Residents should make request to the Director of Clinical Training and Program Coordinator in writing via the Time Off Request Form and present the conference program to the Educational Coordinator. The Director of Clinical Training will authorize the leave commensurate with the educational and travel requirements of the conference. Residents will be provided with notice via the signed Time Off Request Form if their request has been approved or denied.

Effective Date: July 1, 2018
Grievance Policy and Procedures for Health Psychology Residency Program

Purpose:
The policy purpose is to afford residents a mechanism by which to raise and see to appropriate resolution certain grievances at the Medical College of Wisconsin (MCW).

Policy:
The Froedtert and the Medical College Health Psychology Residency Program seeks to review and resolve in an appropriate, effective and timely manner certain grievances, as described herein, raised by a Resident. A Resident may use the informal and/or formal grievance procedures set forth below.

This policy applies to the following types of grievances:
- Inappropriate conduct by MCW faculty or staff toward resident, including mistreatment and/or failure to abide by Program policies and procedures.
- Inappropriate conduct by MCW Affiliate (including Froedtert) staff toward resident
- Program non-compliance with the American Psychological Association (APA) Accreditation Standards or the Association of Psychology Postdoctoral and Internship Centers (APPIC) Policies and Procedures.

Grievances or concerns which are in response to competency, performance-related or professional actions taken or decisions made by MCW in accordance with the Policy and Procedure for Management of Insufficient Competence, Due Process, and Appeal for Health Psychology Residents will be handled under and subject to such Policy, and the applicable institutional policy/ies as appropriate.

Grievances regarding content of Program policies or procedures, or accreditation guidelines, will involve review by and input from the Chair of the Department of Psychiatry and Behavioral Medicine and other institutional leaders, as appropriate.

Procedure:

Informal Grievance Procedures
If a resident has a grievance subject to this policy, he/she should first address this matter with an immediate supervisor as soon as possible (e.g., within 7 days). Residents may also consult with another clinical supervisor and/or the Residency Training Director on manners for informal resolution. If the resident is not comfortable bringing the issue to an immediate supervisor, he/she may bring the matter directly to the Residency Training Director. If the matter remains unresolved, is not resolved to the resident’s satisfaction, or if the resident is uncomfortable using these informal grievance procedures, the resident may file a formal grievance.

Formal Grievance Procedures
All formal grievances should be submitted in writing, not to exceed five pages single spaces, in reasonable size, color and style font, to the Residency Training Director unless the grievance involves the Training Director, in which case the grievance should be submitted to the Vice Chair for Education in the Department of Psychiatry and Behavioral Medicine within 7 days of an occurrence. The person to whom the grievance is submitted (Training Director or Vice Chair for Education) will serve as the Grievance Committee Chair. The Grievance Committee Chair will make all efforts to assemble a three-person committee, which will be composed of members for the Psychology Residency Training Committee, within five business days of the grievance being submitted. In the event assembly will exceed five business days, the resident will be informed of
the same and provided an estimated timeframe by which assembly will occur. The Committee will be composed of one MCW Health Psychology faculty member who is chosen by the resident and two members appointed by the Grievance Committee Chair. The Committee will gather information regarding the grievance, inform the resident of the findings, and offer recommendations to the Grievance Committee Chair. In the event the grievance is about or directly pertains to a particular individual, such individual will not part of the Committee.

Appeal
The resident has the right to contest any decision of the Committee. Should this occur, the resident can take the issue to the Chair of the Department of Psychiatry and Behavioral Medicine who will review the information collected by the Grievance Committee and render a final decision. The final decision will be communicated concurrently in separate written communications to the resident and other person(s) who are responsible for executing resolution.

All Grievance Committee Proceedings will have formal minutes taken, which will include date and time of the meeting, people in attendance, grievance brought forward, solutions attempted to date, and results of the review. The grievance, grievance procedure, documentation, evidence and attestations, and documentation of the Grievance Committee proceedings (minutes and documents reviewed) will be logged and maintained in a Grievance Log.

Disclaimer
Notwithstanding anything stated herein to the contrary, matters involving discrimination (including sex-based) will be handled under the applicable institutional policy(ies). See the MCW Anti-Harassment and Non-Discrimination Policy (AD.CC.050) and MCW Prohibitions on Sex Discrimination and Related Misconduct Policy (AD.CC.080) for more information. Furthermore, MCW recognizes issues may arise which contain components crossing multiple program and institutional policies. In such instances, MCW will respond in a manner and under the policy(ies) which, in its sole discretion, allows full compliance with applicable laws, rules and regulations.

Effective Date: July 1, 2018
Health Psychology Residency Diversity and Non-Discrimination Policy

Applies to:
Residents of the Health Psychology Residency Program

Purpose:
Outline the Program’s mission statement on diversity and non-discrimination.

Policy:
The F&MCW Health Psychology Residency highly values the strength of a diversity and believes in creating an equitable, respectful, professional, safe, and inclusive learning environment for all residents. Diverse experiences, backgrounds, and identities strengthens our safe and collaborative environment that promotes growth and optimal training. As such, the program strives to create and foster an environment of multiculturalism and respect of the unique experiences and identities of our residents, faculty, colleagues, and patients. As such, F&MCW Health Psychology Residency welcomes and encourages applicants from diverse backgrounds.

The Froedtert and the Medical College of Wisconsin (F&MCW) Health Psychology Residency is part of the Medical College of Wisconsin in sponsorship with Froedtert Hospital. Both Froedtert Health and the Medical College of Wisconsin are dedicated to the creation and maintenance of a safe, diverse work environment. As such, both entities have non-discrimination policies in place that are provided as attachments to this policy. Our program standards meet and exceed the policies of both entities. Resident selection and evaluation are done on the basis of qualification and match with program objectives, competence related to program competencies, and quality of work.

The Froedtert and the Medical College of Wisconsin (F&MCW) Health Psychology Residency does not discriminate on the basis of race, color, national origin, religion, gender identity, pregnancy status, sex, physical or mental disability, medical condition, genetic characteristics, ancestry, marital status, age, sexual orientation, citizenship, service in the armed forces, and/or veteran status. Non-discrimination applies recruitment (i.e., interviews, selection, ranking), training practices (i.e., access to clinical opportunity, training, or evaluation), and benefits (i.e., salary, benefits, sick time, vacation time, dissertation release time, conference time, access to work-related resources).

Please refer to relevant Corporate Policies:


Effective Date: July 1, 2017
Maintenance of Records Policy

Applies To:
Residents of the Health Psychology Residency Program

Purpose:
The purpose of this policy is to outline the procedures for maintenance of records related to the Health Psychology Residency Program in compliance with federal, state and other legal requirements as well as American Psychological Association Commission on Accreditation (CoA) for record retention.

Policy and Procedures:

Maintenance of Application Records:
For each applicant to the Health Psychology Residency, an application file will be created and maintained. The application file will consist of:
- APPI
- Application Review Form (for applicants who are invited to interview)
- Interview Form (for applicants who interview)

Application files will be kept for all applicants indefinitely in electronic or paper form (if originally created in paper form). Application files kept in electronic form will include the APPI and scanned versions of the Application Review Form and Interview Form (for applicants who interview). Original copies of the Application Review and Interview Forms, and any printed APPIs with written content on them will be kept in paper form.

During interview season, the electronic Application Files, consisting of the APPI, will be available to all members of the Core Training Faculty who will be reviewing applications via a secure, confidential server. The faculty member assigned to the initial review of the applicant will complete the Application Review Form, which will become part of the Application File. Any faculty member who interviews an applicant will complete an Interview Form that will also become part of the Application File.

After interview season, electronic application files (including the APPI, scanned Application Review Form, and scanned Interview Forms) will be kept in an archived file on a storage secure, confidential server, with only the Training Director, Associate Training Director, and Educational Coordinator having access to the files. Application files kept in paper form (including Application Review Forms completed on paper, Interview Forms, and any printed APPI with written notes on it) for the current year will be kept on site at the Department of Psychiatry and Behavioral Medicine in a secure, confidential, locked file cabinet and application files from previous years will be kept off site at a secure, confidential data management service, Coakley.

A summary data log will also be kept, which will include program related data included by not limited to: number of applicants, number of applicants offered interview, and rank order list.

Maintenance of Training Files and Training Records:
Each Health Psychology Resident will have a separate training file and record that is kept in either electronic or paper form. For the purpose of this policy and program, a Training File is a
file (both paper and electronic) that encompasses all elements of the resident’s training including formal records and informal information, feedback, and informal remediation measures. Elements of the Training File will remain confidential and not be released to third parties. A Training Record is a formal subset of the Training File that includes formal information that may be released to third parties. Training files and folders kept in electronic form will be maintained on a secure, confidential archived server and training folders kept in paper copies (for all data created in paper form) for the current year will be kept on site at the Department of Psychiatry and Behavioral Medicine in a secure, confidential, locked file cabinet and application files from previous years will be kept off site at a secure, confidential data management service, Coakley. Training folders will be available to all members of the Core Training Faculty for review as needed. Training records will be kept indefinitely.

**Training File will include:**
- Release to discuss training with Doctoral Training Program
- Quarterly evaluations made by rotation supervisors
- Quarterly evaluations made by BMPC clinic supervisors
- Summative evaluations made by Training Director
- Interactive Ethics Conference: Case Study Review and Discussion Evaluation
- Resident Scholarly Project Evaluation Form
- Resident Supervisor Evaluation Form
- Notes from Training Committee Resident Review meetings
- Copy of Certificate of Completion
- Relevant email communications and/or written documentation regarding informal training issues to be addressed in supervision
- Relevant written documentation of informal remediation procedures
- Information relevant to competency evaluations, including:
  - Informal plans for supervision on issues (see note below)
  - Remediation plans

Please note that information regarding informal plans to improve competence will not be noted in the file as remediation plans, but instead kept as additional information and correspondence that will not be released from the institution.

**Training Record will include:**
- Release to discuss training with Doctoral Training Program
- Quarterly evaluations made by rotation supervisors
- Quarterly evaluations made by BMPC clinic supervisors
- Summative evaluations made by Training Director
- Interactive Ethics Conference: Case Study Review and Discussion Evaluation
- Resident Scholarly Project Evaluation Form
- Resident Supervisor Evaluation Form
- Notes from Training Committee Resident Review meetings
- Copy of Certificate of Completion
- Information relevant to competency evaluations, including but not limited to:
  - Development plans
  - Progress report on development plan

**Maintenance of Program Grievance and Due Process Records:**
If a situation arises where a resident files a formal grievance against the program, a faculty member, a staff member, or the institution, a Grievance File or Appeal/Due Process File will be created. Grievance Files and Appeal/Due Process Files will be kept in paper form in a locked file cabinet with only the Training Director, Associate Training Director, and Educational Coordinator having access. Should the complaint be against any of those parties, the Grievance and/or Appeal/Due Process File will be kept in a locked file cabinet in the Office of the Vice Chair for Education.

**The Grievance File will include** (Please see Grievance Process in the Grievance Policy and Procedures for Health Psychology Residency Program for Details):
- Any grievance submitted to the training program
- Evidence gathered by the Grievance Committee
- Findings of Grievance Committee
- Appeals made to the Grievance Committee finding
- Written communication of Appeal Findings
- Grievance committee meeting minutes (date and time of meeting, people in attendance, results of the review)

The Appeal/Due Process File will include the following:
- Submitted written appeal
- All documentation, information, and/or evidence gathered by the Review Panel
- Information and evidence relevant to the initial decision made
- Any oral or written testimony provided as part of Review Panel deliberation
- Review Panel Summary Report

As part of the program records, the program will maintain an ongoing log, organized by training year, of any grievances or due process/appeals made by residents against the program, faculty, or institution.

**The Grievance Log will include the following information:**
- Date of grievance report
- Person to whom grievance was made/reported
- Date of occurrence(s)
- Person or entity grievance is filed against
- Details of the incident(s)
- Program actions
- Location of the grievance file/related information
- Outcome/results

**The Due Process/Appeals Log will include the following information:**
- Date of appeal
- Person to whom the appeal was made
- Date of decision to be appealed
- Details of original action/situation and decision
- Details regarding rationale for appeal
- Program actions
- Location of associated file(s)/related information
- Outcome/result
Log information on grievances and due process/appeal proceedings will be made available to accrediting bodies and site reviewing for regular monitoring.

**Maintenance of Program Records**

- The program will keep the following records for review by regulatory and accrediting bodies
  - Resident Application Data (collected yearly)
    - Applicants to the program (Phase 1)
    - Applicants submitted on APPIC rank order list (Phase 1)
    - Applicants to the program (Phase 2)
    - Applicants submitted on APPIC rank order list (Phase 2)
    - Residents who entered program full time
    - Residents who entered program part time
    - Residents who were funded
    - Residents who were not funded
  - Due Process Log
    - Please see above
  - Grievance Log
    - A log will be kept of all grievances made within the context of the program including but not limited to grievances against the program, supervisors, other staff members, or fellow residents.
    - In the case when a grievance is made, in addition to being logged in the Grievance log, a Grievance File will be created. Please see above for information kept in Grievance File.
  - Demographic information (matriculated students)
    - Racial/ethnic identification
    - Subject to Americans with Disabilities Act
    - Foreign Nationals
  - Program Evaluations
    - Supervisor evaluation forms
    - Orientation evaluation forms
    - Program evaluation forms
    - Didactic evaluation forms
    - Alumni preparedness evaluation form
  - Pre-internship experiences/education
    - Doctoral degree granting institution
    - Area of doctoral study (clinical, counseling, school)
    - Degree program (PhD, PsyD, EdD)
  - Resident Professional Activities (during internship year)
    - Member of professional or research society
    - Scientific presentation (workshops, oral presentations and/or poster presentations at professional meeting where student was an author or co-author)
▪ Scientific publications (books, book chapter, or articles in peer-reviewed professional/scientific journals of which a student was an author or co-author)
▪ Held leadership roles in state/provincial, regional or national professional organizations

  o Outcome data
    ▪ Resident initial employment after graduation
    ▪ Resident initial job title
    ▪ Resident current employment setting
    ▪ Resident current job title
    ▪ Year degree completed
    ▪ Psychology licensure

  o Supervisor Experience and Training

  • Data will be kept primarily in electronic form on a secure server with only the Training Director and Educational Coordinator having access. Information created in paper form originally will be scanned into the electronic file and kept in paper form indefinitely with the current year information being kept on site in the Department of Psychiatry and Behavioral Medicine in a locked file cabinet and subsequent years being stored by a secure file management service, Coakley.

Effective: July 1, 2018
Management of Insufficient Competence, Due Process, and Appeal for Health Psychology Residents

Applies To:
Residents of the Health Psychology Residency Program

Purpose:
To provide policy and procedures for fair and effective management of and response to employment issues and insufficient health psychology resident competence, including remediation, resident appeals and due process. All residents are evaluated in accordance with the expectations and procedures outlined in the Resident Evaluation Procedure Policy, and with the employment expectations set forth in applicable institutional policies.

Policy:
The goal of this policy is to promote resident competency and performance in line with American Psychological Association Standards, APA Professional Ethics, applicable laws and Medical College of Wisconsin (MCW) policies.

For purposes of this policy, references to competency matters mean those which are competency and academic progress in nature. Competency may involve professionalism components, which include but are not limited to those which are behavioral or attitudinal in nature. Professionalism issues may also arise separately from any competency issues. Finally, certain complex issues may contain both competency and professionalism components, and may rise to a level requiring employment-related action or decisions (examples of which include suspension or termination). In all instances, MCW will respond to issues in a manner and under the policy(ies) which, in its sole discretion, allows full compliance with applicable laws, rules and regulations. Furthermore, any ambiguities in this policy will be construed in a manner allowing for full compliance with applicable laws, rules and regulations.

Competence and Professionalism Issues
Health Psychology residents will be expected to develop their clinical competencies at an appropriate, expected pace throughout residency, including the development of professionalism, knowledge, and skills needed to competently practice health service psychology. A resident may demonstrate below-expected level competence across any of the outlined clinical competencies in general domains of professionalism, knowledge, and/or skills. Most below expected level competence can and, wherever possible, will be corrected through the standard supervisory process.

Should below expected level competence continue even after guidance in supervision, formal remediation may be required. Additionally, some problems that are either of a sufficiently serious manner or not amenable to standard supervision or formal remediation, may prove irremediable.

Professionalism and insufficient competency problems typically reach the level of persistent problems if they include one or more of the following characteristics:
  - Unwillingness to acquire and incorporate professional standards into professional behaviors
• Inability to acquire sufficient professional skills to reach an acceptable level of competency
• Inability to manage personal stress, psychological dysfunction, and/or strong emotional reactions that interfere with professional functioning.
• Resident does not acknowledge, understand, or address an identified problem
• Problem requires a disproportionate amount of time to be addressed by the training staff
• Resident performance does not improve as a function of feedback or remediation efforts after a period of time identified for effective remediation

**Issues Requiring Employment-Related Action**
When a resident demonstrates behavior that violates institutional policies and procedures or when there is a safety risk, MCW will evaluate whether employment related action is needed. Examples include but are not limited to:

• Resident actions result in a negative impact on the quality or safety of services provided
• Resident violates an institutional policy that creates an unprofessional or unsafe work environment for patients or co-workers.
• Problem is diffused and not restricted to one area of professional functions

**Procedure:**

**Informal Remediation**
If, after prior discussion in supervision, a supervisor continues to observe behavior or performance that indicates the resident is exhibiting or experiencing professionalism issues, or is not achieving expected levels of competence, it is the responsibility of the supervisor to communicate written feedback, expectations and the consequences of uncorrected behavior in a specific and concrete manner. Concerns must be addressed in a consistent manner, free of prejudice and bias, and without discrimination.

The clinical supervisor should directly discuss the concern(s) with the resident in supervision. Should the concern(s) be identified by other faculty or staff members, the same should be reported to the clinical supervisor and/or Training Director. The insufficient competency and/or professionalism issues should be addressed by the most appropriate faculty member, either the clinical supervisor and/or Training Director. When a resident is demonstrating below expected level of competence in need of informal remediation, feedback detailing the specific behaviors observed or omitted, the competencies and elements in need of development, and behavioral outcomes needed to demonstrate sufficient competence will be provided in writing and discussed in supervision. This documentation will be placed in the resident’s training file (please see Clinical Supervision Form) and employment record, as appropriate.

**Formal Remediation / Corrective Action**
Should the problem persist, the Training Director will work with the clinical supervisor to develop a written Development Plan (as described in detail below) to facilitate improvement in the resident’s performance.

The Development Plan should be reviewed and discussed with the resident, supervisor, and Training Director. After verbal discussion, a signed and dated copy (signed by the resident, supervisor, and Training Director) will be given to the resident and placed in the resident’s training record. The Program will also present a copy of the Development Plan to the Director.
of Clinical Training at the resident’s academic program of origin, and provide a copy of the same to the Office of Human Resources.

If at any time during the review process the resident’s performance is determined to be potentially threatening to patient care or the resident’s personal welfare, the resident’s work assignment/access to provide direct clinical care may be reduced or revoked for a specified period of time determined appropriate by the clinical supervisor, Training Director and the Office of Human Resources. Should this occur, the resident’s academic program Director of Clinical Training will be notified of this action. At the end of the specified period of time, the resident’s primary supervisor in consultation with appropriate staff (including but not limited to the Office of Human Resources, the Training Director, and the Training Committee) will assess the resident’s capacity for safe and effective functioning to determine whether work assignment with direct patient care will be restored or whether reduction in clinical exposure or removal from the program is appropriate.

MCW may determine, in its sole discretion, that certain issues warrant immediate intervention to ensure the safety of patients and/or a safe working or learning environment. MCW shall intervene as it deems appropriate for the circumstances. Furthermore, should a resident be charged with any crime, s/he must notify MCW of the same as soon as possible but no later than the next business day. This includes but is not limited to those crimes prohibited under the Wisconsin laws governing caregivers, and the related MCW Caregiver Background Checks Policy (HR.EE.050). Depending on the nature of the crime, this may result in immediate suspension until MCW can complete an investigation of all available information. If a resident is alleged to have had sexual contact with a patient, or alleged to have made a serious ethical violation, the resident may also be placed on immediate suspension with cessation of access to patient care, the medical record, computer systems, and Froedtert and the Medical College of Wisconsin facilities. The disposition of the resident will be determined by the Residency Training Director in consultation with the Residency Training Committee, following a full evaluation of all available information. In addition to consulting appropriate academic stakeholders, the Residency Training Director will also engage institutional stakeholders, including the Office of Human Resources and others as appropriate.

**Notification and Remediation**

It is the goal of the program to provide feedback about professionalism issues and insufficient competence as early as possible with the goal of remediation, unless remediation conflicts with MCW’s primary obligation to ensure safe patient care, working and learning environments in which case(s) MCW will take all action necessary to preserve such environment(s). When a professionalism or competence matter is identified and remediation is an appropriate objective, notification and remediation will move through the following levels:

**Official Warning:** This level of notification is appropriate for less serious professionalism or insufficient competence problems that can be remediated through education and supervision (i.e. informal remediation). The Official warning mechanism is receiving a Clinical Supervision Form in supervision. This mechanism is designed to be educative and directly linked to clinical competencies; this will be addressed in supervision. This level of warning (Please see Clinical Supervision Form) includes a clear description of the insufficient competence (including behavior, attitudes, and omissions) and will link directly to the program competencies and associated elements. The resident is provided with a clear description of expectations for improvement in professional behavior or sufficient competence. The problem may result in
increased supervision time or other action as MCW deems appropriate. The supervisor will provide a copy of the Clinical Supervision Form detailing the aforementioned elements to the resident and place a copy in the resident’s training file. This level of remediation is not part of the resident’s permanent training record but will be retained as part of his/her training file, as appropriate.

**Development Plan:** This occurs when the professionalism or insufficient competence problem does not resolve through an official warning or if a problem is moderately serious and a verbal warning does not, in MCW’s discretion, constitute a sufficient response. In this case, the resident will be informed of the level of concern and a Development Plan will be developed. A Development Plan includes:

List of problematic behavior, performance, or insufficient competence as well as how these map onto the specific competencies and elements outlined for the program.
- The date(s) when the problem was brought to the Resident’s attention, who notified the Resident of the issue, and what steps have been taken thus far to rectify the problem
- Expectations for improvement or remediation
- Resident responsibilities in development plan
- Supervisor/Training Director responsibilities in development plan
- Timeframe for acceptable performance
- Assessment methods for determining acceptable performance
- Dates of follow-up evaluation
- Consequences of unsuccessful remediation

This level of remediation is documented in the resident permanent training record employment record and is also shared with the resident’s academic program Director of Clinical Training.

**Extension of Residency Training or Recommendations for a Second Residency/Internship:** This level of remediation is appropriate in instances where a resident has made progress toward remediation of insufficient competence, but insufficient progress prior to the end of the training year, and/or where a resident requires additional time to develop or improve professionalism and/or competency-related skills. The resident may be required to extend his or her residency at this site to complete relevant requirements. The resident may also be required to complete all or a part of another psychology residency/internship. In order to fulfill this level of remediation, the resident must sufficiently demonstrate among other things the willingness and capacity to engage in and progress through remediation. The resident’s academic program Director of Clinical Training and Office of Human Resources will be notified and consulted on the training and employment aspects of the process, respectively.

**Suspension or Dismissal:** This level of remediation is considered under the following circumstances (this list is not exhaustive):
- Serious violations of APA Code of Ethics, state or federal regulations/statutes/laws
- Imminent harm to a patient
- A pattern of unprofessional behavior
- Evidence of professional impairment including but not limited to professional impairment associated with substance abuse and mental illness impacting competency and/or qualification
• Demonstrated inability to remediate a performance problem
• Any other situation that MCW deems a serious violation of policy, practice, or behavior.

Suspension is the mandated leave of absence without pay, release from clinical duties, and restriction of access to MCW/FMLH IT portals as well as the MCW/FMLH physical space for a designated period of time. Suspension for professionalism or insufficient competence reasons must be approved by the Training Director and the Office of Human Resources. The Training Director must also consult through Association of Psychology Postdoctoral and Internship (APPIC)'s Informal Problem Consultation and work collaboratively with APPIC should a resident require suspension.

Dismissal is a permanent termination from the training program at MCW that includes termination of employment and non-completion of the training program at MCW. Dismissal for insufficient competence or professionalism reasons must be approved by the Department of Psychiatry and Behavioral Medicine Vice Chair for Education, and the Department of Psychiatry and Behavioral Medicine Chair, and the Office of Human Resources. The Training Director must also consult through Association of Psychology Postdoctoral and Internship (APPIC)'s Informal Problem Consultation and work collaboratively with APPIC should a resident require termination.

If a resident faces suspension or dismissal, the resident will be notified of this immediately and provided documentation of the reasons for the suspension or dismissal. The resident will then be provided with the procedure for appealing the suspension and/or dismissal.

Should the decision to suspend or dismiss a resident be made, the Residency Training Director will make all efforts to provide a written notification to the resident's academic program Director of Clinical Training within two working days after the decision was made. In the case of dismissal, the Residency Training Director will send written notification to the academic program Director of Clinical Training and include recommendations to the academic program regarding professional development options for the resident.

Due Process and Appeal Procedures for Residents

Notice and Appeal
Should a resident desire to appeal the notice of a problem with competency, performance or professionalism, the resident must use the appeal procedures outlined below.

Appeal Process
Professionalism and Insufficient Competence - Residents can appeal decisions or actions taken by a clinical supervisor, the Training Committee, and/or the Training Director as stated in the Grievance Policy for Health Psychology Residency Program. Decisions and actions respect competence, professionalism, program-related suspension/dismissal and exclude employment-only related suspension or dismissal, which shall be handled pursuant to the below section. All academic appeals are recorded in an Appeal Log, with the steps in the procedure being behaviorally and specifically documented. The copy of the Appeal will be provided to the resident and the Residency Training Director.

Employment – Appeals of employment-related decisions or actions will be handled under the MCW Staff Conflict Resolution Policy (HR.ER.080). Pursuant to such Policy, residents may
appeal employment related corrective actions or terminations, provided the Resident has completed the six-month Trial Period with MCW successfully.

**Appeal Procedures**

1.) The resident must file an appeal of any competency decision or action in writing to the Residency Training Director or designee (the Department of Psychiatry and Behavioral Medicine Vice Chair for Education if the complaint is against or otherwise involves the Training Director) within seven (7) days of the decision being appealed and/or action or event that took place. The appeal should include:
   a.) Reasons resident is filing the appeal
   b.) Documentation regarding the decision/event/action that is being appealed
   c.) Rationale for why the decision/action/appeal should be reconsidered or withdrawn

   i.) Note- the resident will have access to all documentation used by the Clinical Supervisor, Training Committee, or Training Director in making their original decision the resident is seeking to appeal, unless otherwise protected or prohibited by law.

2.) Within five business days of when the written academic appeal was received, the Residency Training Director or his/her designee will appoint a Review Panel. The Residency Training Director (or designee) will chair the panel that will consist of two supervisory faculty members selected by the Chair and two supervisor staff members selected by the resident. All such individuals will be vetted for known conflicts of interest that may impair an objective review of the matter.

The Panel Chair will secure all documentation related to the academic decision/action under appeal and will interview persons s/he believes who have information helpful to the Panel deliberation. The resident may, but is not required to, make an oral or written testimony as part of the deliberation process. Such oral testimony shall not exceed 15 minutes in duration, or if written five (5) pages single spaced, of reasonable font size, color and style.

The Panel Chair will present the findings and recommendations of the Review Panel in writing to the Chair of the Department of Psychiatry and Behavioral Medicine within five business days of adjournment of the Review Panel. A simple majority will decide all academic appeal decisions. The Panel Chair will cast the vote only in the event of a tied vote.

**Final Adjudication:** The Chair of the Department of Psychiatry and Behavioral Medicine will respond to the Review Panel’s recommendations within five business days of receiving the Review Panel summary report. The Department of Psychiatry and Behavioral Medicine Chair may accept, modify, or overrule any of the Review Panel’s recommendations in the event s/he determines such recommendation(s), or portion(s) thereof, resulted from arbitrary and/or capricious means; and/or a misapplication of relevant policies and/or procedures. The Residency Training Director and the Resident will be informed of the final decision by the Chair of Psychiatry and Behavioral Medicine.

**Notice to Resident:** The Resident appealing the academic action will be informed in writing of the outcome within five business days of the final decision being reached.
Notwithstanding anything stated herein to the contrary, matters involving discrimination (including sex-based) will be handled under the applicable institutional policy(ies). See the MCW Anti-Harassment and Non-Discrimination Policy (AD.CC.050) and MCW Prohibitions on Sex Discrimination and Related Misconduct Policy (AD.CC.080) for more information. Furthermore, MCW recognizes issues may arise which contain components crossing multiple program and institutional policies, or which are complex in nature. In such instances, MCW will respond in a manner and under the policy(ies) which, in its sole discretion, allows full compliance with applicable laws, rules and regulations. Ambiguities under this policy will be construed in a manner allowing for the fullest compliance applicable laws and institutional policies.

Effective: July 1, 2018
Clinical Supervision Form

**Purpose:** To provide specific, competency-based feedback on areas of needed growth to accomplish sufficient competence in the Residency Program.

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<thead>
<tr>
<th>Rotation Name:</th>
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<tr>
<td>Date:</td>
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<td>Resident:</td>
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<td>Clinical Supervisor:</td>
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Description of behavior not meeting expected level of competence. Please provide feedback in specific, behavioral terms (i.e., When observed, where observed, type of behavior).

Identification of **specific competency** and **elements** of the competency where work is needed to achieve expected level of competency.

Description of behaviors that need to be observed by supervisor to demonstrate appropriate progress toward sufficient competence.

Timeline for review of progress toward sufficient competence.

Effective July 1, 2018
Orientation Policy and Procedure Verification

During the orientation for the Health Psychology Residency I, __________________, received a copy of the policies and procedures related to the Health Psychology Residency program, policies, and completion criteria. I attest that these policies were reviewed in depth with me during the orientation.

<table>
<thead>
<tr>
<th>Psychology Resident Name (print)</th>
<th>Psychology Resident Signature</th>
<th>Date</th>
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</thead>
<tbody>
<tr>
<td>Director of Clinical Training (print)</td>
<td>Director of Clinical Training Signature</td>
<td>Date</td>
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Effective: July 1, 2017
Resident Evaluation Procedure Policy

Applies To:
Residents of the Health Psychology Residency Program

Purpose:
To set forth specific and measurable procedures for ensuring residents are progressing through their training and achieving training-level appropriate competency, so that they are competent for entry level practice as a health psychologist by the end of the training year.

Policy:
The Froedtert and the Medical College of Wisconsin Health Psychology Residency is dedicated to helping residents work toward competency through frequent and transparent feedback and evaluation regarding clinical competencies.

Procedures:

Informal Evaluation Procedures
1. Clinical supervisors will provide real-time feedback to residents regarding their cases, skills, professionalism, and work toward competence.
   a. Feedback will be given to residents based on (i) observation of clinical work, (ii) review of clinical work and case consultation, (iii) review of written work product, and (iv) observation of resident verbal presentation of clinical work.
   b. Feedback on clinical skills will be provided verbally in clinical supervision and the supervisor will be available for discussion of the feedback.
   c. Feedback on written materials will be provided both in written form and in verbal feedback, depending on the level of graded independence the resident has demonstrated.
2. It is the responsibility of the resident to integrate feedback about their clinical and professional strengths and weaknesses and work toward developing competence.
3. Clinical supervisors will provide concrete feedback on how to develop competence; however, it is also the responsibility of the resident to request additional feedback from the supervisor as necessary regarding their own clinical work and professional development. It is also the responsibility of the resident to seek clarification on feedback as necessary to develop competence.

Formal Evaluation Procedures:
1.) Quarterly Evaluations by Clinical Supervisor
   a. Each resident will be formally evaluated by their clinical supervisors in both their specialty rotation and continuity clinic at least once every three months.
   b. Because not every clinical competency will be included in every rotation of the Residency, quarterly evaluations will cover the clinical competencies generally applicable to the specialty rotation participating in the resident’s evaluation. Residents will be informed as to which competencies are covered prior to the beginning of each specialty rotation.
   c. The clinical supervisor will complete the standard rotation evaluation form and discuss the numeric values as well as provide narrative feedback on suggested areas for continued growth throughout the rest of residency. The resident will have the opportunity to discuss and clarify their evaluation and request further narrative feedback.

2.) Monthly Review by the Training Committee and Ongoing Narrative Feedback
a. The Training Committee will convene monthly to discuss resident progress toward program-wide competencies, including areas of strength and areas for further training. The Training Committee will determine whether residents are on track for achieving sufficient competency by the end of residency or whether additional training and support may be needed.

b. The clinical supervisor working with the resident will share data from these meetings with the resident in clinical supervision on an ongoing basis in order to setting goals for continued development of competence. This is not a corrective or formal feedback process, but instead will be used to facilitate progress toward competence.

c. Rotation supervisors will also provide written narrative feedback to the resident half way through the rotation to help facilitate progress toward competence.

d. Should the clinical supervisor, Training Committee, or Training Director determine that a resident is not on track to meet competence by the end of residency, the informal and formal remediation process will begin immediately (please see remediation process policy).

3.) Bi-annual Program Evaluation
   a. The Training Director will aggregate the four numeric evaluations (two from the clinical rotations and two from the continuity clinic) and Training Committee findings and provide relevant feedback to the Resident twice per year, at the midpoint and prior to graduation.
   b. This will involve a formal summary evaluation, which will be discussed in a meeting with the Training Director.
   c. Should any insufficient competency be identified by the clinical supervisor or Training Committee, the informal and formal remediation processes will begin immediately (please see remediation process policy).
   d. Bi-annual Program Evaluations will be shared with the resident’s doctoral program training director at mid-year and end-of-year.

4.) Should the resident have a grievance with the evaluation procedure or any decision by the clinical supervisor, Training Committee, or Training Director, please refer to the Resident Grievance Policy and Procedure for the process related to grievances.

5.) Resident evaluation of the supervisor
   a. Residents are encouraged to provide informal feedback to their clinical supervisor on supervisory style and resident training goals with the goal of improving clinical training.
   b. Residents will complete a formal evaluation of each clinical supervisor at the end of the clinical rotation. Residents are encouraged to share the evaluation with their clinical supervisor and discuss in supervision with the goal of improving clinical supervision and training.
   c. The resident may also provide feedback regarding his/her clinical supervisor to the Training Director. The Training Director will provide mentoring and guidance on how to communicate professionally and navigate conflict management between residents and supervisors.
   d. Residents will also provide feedback on supervisors at the end of the year that will be collected and managed at the programmatic level.

6.) Resident evaluation of the program
a. The resident will provide feedback to the program in the form of a bi-annual written evaluation of the program.
b. Feedback will be used to determine resident perceptions related to the training program and its effectiveness in developing competence, and for ongoing program improvement.
c. Should the resident feel uncomfortable providing feedback to the program, the resident should be advised to seek consultation with the Training Director or utilize the grievance procedure.

7.) Evaluation of Orientation and Onboarding
   a. Residents will be asked to evaluate the orientation and onboarding process bi-annually, once after orientation and once at the end of the year.
b. The goal of orientation evaluation is to assess comprehensiveness and appropriateness of the orientation material provided to ensure adequate training for residents to engage optimally in the residency training program.

8.) Requirements for Successful Completion of the Residency Program
   a. Complete one year of full time clinical work, averaging 40-45 hours per week. Resident vacation, sick time, and dissertation release time that is within the allowed limited outlined in the Stipend and Benefit Policy does not count against time required for successful completion.
b. Complete at least 500 hours of direct clinical work summed from across the five clinical rotations
c. Complete at least 200 hours of clinical supervision
d. Complete a Scholarly Project approved by a faculty mentor and the Training Director
e. Completion of at least 96/100 didactic seminars from the Didactics Seminar Series, with the exception of allowed time out of the office.
f. Attend at least 95% of Group Supervision, Group Case Series, and Required Grand Rounds meetings, with the exception of allowed time out of the office.
g. Complete all required documentation, including clinical (i.e., reports, intake notes, progress notes, etc.) and administrative (i.e., data monitoring, evaluation procedures) documentation in a timely manner, which includes seeking appropriate supervisor sign off on documentation in a timely manner.
h. Attain supervisor evaluation forms demonstrating competence across all APA defined competency areas as demonstrated by:
   i. Residents are expected to achieve on track or above ratings of competence on each element (2-3 by first quarter; 3-4 by mid-year; 4-5 by third quarter; 6 by end of year) at each evaluation point and entry-level competency by the conclusion of the residency year.
   ii. Should a resident demonstrate below expected competence appropriate to his/her developmentally expected level, a Development Plan as outlined in the Remediation Process Policy will be prompted implemented.
   iii. Successful completion of any Development Plan should one be implemented.
i. Complete all programmatic evaluation forms in a timely manner

Effective: July 1, 2018
**Responsible Use of Technology Policy**

**Applies To:**
Residents of the Health Psychology Residency Program

**Purpose:**
To define appropriate use of electronic resources.

**Policy:**

**Computer Usage**
All health psychology residents may be assigned or check out a Medical College of Wisconsin Chromebook for professional use. Chromebook computers are to be used as portals to access the secure network (Medical College of Wisconsin servers and Froedtert Health Epic Medical Record). In order to ensure maintenance of security of patient health information, absolutely no documents are to be saved on the hard drive, desktop, or documents of the laptop computer. All residents will be assigned a secured, remote drive where they will be able to save all data, including sensitive and other information.

Additionally, residents will submit work product (e.g., psychological reports, etc.) to their supervisors through a secure folder to which the resident and his/her supervisor will have access. Residents are not to send any work information (e.g., notes, psychological reports, information about patients) over non-MCW email. Notes, psychological reports, and communications about patients may be sent through the Epic secure messaging system or only from an MCW email account to another MCW email account. Best efforts should be made to use the Epic system and secure servers.

**Use of Internet and Email**
Residents are not to access, transmit, store or distribute any inappropriate materials or access any website that contains any inappropriate materials from their Medical College of Wisconsin laptop, any MCW desktop, or Froedtert Health computer. Inappropriate materials may include, without limitation, content that is derogatory, sexually explicit, harassing, abusive, hateful, indecent, harmful, fraudulent or otherwise violates applicable law, including intellectual property laws, or the policies of MCW.

**Use of Social Media**
Residents will not use social media or other internet-based tools such as web browsers to interact with or gather information about patients without prior approval from their supervisor. If a patient asks a psychology resident look at his/her social media profile, this will be done only after considering the clinical utility and done in the context of a therapeutic session on the patient’s device. Residents will not seek out or accept social media contact with their patients, patients’ family members, members of the Training Faculty, supervisors, or other faculty members during the training year. After completion of training, residents are strongly advised against connecting with patients and patients’ families through social media. Residents and faculty members (either members of the training committee or general faculty) may engage in social media relationships to the extent that both are comfortable with the relationship and that there is no longer a current evaluative/supervisory relationship.
Residents are encouraged to review the security settings of all social media sites and profiles to ensure they understand what information about themselves is publicly available. Residents must portray a professional and appropriate boundary via their social media presence.

Contact with Patients and Patients' Families
Residents should use only MCW/FMLH equipment (e.g., office phone) to communicate with patients and patient families. Emailing and other forms of electronic communication with patients or their family members are generally prohibited and must be cleared with a clinical supervisor prior to communication.

Other Applicable Policies
Health Psychology Residents are also subject to the MCW Use of Electronic Equipment Policy (IT.IS.030) and MCW Email Usage Policy (IT.IS.040).


Stipend and Benefits Policy

Applies To:
Residents of the Health Psychology Residency Program

Purpose:
To outline the Stipend and Benefits resources available to Residents

Policy:
Stipend
Residents will receive a competitive stipend paid in monthly installments on twelve separate occasions. The current stipend for a Health Psychology Resident is $31,000 annually.

Benefits
Residents have access to benefits in line with exempt staff employees at the Medical College of Wisconsin. Benefits are modified yearly, and eligibility and offerings are described within the MCW Benefits Eligibility – Exempt Staff policy: https://infoscope.mcw.edu/Corporate-Policies/Benefit-Eligibility-Exempt-Staff.htm

Health Benefits: Health insurance (for self, spouse, and legal dependents), is an included benefit of the residency program. Please refer to the link above regarding coverage and cost of health insurance.

Retirement Benefits: Residents are eligible to participate in the MCW voluntary retirement 403b plan. Residents may voluntarily elect to tax shelter non-matched contributions to an approved 403(b) account within IRS limits. Residents can begin and end this account at any time

Holidays and Leave: Residents receive 8 holidays per year. Additionally, residents accrue 1 hour of sick leave for every 30 hours worked, with a maximum of 56 hours banked at any given time. They also accrue or receive 20 vacation days per academic year.

Authorized Absence
Authorized Absences are separate from the holiday and other leave set forth in the applicable MCW benefits policy(ies). Residents can be granted an authorized absence for professional conferences and workshops at the discretion of the Training Director. Presentation of scientific material and/or engagement in a professional activity is typically required for release time, although exceptions can be made if the conference activity furthers professional goals as a health service psychologist. Residents can also be granted authorized absence(s) for dissertation defense time. Dissertation defense time is used only for time involved in travel and defense of a dissertation. Residents are also granted authorized absence(s) (professional leave time) for post-doctoral fellowship and/or job interviews. Professional leave time should only be used for the time involved in travel and interviewing. All authorized absences should not exceed five (5) work days.

Clerical Support
The Health Psychology Residency Program is supported by an Educational Coordinator. The Educational Coordinator is available for assistance in coordinating time off from rotation, leave requests, or other administrative concerns. The Educational Coordinator will also (a) distribute necessary rotation information prior to rotation switch, (b) coordinate didactics schedule and
communicate changes, (c) coordinate and communicate supervisory back up information, (d) coordinate and communicate sick time off from residency (although resident is responsible to contact Educational Coordinator and Clinical Supervisor), and (e) coordinate request for completion of forms and documentation (e.g., licensure, etc.).

Additional Clinical Resources
All residents will be assigned a pager and lab coat. Additionally, all residents have ability to check out a Chromebook computer (please see the applicable institutional policy(ies) governing computer usage) and will have access to a dedicated desktop computer on each clinical rotation. All residents will also have access to office supplies, printing, internet (in accordance with internet usage policies), office phones, and voicemail. Upon completion of the Residency program, residents must return all MCW property.

Liability Protection: When providing professional services on behalf of the Medical College of Wisconsin, Inc., sponsored trainees acting within the scope of their educational programs are protected from personal liability under The Medical College of Wisconsin Professional Liability Insurance Program, as approved by the Wisconsin Commissioner of Insurance.

Effective Date: July 1, 2019
Supervision Policy

Applies To:
Residents of the Health Psychology Residency Program

Purpose:
To ensure the Residency Program is maintaining high standards for supervision in alignment with the Guidelines for Clinical Supervision in Health Service Psychology (APA, 2014).

Policy:

Definition: “Supervision is a distinct professional practice employing a collaborative relationship that has both facilitative and evaluative components, that extends over time, which has the goals of enhancing the professional competence and science-informed practice of the supervisee, monitoring the quality of services provided, protecting the public, and providing a gatekeeping function for entry into the profession. Henceforth, supervision refers to clinical supervision and subsumes supervision conducted by all health service psychologists across the specialties of clinical, counseling, and school psychology.” (APA, 2014, p. 6).

Scope: A supervisory relationship is one where an evaluative relationship is established as part of the health psychology residency. Other members of the treatment team (e.g., physician colleagues, nurse colleagues, clinic managers, and other non-psychology medical colleagues) are not considered to be supervisors, although they may provide feedback to the resident’s supervisor regarding a resident’s performance across the range of competency domains. Faculty members consulting on the resident’s scholarly project may or may not be considered supervisors, depending on the extent of an evaluative role undertaken with respect to the project. For example, the major supervisor for the project would constitute a supervisory role, but a minor consulting faculty member would not. The Training Director can determine from time to time whether a relationship is supervisory and therefore whether the relationship is covered by this policy.

Exclusions: Absent an additional evaluative component, a supervisory relationship is not established between a resident and a faculty member providing primary didactic training related to the residency program (for example, under the core didactic series or multidisciplinary health psychology case conferences).

Supervision Requirements:
- Residents are required to complete at least four hours of supervision per week for every week they are present throughout the academic year.
- Residents are also required to have at least two of the four hour per week requirement to be 1:1 individual supervision with a Wisconsin State licensed doctoral level psychologist.
- To meet these requirements:
  - Residents will complete at least two hours per week of individual supervision with their major rotation supervisor.
  - Residents will complete at least one and a half hours per week of individual supervision with their continuity clinic (BMPC) supervisor.
  - Residents will complete at least one hour per week of group supervision with the Training Director.
Residents will also complete at least 30 minutes per week providing supervision to their doctoral practicum student.

**Supervision Coverage:**
- There are two levels of supervision coverage to account for supervisor absences.
  - **Supervision coverage on rotations:** Each rotation has two faculty psychologists with supervisory responsibility. Should a faculty supervisor be absent for any reason, the resident will have the opportunity to meet with the other faculty member for supervision in lieu of their primary supervisor as needed. Given the need for ongoing management of a case, routine supervision will not be done when a resident is scheduled to be out of the office. Any missed supervision on weeks when the resident is working must be rescheduled.
  - **Supervision coverage for immediate concerns:** The Program Coordinator will track the presence and absence of all faculty supervisors associated with the program. In the case when one faculty supervisor is absent, the other supervisor on the rotation will act as back up emergency supervisor and be available via pager and in person (on site) for supervision as needed. Should both faculty members on a rotation be absent on the same day, the Program Coordinator will communicate back up supervision for immediate concerns with the (a) resident and (b) another supervisor. A supervisor will at all times be available via pager and/or in person (on site) for supervision as needed.

**Location of Supervision:**
- All supervision for clinical work will be provided at the same location where such clinical services are provided.
  - Except in exceptional cases, scheduled 1:1 supervision will occur at the location where clinical services are provided.
  - Group supervision will be held at the Department of Psychiatry and Behavioral Medicine.
  - Should the resident’s primary supervisor be out of the office for any reason, an on-site, back-up supervisor will be provided.

**Oversight of Supervision:**
- The Training Director will have primary responsibility and oversight for supervision of the Health Psychology Residents. Should a resident not receive sufficient supervision, the Training Director will (a) provide corrective action toward the rotation providing insufficient supervision and (b) provide supervision to the resident on cases where supervision is insufficient.
- The Training Director also provides general supervisory oversight of the residents through integration feedback from faculty supervisors as well as the Training Committee.

**Supervisory Assignments:**
- Residents will have the opportunity to work with both major rotation supervisors as well as supervisors in the continuity clinic (BMPC).
- **Rotations Supervisors:** The establishment of the supervision relationship will be discussed at the beginning of each rotation with the resident. Residents will generally have the opportunity to be supervised by both faculty psychologists in the rotation on practice areas that most closely align with the faculty member’s practice. The resident and faculty supervisor will complete a supervision contract (please see Supervision Contract) at the beginning of each supervisory relationship.
• **Continuity Clinic (BMPC) Supervisors:** Residents will be assigned to a faculty supervisor for the entire academic year but may be switched at the discretion of the Training Director should the resident have concern with the assigned BMPC faculty supervisor. The resident and faculty supervisor will complete a supervision contract (please see Supervision Contract) at the beginning of each supervisory relationship.

**Type of Supervision:**
- **Live Supervision**
  - In the major rotations, live supervision will generally be used (i.e., where a resident observes a faculty psychologist and then discusses a case or a faculty psychologist observes a resident and discusses the case). However, video and/or audio recording may also be used from time to time.
  - In the BMPC, residents will tape their sessions via an in-room closed circuit monitoring system. The faculty supervisor will either observe the session with the resident live or review the tape-recorded session with the resident.
  - All residents will have live supervision on all rotations, particularly early in their training experience and/or should the supervisor feel that further direct observation is needed for feedback to develop sufficient competence.
- **Case Review**
  - Residents will staff their cases with their supervisor, discussing the details and management of the case.
- **Review of Case Files and Material**
  - Residents will be evaluated on their work product.
  - Written and oral feedback will be given on psychological reports, progress notes, and presentations.

**Supervision and Diversity:**
- Clinical supervisors will discuss multiculturalism in supervision across domains.
  - Specifically, supervisors will encourage residents to consider the cultural impact of self and others as it applies to the provision of psychological services.
  - Supervisors will also encourage discussion of culture as it applies to the interaction in supervision.
  - Residents will demonstrate integration of multicultural competence by routinely discussing cultural and diversity related issues in supervision.

**Minimum Number of Supervisors:**
- Each resident will have the opportunity to work with at least 5 supervisors throughout their training year.
- Most residents will have the opportunity to work with approximately 8-10 supervisors throughout their training year.

**Tracking of Supervision:**
- Residents will be provided a supervision log at the beginning of their training year.
- Residents will be expected to keep track of their supervision on a weekly basis.
- Residents will submit their supervision log to the Program Coordinator weekly for review by the Program Coordinator, Associate Training Director, and/or Training Director.

**Medical Record Documentation:**
- Residents will be responsible for documenting the legally responsible supervisor in the medical record.
• Clinical supervisors will attest all documentation in the medical record in a manner consistent with Froedtert and the Medical College compliance office policies.
• The clinical supervisor will close all medical record encounters after appropriate review of documentation and attestation.


Effective: July 1, 2018
Supervision Contract

Froedtert & the Medical College of Wisconsin
Health Psychology Residency
Supervision Contract

This is an agreement between the resident _________________________ and the supervisor(s)________________________________________________________ for the Health Psychology Residency Program at Froedtert & the Medical College of Wisconsin. All parties agree to abide by the Policies and Procedures set forth in the Supervision Policy as well as the following procedures:

1. Purpose of Supervisory arrangement:
   a. Monitor and ensure the welfare of patients seen by the resident.
   b. Establish and develop resident's competence in Health Service Psychology, particularly as it applies to a health psychology population.
   c. Fulfill academic requirements for resident's predoctoral residency (Internship).

2. Terms and modalities of supervision:
   a. Term of supervision will be from ____________ to ____________.
   b. Supervision will be provided by:
      (** Note. The Resident will receive 2 hours/week of 1:1 supervision in their major rotation, 1.5 hours/week of 1:1 supervision in their BMPC rotation, and 1 hour/week of group supervision)
      i. _____ hours per week individual supervision by faculty supervisor(s)
         o Supervisor(s) - if multiple supervisors, please indicate the amount of supervision provided per week by each individual supervisor
         ______________________________________________________
         ______________________________________________________
         ______________________________________________________
   c. Supervision will include the following modalities:
      i. Live supervision (Supervisor, please check applicable modalities)
         o Co-treatment
         o Direct observation
         o Review of audio/videotaped session
      ii. Case review
         o Staffing and discussion of cases involving review of details and management of the case
      iii. Review of clinical documentation and other written material
         o Written and oral feedback on documentation and written material
         o Discussion of assigned readings
   d. Residents agree to be video/audio recorded and/or directly observed as part of their training experience

3. Delineation of hours and vacation time:
   a. Residents can expect the following approximate delineation of time in the clinical rotation:
      i. Inpatient Consults and Treatment: __________________________
ii. Outpatient Therapy Patients: ______________________________

iii. Outpatient Assessment Cases: ______________________________

iv. Outpatient Group Therapy: _______________________________

v. Multidisciplinary Conferences: _____________________________

vi. Treatment Team Consults: ________________________________

vii. Documentation Time: ____________________________________

b. Residents accrue vacation amounting to 20 vacation days for the calendar year. In order to ensure sufficient training in each major rotation, no more than 5 vacation days may be taken during each major rotation. Please see the vacation request form (Form available from Educational Coordinator).

c. For unscheduled absences, notify your primary supervisor for that day (major rotation) and the Training Director by no later than 7:30am. Individual rotation supervisors will provide you with information on who to inform of an unexpected absence. Please note, the resident must also inform Karen Hamilton, Educational Coordinator, of unplanned absences.

d. Scholarly Project: The resident will spend 4 hours per week working toward the completion of a research project. This time will generally be taken at the following time for this rotation (depending on clinical demands):

4. Evaluation:

a. Supervisors will continually evaluate the appropriateness of the services rendered and the professional development of the resident. Resident progress toward the defined competencies will be reviewed by the Core Health Psychology Training Faculty monthly at the Health Psychology Residency Training Committee Meeting. Progress toward development of competence will be kept in meeting minutes and the portions of the minutes relevant to each resident will be tracked in the resident file.

b. Formal evaluation of the resident will occur at the end of each major rotation. The supervisors will evaluate the resident using standardized forms provided by the Froedtert & MCW Health Psychology Residency program. A blank copy of the evaluation form will be provided to the resident at the onset of the residency program. The supervisors’ evaluations and information discussed in the Health Psychology Residency Training Committee Meeting will be used by the Training Director for development of two summative evaluations. Summative evaluations and any concerns regarding insufficient competence will be shared with the resident’s Doctoral Director of Clinical Training.

c. Narrative feedback regarding performance across the competencies will be completed by rotation supervisors at the half way point of the rotation. The feedback is intended to examine progress toward defined training goals. A copy will be kept in the Resident Training File.
5. Limits to Confidentiality in Supervision
   a. Generally, supervisors will maintain confidentiality in supervision, particularly as it pertains to other trainees in the program. However, certain limits of confidentiality in supervision are described below:
      i. The health psychology residency faculty will collaboratively discuss all content and process of supervision and resident performance. The Health Psychology Core Faculty Members will convene on a monthly basis in the Health Psychology Training Committee Meeting with the purpose of reviewing progress toward clinical competence across the competencies and elements outlined in the Evaluation Forms.
      ii. Faculty members will also gather feedback and discuss resident progress with members of their multidisciplinary team.
      iii. A summary of this review from each faculty member will be noted and placed in the training file of each resident.
      iv. On a biannual (half year and end of year) basis, the resident’s doctoral program Director of Clinical Training will receive a summative evaluation that is derived from formal evaluations and discussion in the Health Psychology Training Committee Meeting.
      v. Should there be an insufficient competence requiring formal remediation (please see Insufficient Competence Policy and Procedures), your doctoral program Director of Clinical Training will also be notified.

6. Documentation
   a. Intake, consult, and therapy notes: All documentation of patient care must be completed and entered in patient’s electronic medical record within 24 hours of service provided
      i. All inpatient consultation and therapy notes must be completed by the end of day the patient was seen (given the dynamic nature of inpatient practice)
   b. Psychology reports: All documentation of patient care must be completed and sent to supervisor by:
   c. Residents are expected to maintain all patient information physically on site at FMLH and not remove patient information, either physically or electronically, from the facility.
      i. Residents may utilize the secure drives for storing and sharing clinical documents with their supervisors
   d. Residents are expected to follow all policies and procedures with regard to confidentiality and use of the electronic medical record.

7. Professionalism:
   a. The dress code is business casual.
   b. Residents are expected to act in accordance with professionalism expected of psychologists both with other professionals and within the clinical supervision relationship.
   c. Supervisors are expected to respect professional boundaries with their supervisor (please see Supervision Guidelines).

   a. The supervisor will provide contact information and instructions on when to use different contact forms
b. The supervisor will provide crisis management procedures and review them with each resident (please see below).

I, __________ [resident] understand that I am expected to take part in the full range of clinical activities undertaken in this placement. I will be exposed to, and expected to use a variety of psychology models, which will be applied to a range of clinical problems with a variety of clients. I _______________ [resident and supervisor] will be expected to engage fully and professionally in the supervisory relationship as outlined in the Supervision Policy and Guidelines for Clinical Supervision.

I __________ [resident] will be expected to track supervision as outlined in the Supervision Policy found in the Policy and Procedures Manual. I am also expected to keep records of session with clients in a timely manner (within 24 hours), write reports promptly (within a reasonable time as outlined by the Clinical Supervisor), to work as a member of a multidisciplinary team where appropriate, and to attend rotation rounds or case conferences.

It is expected that on average I will see ______ patients per week on this rotation. I shall keep an up to date clinical log and supervision log during my rotation, to be readily available and signed by my supervisors.

I agree, to the best of my ability, to uphold the directives specified in this supervision contract and to conduct myself in a professional manner in accordance with the APA ethical code.

Resident: _______________________________ Date: ___________

Supervisor: _______________________________ Date: ___________
Appendix A

Crisis Management Procedure: All FMLH Rotations

- Outpatient Suicidal Ideation/Homicidal Ideation: Assess for imminent risk: plan, intent, access, and named individual (HI)
  - If imminent risk:
    - Contact Froedtert Security (414-805-2828), either from your office or inform clinic staff to call
    - Page supervisor, or inform clinic staff to page
    - If no threat to you, attempt to maintain rapport and engagement
  - If no imminent risk:
    - Schedule follow-up visit
    - Discuss safety plan: Call 911 or go to nearest Emergency Department if suicidal ideation is expressed with a plan or the intent to kill oneself
    - Have patient verbalize understanding and agree
    - If patient does not – reassess for imminent risk
    - Reinforce patient may call to schedule earlier, but office # is not emergency number and to use 911/ED in emergency
    - Page supervisor as necessary

- Inpatient SI/HI:
  - Assess for risk as above for documentation
  - If imminent: Has Inpatient Psychiatry been consulted? If not, recommend a consult to psychiatry be placed.
  - Consult supervisor.

- Outpatient Threatening Language and/or Behavior
  - Ensure your safety (e.g., leave the room; end the session)
  - Contact Froedtert Security (414-805-2828) as necessary, or contact clinic staff to do so
  - Page supervisor as necessary
# Time Off Request Form

**Resident Name:**

**Date submitted:**

**Leave type (vacation, education, planned sick, etc.)** *Circle please*

<table>
<thead>
<tr>
<th>Rotation</th>
<th>EXACT Dates away from rotation</th>
<th>Scheduling Notification***</th>
<th>Supervisor Signature &amp; PRINT their name</th>
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Total # of days off:

**First date returning to rotation:**

**Residency Director’s Signature:**
Department of Psychiatry
Health Psychology Resident Vacation and Leave Policy

* Residents must request time off at least 60 days prior to the time taken off to ensure adequate schedule management. Dissertation release time should be requested as soon as possible, preferably at least 30 days prior to the absence. Exceptions can be made on a case by case basis by the Training Director.

* In order to ensure sufficient training experience, residents may not miss more than one week of training in each of their four major rotations (Guideline excludes BMPC continuity clinic). Exceptions may be considered on a case by case basis as approved by the Rotation Supervisor and Training Director. Vacation and administrative leave is not automatically granted and must be negotiated with the training director in advance to ensure adequate schedule cancellation notification.

* The leave request form must be signed by the rotation supervisor PRIOR to submission for the Residency Director’s signature.

* Failure to comply with these procedures may mean denial of the vacation request

*** Please list which clinic staff you informed about your time off and verify that your schedule has been cancelled for that time.
Relevant Medical College of Wisconsin Corporate Policies and Procedures
Americans with Disabilities Act Amendments Act

Corporate Policies and Procedures: Human Resources (HR)
Americans with Disabilities Act Amendments Act

Category: Employment (EE)
Policy #: HR.EE.020
Applies to: All employees

PURPOSE:

To ensure compliance with the Americans with Disabilities Act (ADA) of 1990, the Americans with Disabilities Act Amendments Act (ADAAA) of 2008 and the Wisconsin Fair Employment Act (WFEA) concerning the employment of persons with disabilities.

DEFINITIONS:

Confidential Medical Records - All employee medical records are confidential and will be kept separate from employee personnel records. All medical records, requests for accommodation and reasonable accommodations will be kept confidential as required by law, except to the extent necessary to effectuate the reasonable accommodation. When a reasonable accommodation has been given to an employee with a disability pursuant to this policy neither the accommodation made nor the reason for the accommodation shall be discussed with coworkers or other employees.

The following exceptions may apply with regard to confidential medical records, conditions or accommodations:

- Supervisors and managers may be informed regarding necessary restrictions on the work or duties of the employee and any necessary accommodations.
- Government official’s investigation in compliance with the ADA, ADAAA and/or the WFEA shall be provided relevant information upon request. Results of pre-employment medical examinations will be subject to the above confidentiality provisions.

Disability - A person with a disability is an individual who has:

A. A physical or mental impairment that (1) substantially limits one or more of the individual's major life activities such as caring for oneself, performing manual tasks, walking, speaking, seeing, hearing, breathing, learning, working, eating, concentrating, communicating or reading; (2) substantially limits one or more of the individual's major bodily functions, including but not limited to functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain,
respiratory, circulatory, endocrine, and reproductive functions; and/or (3) makes achievement unusually difficult or limits the capacity to work.[1]

B. A record of such impairment; or

C. Is regarded as having such impairment, whether or not the impairment actually limits or is perceived to limit a major life activity.

**Direct Threat to Safety** - A significant risk to the health and/or safety of the individual or others which cannot be eliminated by reasonable accommodation.

**Essential Job Functions** – These core activities of a job are determined by a factual analysis of factors such as: 1) whether the position exists to perform that function; 2) whether removing the function would fundamentally change the job or eliminate the need for it; 3) whether there are other employees who could perform the function; and 4) whether the employee was hired to the position for his/her expertise or skill required to perform the function.

Other factors that may be considered in determining whether a function is an essential one to the job include, but are not limited to: the amount of time an employee spends performing the function, the work experience of previous employees who held the job and the work experience of employees in similar jobs.

**Interactive Process or Interactive Dialog** - The process in which the Medical College of Wisconsin (MCW) and the individual requesting an accommodation engage to discuss physical, mental abilities and limitations as they relate to the Essential Job Functions and to determine appropriate, reasonable job accommodations.

**Qualified Individual** – An individual who possesses the required training, skills, experience, education and/or other job-related requirements and who can perform the Essential Job Functions job with or without accommodation.

**Reasonable Accommodation** - A modification or adjustment to a job, the work environment or business practices that enable a Qualified Individual with a disability to be considered for the job and to continue to perform the Essential Job Functions.

**Undue Hardship** - An accommodation is unduly costly, extensive or disruptive to the employer. MCW is not required to make an accommodation that would cause an undue hardship.

[1] Part A would include an impairment that is episodic or in remission if the impairment would substantially limit a major life activity when active. In determining whether an individual has a disability, the effect of mitigating measures, such as medications, medical devices or prosthetics are generally not considered. The only mitigating measures to consider are eye glasses and contact lenses.

**POLICY:**
In accordance with the ADA, ADAAA and WFEA, MCW prohibits discrimination against Qualified Individuals with disabilities in all employment practices including: job application procedures, hiring, firing, advancement, compensation, benefits, classification, leaves of absence, training, and other terms, conditions and privileges of employment. MCW is committed to providing reasonable accommodations for Qualified Individuals, and/or applicants with documented disabilities.

PROCEDURE:

Application Process:

In accordance with applicable law, all applicants for positions at MCW must have equal consideration in the selection process and are protected from disability related questions that could potentially screen applicants out of the application process. Applicants may not be asked questions that are likely to elicit information about a disability. Inquiries regarding an applicant’s medical or worker’s compensation history may not be asked. However, applicants may be asked questions concerning their ability to perform the Essential Job Functions of the position for which they are applying, with or without accommodation.

Reasonable accommodation will be provided to qualified applicants during the selection process to ensure that all applicants have accessibility to all phases of the process. Requests for accommodation during the interview/selection process should be made to the Office of Human Resources.

Pre-Employment Process:

After an offer of employment has been extended, it may be conditioned on the results of a medical examination, as long as all individuals in the same job category undergo a medical examination. The information received during medical examinations will be considered confidential medical information and treated the same as a Confidential Medical Record as defined in the definition section of this policy. However, a supervisor may be told of a candidate’s necessary restrictions and/or accommodations.

If the existence of a disability is revealed during the medical examination, the offer of employment may be rescinded if the reason for rescinding the offer is job related and consistent with business necessity and no reasonable accommodation can be made that would permit the individual to perform the Essential Job Functions. The process of evaluating reasonable accommodation in the pre-employment process will follow the same process outlined below for existing employees.

Reasonable Accommodation for Employees:

An employee who believes he or she needs a reasonable accommodation in order to perform an Essential Job Function of their position should make the request through his or her direct supervisor or the Office of Human Resources. When a request for accommodation is received by a supervisor, the supervisor should immediately contact the Office of Human Resources to review the request.
MCW will engage in an interactive dialogue with the employee concerning the accommodation request. The employee will always be the primary person consulted when determining appropriate accommodations. This means it is the employee's responsibility to provide any additional medical information or clarifications necessary in this interactive process, and to do so in a timely manner.

MCW reviews all requests for accommodation on a case-by-case basis and may provide a reasonable accommodation that allows the Qualified Individual with a disability to achieve the same level of job performance as other similarly skilled employees. MCW is not obligated to provide an accommodation that causes an Undue Hardship.

If upon initial review of the nature of the disability and the accommodation request, MCW believes there may be a threat to the safety and well-being of the employee or others, MCW may place the employee on a leave of absence until the completion of the interactive dialog process.

All accommodations granted will initially be on a temporary basis and will be evaluated on an ongoing basis. MCW reserves the right to request additional information or documentation at any time concerning the employee’s ongoing need for accommodation, to address any changes in the employee’s condition and to assess the appropriateness of the accommodation based on business needs or operations.

REFERENCES:

- Americans with Disabilities Act (ADA) of 1990 as amended by the Americans with Disabilities Act Amendments Act of 2008
- Wisconsin Fair Employment Act

ATTACHMENTS:

Not Applicable

Effective Date: 03/2001
Revision History: 06/26/2008, 09/21/2012
Supersedes Policy: Formerly Policy # 2.1.1
Review Date: N/A
Approved by: John R. Raymond, Sr., MD
President and CEO
Medical College of Wisconsin
Anti-Harassment and Non-Discrimination

Corporate Policies and Procedures: Administrative and Organizational (AD)
Anti-Harassment and Non-Discrimination

Category: Conduct and Conflicts (CC)
Policy #: AD.CC.050
Applies to: All Employees

PURPOSE:

To ensure a work environment free of harassment and discrimination.

DEFINITIONS:

The Medical College of Wisconsin (the College) expressly prohibits any harassment or discrimination based upon sex, age, religion, disability, marital status, national origin, sexual orientation, gender identity, and any other basis prohibited by law or regulation.

Discrimination may occur when employment or academic decisions are threatened or made, implicitly or explicitly, based upon race, sex, age, religion, disability, marital status, national origin, sexual orientation, gender identity, or any other basis prohibited by law or regulation. All decisions are to be made with a legitimate business or educational purpose and rationale.

Harassment may occur whenever unwelcome verbal or nonverbal conduct, comments, touching, teasing, joking or intimidation based on any of the behaviors, interferes with work or creates an intimidating, hostile or offensive work environment.

Unwelcome sexual advances, requests for sexual favors, and other verbal or nonverbal, visual or physical conduct of a sexual nature, such as comments, touching, teasing, joking or displaying sexually explicit materials or other behaviors that unreasonably interfere with work or academic activities, are also serious violations of this policy and are prohibited.

Harassment occurs:

• whenever submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment, or
• whenever submission to or rejection of such conduct is used as a basis for decisions, or
• when such conduct unreasonably interferes with an individual's performance or creates an intimidating, hostile, or offensive work environment.
Retaliating or discriminating against anyone for complaining about harassment or discrimination is prohibited. Retaliating against witnesses or other individuals who cooperate in a harassment/discrimination investigation is also prohibited.

POLICY:

The College is committed to providing an environment free from all forms of harassment, discrimination and all other negative conduct that inhibits effective communication and productivity. The College will take immediate and appropriate action when it determines that harassment and/or discrimination has occurred.

PROCEDURE:

It is difficult for leaders to learn of, and take corrective action to halt harassing or discriminatory behavior, unless the affected individual reports the behavior that is inappropriate, offensive or unwanted.

The individual is encouraged to approach the alleged violator of the policy to discuss the issue and ask him/her to immediately stop the offensive activity. This step is not required if it makes the individual uncomfortable.

Regardless of whether the individual decides to talk with the alleged violator of the policy, the individual or witness is required and has a duty to promptly report the conduct to any of the following individuals:

1. The employee’s immediate supervisor, manager, or Department Administrator; instructor, Chair, or Sr. Associate Dean; or

2. Human Resources – Human Resource Consultant, Director of Benefits, Employee Relations and Payroll or VP of Human Resources.

All claims of harassment will be treated seriously and will be investigated in a timely and thorough manner. Confidentiality will be maintained by MCW Management as much as possible during the investigation.

If an investigation reveals that discrimination, harassment or retaliation has occurred, management will take immediate and appropriate corrective action reasonably designed to halt the discrimination, harassment or retaliation, and prevent recurrence, which may include corrective action up to and including termination or dismissal.

It is the responsibility of the management team to understand the content of all policies and to ensure their proper implementation.

Any individual found to be making knowingly or intentionally false accusations of discrimination, harassment or retaliation or providing knowingly or intentionally false information with respect to a harassment investigation will be subject to disciplinary action up to and including termination or dismissal from employment.
Corrective Action and Rules of Employee Conduct

Corporate Policies and Procedures: Human Resources (HR)
Corrective Action and Rules of Employee Conduct

Category: Employee Relations (ER)
Policy #: HR.ER.050
Applies to: All employees are subject to all job performance standards and Rules of Employee Conduct. Only Exempt and Non-Exempt Staff are covered by the corrective action procedures as outlined in this policy.

PURPOSE:

The objective of this corrective action policy is to provide a mechanism to communicate, address and correct unsatisfactory job performance and unacceptable behavior that is negatively impacting the work environment and/or stakeholders. This is necessary to ensure an inclusive and welcoming environment and the necessary job performance required to provide quality services to our stakeholders.

A corrective action process should have a developmental focus to achieve necessary improvement, whenever possible. It is designed to incorporate the recognition of the worth and dignity of each individual employee under the assumption and belief that all employees want to strive for and can reach their highest potential.

DEFINITIONS:

At Will Employment
Employment “at will” means that while the Medical College of Wisconsin (MCW) intends to maintain a positive working relationship with all employees, employees have the right to end employment at any time and MCW reserves the same right. This “at will” relationship remains in full force and effect, notwithstanding any statements to the contrary made by any MCW employee, representative, or agent, or set forth in any other document.

Stakeholder
“Stakeholder(s)” represent the individual(s) an employee is required to interact with, directly or indirectly, in their role and employment at MCW. Stakeholders can include the institution of MCW, Staff, Faculty, Students, Residents, Patients, Visitors and Business Partners.

POLICY:

It is the policy of MCW that corrective action is used when an employee engages in conduct that interferes with operations, performs poorly, violates work rules, policies,
guidelines or specific department regulations, discredits the organization, or is offensive to a fellow stakeholder. When a performance and/or behavior issue exists, it is the supervisor’s responsibility to recommmunicate expectations to the employee and the consequences of uncorrected behavior, so the employee can work towards correction of the problem. Corrective action must be applied in a consistent manner, free of prejudice and bias, and without discrimination as outlined in MCW’s Equal Employment Opportunity (EEO)/Affirmative Action policy (HR.EE.010).

MCW expressly reserves the right to terminate the employment relationship “at will” as defined above and by state law. However, corrective action may be suggested whenever management believes the employee’s less than satisfactory performance or conduct could be improved through adequate counseling or additional training/development. Even if corrective action is implemented, the employment relationship may be terminated at any step, at the discretion of management. Management, in its sole discretion, may warn, suspend or discharge any employee at will, at any time, after consultation with the Office of Human Resources.

Employees are encouraged to seek clarification from supervisors as needed in situations where rules or standards may be unclear to the employee to prevent performance or conduct issues.

**PROCEDURE:**

All employees are expected to assume responsibility for their actions and to conduct themselves in a manner that supports the MCW’s mission, reflects its values, and is conducive to efficient operations. Every employee is responsible for satisfactory performance of assigned duties and it is the responsibility of every employee to be aware of and abide by existing policies and procedures. An employee who violates this policy or any MCW policy, guideline, expectation or standard may be subject to corrective action up to and including immediate termination of employment.

Supervisors should proactively encourage employee job success by:

- Establishing and communicating clear expectations and standards for successful performance
- Providing onboarding and training of responsibilities and duties
- Providing timely feedback and identifying job performance or behavior that does not meet expectations
- Creating clear ongoing training/development plans to help employees continuously achieve successful performance

Employees can engage in their own success by:

- Demonstrating an ongoing commitment to continuous learning and self-improvement in one’s area of responsibility
- Exhibiting initiative and ingenuity by taking ownership of tasks to proactively improve services, avoid problems, or develop opportunities
- Asking for, embracing and acting upon feedback in a respectful and constructive manner

Examples of violations include, but are not limited to:
1. Insubordination, including failure or refusal to follow the lawful directions of a supervisor to perform assigned work, or otherwise intentionally failing to perform an expected assignment or job responsibility in a timely and proper manner.
2. Violation(s) of any MCW policy, guideline, procedure or established standard of practice.
3. Violation(s) of any state or federal law or regulation, specifically including: HIPAA, criminal background and state caregiver laws, or the Office of Inspector General regulations.
4. Dishonesty, misrepresentation, or omission including but not limited to: falsification of any records; theft or misappropriation of property; providing incorrect or misleading information; circulating false or malicious rumors; damaging the reputation of a stakeholder; and/or unauthorized use of overtime.
5. Functioning in an impaired state. This includes, but is not limited to, violating the Drug Free Work Place policy (HR.ER.140), and being unfit for duty.
6. Deliberate misconduct or gross negligence that could or does result in damage to any person or property.
7. Hindering MCW’s ability to maintain an inclusive environment free from discrimination and harassment towards all stakeholders.
8. Failure to follow safety regulations. Failure to immediately report an accident or injury to the supervisor as required under Employee Accident and Injury policy (HR.OC.020).
9. Misuse of confidential information in violation of the Code of Conduct policy (AD.CR.010) and policies governing confidentiality and proprietary information.
10. Violating the Conflict of Interest, Outside Professional Activities and Consulting policy (AD.CR.030) by receiving or soliciting tips, favors, or gifts from a stakeholder of the organization.
11. Unwillingness to cooperate, assist and work in harmony with others and discourtesy or conduct creating disharmony, irritation or friction among a stakeholder.
12. Careless, negligent or inefficient performance of duties, including failure, inability or lack of effort to maintain proper standards of performance.
13. Leaving the regularly assigned work location without notifying the immediate supervisor. Leaving the workstation without authorization or proper relief. Sleeping or the appearance of sleeping while on the job.
14. Eating or drinking in unauthorized areas.
15. Unsafe or unauthorized use of machines, tools, resources or equipment; or, use of materials, tools or equipment for commercial use or personal gain. This includes, but is not limited to: telephones, voicemail, computers, and medical equipment.
17. Performing unauthorized personal work during scheduled working hours.
18. Exhibiting behavior that is threatening or abusive, unsafe, disruptive or results in inefficiency. Disorderly conduct of any kind such as fighting, horseplay, harassment, intimidation, or using abusive, obscene or threatening language or gestures toward a stakeholder.
19. Engaging in a pattern of excessive absenteeism or tardiness as defined in the Attendance policy (HR.ER.030) or an approved departmental attendance guideline.
20. Stealing property from the organization or a stakeholder.
21. Carrying or possessing weapons or firearms in violation of the Workplace Violence Prevention policy (CO.PS.040).
22. Gambling during work hours including sports pools, lottery tickets, or raffles other than those sponsored by the organization.
23. Failure to adhere to dress code, poor personal hygiene or the Personal Appearance for Employees and Volunteers policy (HR.EE.150).
24. Violations of the Smoking and Tobacco Free Campus policy (AD.CR.120).

Pre-Corrective Action

Providing on-going positive and constructive job performance feedback to an employee is helpful and should occur regularly. If an employee’s performance is not meeting expectations, developing a plan to close gaps is the first step in pre-corrective action. Plans can leverage a variety of development approaches including coaching, counseling, and retraining.

A Performance Improvement Plan (PIP) is a tool for clearly communicating areas in need of improvement, and setting expectations for success and approaches to achieving them, with up to a 90-day timeline for addressing these concerns. The application of a PIP does not represent corrective action, though its intent is to alert an employee of concerns with their job performance and behavior. Employees who receive informal counseling or a PIP continue to be eligible for merit increase and transfer and promotion opportunities, if they have been in their position for twelve months (see Employee Transfer and Promotion Policy, HR.EE.140).

Corrective Action Procedures

MCW is committed to ensuring all corrective action is administered in an equitable, impartial, thorough, and thoughtful manner. The steps outlined in this policy are intended to be tools for addressing and modifying inappropriate behavior or unacceptable job performance. Formal corrective action may follow coaching and counseling that have not resulted in necessary and sustained improvement in job performance.

The corrective action process is cumulative. Once an employee has been informed of behavior or performance expectations and an infraction occurs, appropriate corrective action will be administered. Policy violations need not be identical in nature to be cumulative. This means it is not necessary to return to the first step each time any type of violation occurs. Violations of policies, guidelines expectations and standards are subject to corrective action, up to and including termination, depending on the seriousness of the violation and the surrounding circumstances.

Corrective action should be taken after consideration of the following:

1. The employee knew, or should have known, of the particular standard of conduct, performance standard, rule, guideline or policy he/she is charged with violating.
2. The rule is reasonably applied to the situation.
3. The supervisor made an effort to investigate and evaluate all pertinent facts. The employee should be provided an opportunity to explain what he/she knows about a situation before any corrective action is taken.
4. The proposed corrective action is equitable, consistent, and related to the seriousness of the misconduct and the past record of the individual.
Level I - Written Warning

The supervisor meets with the employee to discuss the facts around the performance or behavior issue(s) needing attention, the required improvements needed to correct the issue(s), the timeframe in which improvement is expected, and the consequences of the employee's failure to make those improvements.

The employee will be asked to sign the Employee Corrective Action document as acknowledgement of receipt. If an employee wishes to provide additional written comments, they can be submitted on a separate sheet of paper that can be attached to the original Employee Corrective Action document in the employee’s file kept in the Office of Human Resources. If the employee refuses to sign the Employee Corrective Action document, the refusal to sign should be noted on the Employee Corrective Action document in the signature section and witnessed and signed by another manager or by a representative from the Office of Human Resources. An employee need not sign the document for it to be valid. The original signed document along with any employee comments or response should be provided to the employee and a copy is forwarded to the Office of Human Resources to become part of the employee’s personnel file.

Level II - Final Written Warning

In most instances, the last step in the corrective action process before termination is a final written warning. Though it is completed in the same manner as a Level I - Written Warning(s), it serves to notify the employee that further behavior or performance issues will lead to termination of employment. If appropriate, an unpaid suspension may be issued.

Level III - Termination

If sustained improvement has not occurred following corrective action, or if a serious violation has occurred that cannot be tolerated, the employee’s employment may be terminated. All potential terminations must be reviewed with the Office of Human Resources. After review of the situation, the supervisor will notify the employee of the termination. Written documentation of the termination notification is given to the employee and a copy of the termination notification should be forwarded to the Office of Human Resources to become part of the employee’s personnel file.

Suspensions Pending Investigation

For serious misconduct or offenses in which the organization has reason to believe employees, visitors, students, or patients may be at risk or harm or that the employee should not continue his/her job duties, the employee who is the subject of the investigation may be suspended without pay pending a full investigation of the facts. The employee will be informed of the allegations, given an opportunity to provide information and then suspended without pay pending the outcome of an investigation. While suspended the employee should not come on MCW owned or leased property, or anywhere on the Milwaukee Regional Medical Center campus unless it is for emergency medical treatment of themselves or an immediate family member until they are notified they are able to return. While suspended, the employee will be asked to surrender their identification badge, keys, pager or phone, and any laptop computers or other equipment pending the investigation. If the investigation finds that the employee was not at fault, pay for any lost time may be provided.
Trial Period (Trial Period Policy HR.ER.010)

All newly hired or transferring exempt and non-exempt employees will have a six-month Trial Period. During this period, the supervisor reviews the employee’s qualifications, behavior and job performance to determine ability to meet job requirements on a continuing basis. In rare circumstances, the Trial Period may be extended for up to sixty (60) days past the original six (6) months following approval by the Office of Human Resources.

Other Corrective Actions

Other corrective actions, short of termination, can be used in recurring cases of deficiencies in performance or reliability to assist the employee in their success. These could include demotion, reduction in full-time equivalency (FTE), and reassignment of work location as examples.

Corrective Action Status and Records of Infractions

Corrective action remains active for twelve (12) months from the date it is issued to the employee. Corrective action documentation is retained in the employee file indefinitely for subsequent reference.

Employees in active corrective action are ineligible for a merit increase and, consistent with the Employee Transfer and Promotion policy (HR.EE.140), employees are ineligible for a transfer or promotion within MCW for 12 months following the date corrective action is issued.

REFERENCES:

Performance Improvement Plan (PIP)
Equal Employment Opportunity and Affirmative Action Policy (HR.EE.010)
Drug Free Workplace Policy (HR.ER.060)
Anti-Harassment and Non-Discrimination policy (AD.CC.050)
Employee Accident or Injury policy (CL.OH.010)
Code of Conduct Policy (AD.CC.010)
Confidentiality - Access To & Use of MCW, Employee, Student, and Patient Information Policy (AD.CR.010)
Conflict of Interest, Outside Professional Activities and Consulting policy (AD.CC.030)
Use of Electronic Equipment policy (IT.IS.030)
Attendance (Absenteeism, Tardiness, and Leaving Early) policy (HR.ER.030)
Personal Appearance for Employees and Volunteers policy (HR.EE.080)
Smoke, Tobacco and Vape Free Campus policy (AD.WP.020)
Trial Period Policy (HR.ER.010)
Employee Transfer and Promotion policy (HR.EE.090)
Staff Employee Handbook
Professional Conduct Policy (AD.CC.060)
Employee Corrective Action Form

ATTACHMENTS:

N/A

Effective Date: 04/01/1991
Supersedes Policy: Formerly Policy # 3.6
Review Date: N/A
Approved By:  

John R. Raymond, Sr., MD, President and CEO
Medical College of Wisconsin
Document Retention

Corporate Policies and Procedures: Administrative and Organizational (AD)
Document Retention

Category: Governance, Legal and Risk Management (LG)
Policy #: AD.LG.020
Applies to: All MCW Departments and Personnel

PURPOSE:

This policy provides guidelines for retention of official MCW documents. It applies to all MCW administrative departments, offices and employees who create, receive or maintain such records in the course of MCW business. This policy seeks to:

- Promote compliance with federal, state and other legal requirements for record retention.
- Promote efficient management, sharing and transfer of information among authorized MCW staff within prescribed standards.
- Effectively utilize limited office and electronic storage space for records.
- Ensure the preservation of records for the appropriate duration.
- Ensure the appropriate and approved method of destruction for the type of record under consideration.

DEFINITIONS:

The following definitions are used for purposes of this policy.

Active Files: Files needed to support the current business activity of a department. The active period may be determined by record category pursuant to the retention schedule developed by the department according to the procedure below.

Archival Files: Files which have long-term value to MCW, such as historical documents.

Inactive Files: Files for which the active period has passed and are being held for the remainder of the specific retention period. These files may be located in a storage area.

Information/Data Classifications: A determination that information requires a specific degree of protection against unauthorized disclosure or modification. Examples of classifications are:

- Public: Information that is available to anyone for any reason.
- Private: Information/Data about an individual that is available only to the subject and to anyone authorized by the subject or by law to see it, or by an authorized employee of MCW fulfilling his/her job responsibilities.
• **Confidential:** Information/Data about an individual or MCW business activity or other matter relevant to MCW, that is not available to the public or to the subject, but is available to authorized MCW employees and as otherwise required or protected by law.

**Records:** Documents or materials in any format (including but not limited to written and printed matter, drawings, maps, plans, photographs, microfilm, motion picture film, sound and video recordings, computerized data stored in any electronic medium) or copies thereof made or received by an official department of MCW in connection with the transaction of MCW business, and retained by such office as evidence of the activities of MCW or because of the information contained therein.

**Records Management:** The systematic control of information from creation to final disposition.

**Retention Period:** The length of time for which MCW, department, or unit is responsible for the maintenance of a particular type of record. The retention period begins when the fiscal year ends for the referenced transaction or as otherwise required by law.

**Sponsored Award:** An externally funded program or project, conducted over a specified period of time, which obligates MCW to carry out specific work. Typically, it comes in the form of a grant, contract, or cooperative agreement and is governed by explicit terms and conditions. It is separately budgeted and accounted for based on the sponsor’s stipulations and MCW polices.

**POLICY:**

Each administrative office identified below is responsible for developing a procedure and record retention schedule with respect to Records Management for the Records they are responsible to manage for MCW, and to ensure such procedure and record retention schedule comports with MCW-wide requirements stated within this policy. MCW Records must be retained for a period of time necessary to meet operational, administrative and legal requirements, and must then be destroyed according to established Retention Periods.

Record retention schedules apply to records of all formats, including paper records and computer files (email, word-processed documents, spreadsheets, databases and materials in imaging systems). MCW encourages the use of storage methods that eliminate waste, reduce costs and promote efficiency. MCW recognizes the use of electronic storage methods as a form of official record keeping and electronic records may be used to replace the keeping of the paper records, unless specifically required by law. Each administrative office may determine pursuant to their own procedure if their records will be maintained in an electronic or paper format, provided such procedure is approved in accordance with this policy.

MCW records must be maintained in a manner that supports operational needs and internal controls, and must also meet federal, state and regulatory requirements. Document retention standards and systems must ensure that transactions and related authorizations are fully supported in the event of an audit, litigation or other external action.
The destruction of records must be done pursuant to an approved administrative office procedure and record retention schedule. Disposal of records must also consider the Information/Data classification of the records, including Public records which may have different requirements concerning maintenance and destruction. Private and Confidential records must be destroyed in a manner which continues to protect the content of the information contained therein.

As a recipient of Federal funds, MCW must comply with the requirements of the Federal Office of Management and Budget (OMB) 2 CFR Part 200 for the management of Sponsored Awards. OMB 2 CFR Part 200 states that the non-Federal entity should, whenever practicable, collect, transmit, and store Federal award-related information in open and machine readable formats rather than in closed formats or on paper. When original records are paper, electronic versions may be substituted through the use of duplication or other forms of electronic media provided that they are subject to periodic quality control reviews, provide reasonable safeguards against alteration, and remain readable.

PROCEDURE:

**Reporting:**
The following administrative offices are responsible for developing the corporate Record Retention procedures and schedules for MCW Records:

- **Clinical Affairs**: (For all patient/clinic records, billing and collections information, managed care issues, credentialing records, and all other information under their charge. This will include setting the standard for Records housed in other departments/clinics.)
- **Human Resources & Faculty Affairs**: (For all employee records concerning their employment at MCW. This will include information which other departments may maintain concerning their employees. Further they will maintain MCW information concerning employee benefit plans, payroll, immigration and visa information, EEO reporting, compensation, Rank & tenure, faculty committees, Faculty Council actions, employee handbooks, and employee training.)
- **Finance**: (For all records concerning institutional finances, audits, accounts payable, sponsored programs, tax issues.)
- **Office of Research**: (For all records involving research whether human subject, animal or bench research, and the related grants and contracts information. This will include all compliance records concerning such research and the processes they support.)
- **Public Safety**: (For all campus incident reports, compliance reporting and other records under their charge.)
- **Information Services**: (Shall develop policies defining the appropriate method of electronic storage, access, retention and methods of destroying electronic information and related equipment.)
- **Facilities**: (Shall develop policies defining the appropriate method of storing hard copy records including access, archiving and destruction.)
- **Office of the Graduate School**: (For all graduate student records.)
- **Academic Affairs**: (For all medical student records.)
- **AHW**: (For records concerning A Healthier Wisconsin.)
• **Offices of the General Counsel and Compliance:** (For all other areas of corporate records and contracts, or other such Records not identified above.)

Each administrative office listed above must develop a procedure and record retention schedule which identifies the following:

- the categories of Records they maintain for MCW
- the Retention Period for each type of Record
- the Information/Data Classification associated with each type of Record
- the method of storage
- the security associated with Active, Inactive and Archived files
- the method and manner in which such Record will be disposed of at the end of the Retention Period.

Corporate Compliance will develop templates for procedures and record retention schedules and work with each administrative office to ensure accuracy and completeness. Draft procedures and record retentions schedules should be submitted to the Office of Corporate Compliance. Corporate Compliance will review these procedures and record retention schedules, and as appropriate share them with other areas which may need to coordinate on certain policy provisions for corporate consistency purposes. All procedures and record retention schedules will need to be reviewed and approved by the Office of the General Counsel.

**REFERENCES:**

Not Applicable

**ATTACHMENTS:**

- [Human Resources Record Retention Schedule](#)
- [Corporate Compliance Record Retention Schedule](#)

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Approved By:  

John R. Raymond, Sr., MD, President and CEO  
Medical College of Wisconsin
Email Usage

Corporate Policies and Procedures: Information Technology (IT)
Email Usage

Category: Information Services (IS)
Policy #: IT.IS.040
Applies to: All Medical College of Wisconsin (MCW) Faculty, Staff and Students

Purpose:

The purpose of this policy is to ensure that:

- the MCW community uses email in an ethical and considerate manner in compliance with applicable laws and with rules for acceptable use as established by MCW;
- email users are alerted to concepts of privacy and security as they apply to email;
- the risk of disruptions to MCW email and other services and activities are minimized;
- email management and control are centrally designed to reduce risk and meet regulatory and legal requirements.

This policy covers appropriate use of any email sent from an MCW email address and applies to all employees, vendors, and agents operating on behalf of MCW.

Definitions:

All terms relevant to EPI are included in Policy IT.PI.010 EPI Security Definitions.

Policy:

MCW recognizes that the principles of academic freedom, freedom of speech, and privacy of information hold important implications for email and electronic messaging services. Academic freedom also requires all members of MCW to maintain the highest ethical standards and to act within the law.

MCW supports and encourages the responsible use of email but accepts that email is not a confidential means of communication and can be used inappropriately. Also, consistent with academic freedom, MCW cannot always protect users from receiving email content that they may consider offensive. However, reasonable effort will be made to mitigate against such abuses of the email service.

In order to protect MCW from dispute, users must apply the same personal and professional courtesies and considerations in email as they would in other forms of communication.
MCW does not routinely inspect or monitor email content but reserves the right to do so under the prescribed conditions defined in this policy. However, MCW routinely scans email for viruses, size, and simple automated filtering to protect the reputation of MCW for sent email.

MCW is subject to various regulatory oversights and to legal obligations to provide documents under court order. All electronic communications and email may be subject to these external requirements.

Procedure:

**Personal Use of Email**
The primary function of email is to provide electronic communications in support of MCW’s mission. Workforce members may use email for limited personal use providing that:

- such use does not violate this policy or any other MCW policy, requirement, statute or regulation or law;
- such use does not interfere with network resources;
- such use is not inconsistent with the user's conditions of employment;
- personal views are clearly identified as such;
- such use does not carry with it an unreasonable expectation of privacy;
- the user acknowledges that such usage can be subject to internal scrutiny in the event MCW suspects, based on reasonable evidence, that the user has violated a law or institutional policy; and
- the user acknowledges that such usage can be subject to external scrutiny under court authorization.

**New Email Systems or Servers**
Stand-alone email systems that are independent are not permitted. This includes email systems that use either the standard MCW email address or an alternative.

**Email Standard**

1. MCW faculty and staff and students will use the standard "@mcw.edu" email address for all official MCW communications. The standard exists to create a consistent, organized appearance for MCW’s email structure and reduce confusion. Only the standard email address should be included on professional stationery, business cards and other materials. Any other usage of MCW email must be approved by senior leadership.

2. All organizational processes and systems will use the standard email address. Examples of these systems or communications include benefits, grants, IRB, intranet, facilities, and HR tools including Oracle.

3. Information Services is responsible for the management of all MCW email systems to facilitate general operation, audit, compliance, legal and human resource requirements.

**Responsible Use of Email**
Users of MCW email must at all-times act in a lawful, responsible, and ethical manner. Users who send email containing MCW’s domain address (mcw.edu) or who use their
MCW title may be perceived as reflecting on the character and professionalism of the MCW.

Users must note that:

- Email messages create documents of record on MCW computer systems for the purposes of court proceedings and are discoverable documents to which a party to legal action may demand access. Email messages have been key documents in a variety of legal disputes including sexual discrimination and harassment, unlawful dismissal, defamation, theft of intellectual property, hazardous working conditions, and contract disputes.
- Facts and views expressed in email, even though they may not be intended to be disclosed, could be used as evidence in court against MCW and/or the individual.
- Email may not be used to contact elected officials, their staff or agency officials to express personal viewpoints or advocating a specific position on legislative items or agency policies without direct coordination and pre-approval from the MCW Office of Government and Community Relations. The policy does not prohibit correspondence with government officials that is required to fulfill job responsibilities.
- They must not use the MCW name, logo or trademark to imply the endorsement by MCW of other organizations’ products or services without the written permission of the President.

**Email and Information Security**

1. EPI and other sensitive data should only be shared via email when absolutely necessary. Email that contains EPI, whether in the body or attachment(s), should only be retained until it is no longer actively being used at which time it should be deleted. If the EPI or sensitive data needs to be archived for later retrieval, it should be saved to an MCW-approved, secure, storage service.
2. Users cannot forward/retrieve/store internal email with EPI content to email accounts on external networks (e.g. Yahoo, Google). Consequently, automatic forwarding/retrieving/storing of email in this way is not permitted.
3. Users of email are responsible for ensuring they do not compromise information security.
4. The confidentiality of email cannot be assured. It can easily be modified, saved, copied, forwarded on to others, and/or intercepted by unscrupulous individuals. Users should exercise extreme caution in using email to communicate confidential or sensitive matters, and should not assume their email is private or confidential.
5. Consideration should be given to encrypting sensitive email. Whenever practicable, confidential email should not be sent over external networks (particularly the Internet) unless encrypted. Users should contact Information Services for advice on encryption options.
6. Email communications between MCW, Froedtert Hospital, Froedtert & the Medical College of Wisconsin Community Physicians and Children’s Hospital of Wisconsin are secured by means of an intranet. However, the encryption of data in transit to Clement J. Zablocki VA Medical Center cannot be guaranteed and thus is not considered a secure communication.
7. External email servers and systems such as Google regularly have statements in their end user license agreements that give the providing agency ownership of some or all content, including intellectual property.
8. Users must take reasonable precautions when receiving email attachments or links embedded within messages because of the risk of virus or malware. All email attachments should be treated with utmost caution.
9. Do not distribute malicious software including but not limited to viruses, hoaxes, spyware, malware, and ransomware.
10. Workforce members must not intercept or access another workforce member’s email without proper grounds and authorization, as per applicable MCW policies and law.
11. Information Services reserves the right to refuse, filter, or discard mail and other connections from outside hosts that send unsolicited, mass or commercial messages, or messages that appear to contain viruses.
12. MCW reserves the right to enter a MCW owned mail box and remove or copy any correspondence with proper MCW leadership permission, in accordance with applicable MCW policies.
13. MCW reserves the right to perform an electronic hold on email communication as a result of current or anticipated investigations.

**Email Access and Disclosure**
MCW may access email communications under certain circumstances. MCW may permit the inspection, monitoring, or disclosure of email content:

1. When required by and consistent with Wisconsin and federal law. MCW does not automatically comply with all requests for disclosure, but evaluates all such requests against laws concerning disclosure and privacy, or other applicable law.

2. At the documented request of the President, Dean, the Senior Vice President, Office of the General Counsel, Corporate Compliance or Vice President of Human Resources, if there are reasonable grounds to believe that violations of MCW policies, Wisconsin statutes or regulations, or federal statues or regulations may have taken place.

3. To meet time-dependent, critical business or operational needs or to carry out records management responsibilities. For example, to conduct business during:
   - a crisis if an employee is absent when information is required; or
   - a prolonged absence of an employee when information in the user's email is required.

MCW monitors email:

1. To carry out system management, problem resolution, maintenance and capacity planning, to correct addressing problems or for similar reasons related to performance or availability of the system.
2. To address security issues, including virus management and authorized surveillance, including tracking unauthorized access to a system.

**Information and Assistance**
MCW-IS Service Desk at (414) 955-4357, option 8 or email help@mcw.edu.

**References:**
Equal Employment Opportunity and Affirmative Action

Corporate Policies and Procedures: Human Resources (HR)
Equal Employment Opportunity and Affirmative Action

Category: Employment (EE)
Policy #: HR.EE.010
Applies to: All employees

PURPOSE:

To ensure equal opportunity compliance for all individuals, in all activities related to employment and consistent with applicable State and Federal laws and other pertinent legislation, judicial mandates, and presidential executive orders.

DEFINITIONS:

Not Applicable

POLICY:

The Medical College of Wisconsin (MCW) is an equal opportunity and affirmative action employer. It is the policy of MCW to provide equal employment opportunities to all qualified persons without discriminating based on race, color, sex, age, disability, genetic information, marital status, protected veteran status, past or present service in the uniformed services, sexual orientation, gender identity, national origin, ancestry, religion, arrest or conviction record. Equal employment opportunities shall be provided in accordance with pertinent legislation, judicial mandates and presidential executive orders designed to eradicate discrimination in all areas of employment. MCW is also committed to providing a work and academic environment free from harassment.

Included in the Equal Employment Opportunity Program are all activities related to employment, including recruitment, hiring, promotion, demotion, termination, training, benefits and compensation. In order to ensure ongoing compliance with the Program, MCW has established the following:

- Subject to approval of the Board of Trustees, authority and responsibility for carrying out an affirmative action program have been vested in the Vice President of Human Resources and Faculty Affairs, who is empowered to delegate such authority and to institute mechanisms to assure compliance with such program.

- The Office of Human Resources is responsible for the day-to-day administration of this policy; however, all employees are expected to comply with College policies relating to non-discrimination in employment. An analysis of employee staffing patterns, and all other
factors affecting employment, will be undertaken by Job Group and departments to determine the extent of utilization of protected class individuals. Monitoring and evaluation shall be conducted to assure their timely achievement.

- Concurrently, Human Resources policies and procedures which shall be free of all artificial barriers to employment of all protected classes. These policies and procedures shall also assure that all procedures and tests to determine an applicant’s qualifications for a specific position are job-related and culturally unbiased.

- MCW is committed to maintaining an aggressive outreach and recruitment program to assure that qualified and potentially qualified minorities, women, protected veterans, and disabled individuals are given ample opportunities to become employed and to advance in their career. Employment advertisements placed by MCW will include the phrase “An Equal Opportunity Employer”.

- The Vice President of Human Resources and Faculty Affairs shall be assigned resources, both fiscal and manpower, commensurate with the magnitude of the tasks to be accomplished.

- All clients, suppliers and contractors shall be notified of MCW’s intention to assure equal employment opportunities and its abhorrence of any practices that serve to perpetuate inequities. Therefore, contractors and suppliers must assure they shall observe policies and practices consistent with the above.

- Any person who feels they have been treated in a manner that disregards the spirit or the requirements of this policy should express this concern to their supervisor, manager, Department Administrator or a member of the Office of Human Resources, without fear of retaliation or disciplinary action. The Office of Human Resources will investigate the situation and make recommendations to the Vice President of Human Resources and Faculty Affairs. A complaint can be made in writing or verbally. If made verbally, the complainant will be asked to sign a statement detailing the complaint prior to the investigation. Confidentiality will be maintained as much as possible during the investigation.

PROCEDURE:

Not Applicable

REFERENCES:

Anti-Harassment and Non Discrimination Policy

ATTACHMENTS:

Not Applicable

Effective Date: 02/01/1974
Prohibition on Sex Discrimination and Related Misconduct

Corporate Policies and Procedures: Administrative (AD)
Prohibition on Sex Discrimination and Related Misconduct

Category: Conduct and Conflict (CC)
Policy #: AD.CC.080
Applies to: All Employees (Faculty, Exempt and Non-Exempt Staff, Post-Doctoral Fellows), Students, and Third Parties

Purpose:

The Medical College of Wisconsin (MCW) complies with Title IX of the Education Amendments of 1972 (Title IX), Violence Against Women Act (VAWA), and The Jeanne Clery Disclosure of Campus Security Policy and Campus Crime Statistics Act (commonly referred to as the Clery Act). MCW prohibits sex discrimination, sexual harassment, sexual assault, domestic violence, dating violence, and stalking, and maintains procedures for reporting the same.

Definitions:

Annual Campus Security Report (ACSR): Defined as MCW’s Annual Campus Security Report. This information, prepared in compliance with the Clery Act, outlines MCW’s security policies and discloses campus crime statistics for the three most recent calendar years. An electronic copy may be obtained on the MCW Public Safety website. A paper copy of this document may be obtained by contacting the Medical College of Wisconsin, Public Safety, 8701 Watertown Plank Road, Milwaukee, WI 53226 or by calling (414) 955-8295.

In addition to the information contained in this Report, current MCW policies and procedures are published on the Corporate Policies webpage, in the Administrative Policies and Procedures, Staff Employee Handbook, Graduate Student Handbook and the Medical Student Handbook.

Bystander Intervention: Safe and positive options that may be carried out by an individual or individuals to prevent harm or intervene when there exists any act (or risk thereof) of sex discrimination, sexual assault, dating violence, domestic violence, or stalking.

Campus Security Authority (CSA): A Clery Act specific term that encompasses four groups of individuals and organizations associated with an institution.

- A campus police department or a campus security department of an institution.
- Any individual or individuals who are responsible for campus security but who do not constitute a campus police department or a campus security department.
(e.g., an individual who is responsible for monitoring the entrance into institutional property).

- Any individual or organization specified in an institution’s statement of campus security policy as an individual or organization to which students and employees should report criminal offenses.

- An official of an institution who has significant responsibility for student and campus activities, including but not limited to student housing, student discipline and campus judicial proceedings. An official is defined as any person who has the authority and the duty to take action or respond to particular issues on behalf of the institution.

**Clery Act:** The Clery Act requires institutions to disclose three general categories of crime statistics:

- Criminal Offenses
- Hate Crimes

The definitions of these crimes are taken from the Federal Bureau of Investigation’s (FBI’s) *Uniform Crime Reporting Handbook (UCR)* (PDF) as required by the Clery Act.

**Complainant:** Individual who alleges under this policy to be the victim of sex discrimination, sexual assault, domestic violence, dating violence, and/or stalking.

**Conduct without Consent:** Conduct is considered without consent if no clear consent, verbal or nonverbal, is given. Non-consensual contact is any intentional sexual touching, however slight, with any object, by a person upon another person, that is without consent and/or by force.

**Coercion:** Coercion occurs when a person is persuaded to do something by force or use of threats or intimidation. For the purposes of this policy, coercing someone into sexual activity violates this policy in the same way as physically forcing someone into a sexual act.

**Confidential Resources:** People and organizations that are not required to notify the Title IX Coordinator after receiving a report of a Prohibited Offense from an MCW student, employee or Third Party. *Appropriate* Confidential Resources will submit anonymous statistical information for Clery Act purposes unless they believe it would be harmful to the individual or are prevented from doing so by law, rule or regulation. The following MCW Confidential Resources will not engage the Title IX Coordinator with identifiable information unless the reporting party grants permission for the same, and/or the Confidential Resource determines a danger to other(s) is reasonably believed to exist:

- The Employee Assistance Program (available to employees and students);
• Health care providers, including mental health providers, in their capacities of providing clinical care to students and employees;

• The MCW Ombuds Office, when the Ombuds person is serving in that capacity; note that the Ombuds Office only provides services to employees, and also accepts anonymous reports from employees; and

• The MCW Compliance Hotline, which accepts reports from anonymous and identified individuals.

The following Confidential Resources external to MCW have no obligation to engage MCW (this list is not exhaustive):

• Community Rape Crisis Center;
• Community Domestic Violence resources; and
• Community members of the clergy.

Consent: Words or overt actions by a person who is competent and coherent to give informed consent indicating a freely given agreement to have sexual intercourse, sexual contact or engage in other activities sexual in nature. Wis. Stat. 940.225(4) Previously welcome conduct does not constitute consent for similar or identical conduct in the future.

Dating Violence: Violence committed by a person who is or has been in a social relationship of a romantic or intimate nature with the victim. The existence of such a relationship shall be based on the reporting party’s statement and with consideration of the following factors: the length of the relationship; the type of the relationship; and the frequency of interaction between the persons involved in the relationship.

For the purposes of this definition, Dating Violence includes but is not limited to sexual or physical abuse or the threat of such abuse, but does not include acts included in the definition of Domestic Violence.

Domestic Violence: An act of violence committed by a current or former spouse or intimate partner of the victim, a person with whom the victim shares a child in common, a person who is cohabitating with or has cohabitated with the victim as a spouse or intimate partner, a person similarly situated to a spouse of the victim under the domestic or family violence laws of the jurisdiction in which the crime of violence occurred, or any other person against an adult or youth victim who is protected from that person’s acts under the domestic or family violence laws of the jurisdiction in which the crime of violence occurred.

MCW expects students and employees to comply with Wisconsin law, which defines domestic abuse to include any of the following engaged in by an adult person against his or her spouse or former spouse, against an adult with whom the person resides or formerly resided or against an adult with whom the person has a child in common:

1. Intentional infliction of physical pain, physical injury or illness.
2. Intentional impairment of physical condition.
3. A violation of Wis. Stat. 940.225(1), (2) or (3)

4. A physical act that may cause the other person reasonably to fear imminent engagement in the conduct described above.

**Family Educational Rights and Privacy Act (FERPA):** 20 U.S.C. 1232g; 34 C.F.R. Part 99; a federal law that protects the privacy of student education records. This law applies to all schools that receive funds under an applicable program of the U.S. Department of Education.

**Force:** Force is the use of physical violence and/or imposing on someone physically to gain sexual access and includes threats, intimidation, and coercion that overcome resistance or produce consent.

**Gender Identity:** for purposes of this policy, gender identity is the gender role (such as male or female) with which an individual self-identifies, regardless of whether that role is consistent with the gender role assigned to the person at birth.

**Hostile Environment:** environment which can result from misconduct under this policy sufficiently serious such that it interferes with or limits the ability to participate in or benefit from MCW’s programs (working or learning), or creates an intimidating, threatening or abusive educational environment. A hostile environment can be created by an employee, student, or others such as a visiting student.

**Preponderance of the Evidence:** standard used to determine whether a complaint of a Prohibited Offense is "more likely than not" (or 51% or more) to have occurred.

**Prohibited Offenses:** Sex discrimination, domestic violence, dating violence, sexual assault and stalking (as those terms are defined herein).

**Respondent:** Individual who is alleged to have committed or engaged in a Prohibited Offense (i.e. a violation(s) of this policy).

**Responsible Employees:** Employees that are required to promptly notify and engage the MCW Title IX Coordinator or a Deputy Coordinator any time they receive a report of violation(s) of this policy. All MCW employees meet this definition with the exception of those employees that are Confidential Resources, contracted workers, and Standardized Patients.

**Sexual Assault:** Any type of sexual contact or behavior that occurs by coercion, force or without consent of the recipient. Included in the definition of sexual assault are non-consensual sexual intercourse, non-consensual sexual contact, incest and statutory rape. This definition includes sexual acts against people who are unable to consent either due to age or lack of capacity.

- **Non-Consensual Sexual Intercourse:** Penetration, no matter how slight, of the vagina or anus with any body part or object, or oral penetration by a sex organ of another person, without the consent of the recipient. Intercourse includes vaginal or anal penetration by a penis, object, tongue or finger, and oral copulation (mouth and genital contact) no matter how slight the penetration or contact. Non-consensual sexual intercourse may also be known as rape.
- **Non-Consensual Sexual Contact or attempt to commit the same**: The touching of the private body parts of another person for the purposes of sexual gratification, without the consent of the victim, including instances where the victim is incapable of giving consent because of his/her age or because of his/her temporary or permanent mental or physical incapacity. Non-consensual sexual contact may also be referred to as fondling or groping.

- **Incest**: Non-forcible sexual intercourse between persons who are related to each other within the degrees wherein marriage is prohibited by law.

- **Statutory Rape**: Non-forcible sexual intercourse by a person at or over the statutory age of consent with a person who is under the statutory age of consent.

Wisconsin state law defines sexual assault under Sec. 940.225 Wis. Stats.

**Sex Discrimination**: Treating an individual unfavorably based on their sex, sexual orientation, or gender identity. Forms of sex discrimination include but are not limited to sex-based harassment, violence, assault, exploitation, coercion and stalking.

**Sexual Exploitation**: Taking non-consensual and/or abusive sexual advantage of another for the perpetrator’s own advantage or benefit. Forms of sexual exploitation include invasion of sexual privacy, taking and/or sharing non-consensual images, videos, audio-tapes or other media of sexual activity of or with another person(s), knowingly transmitting a sexually transmitted disease, exposing one’s genitals in a non-consensual circumstance, engaging in voyeurism, and gender identity or sex-based bullying.

**Sexual Harassment**: Unwelcome gender or sexual based verbal or physical contact such as sexual advances, requests for sexual favors, and other verbal or nonverbal, visual or physical conduct of a gender or sexual nature, such as comments, touching, teasing, joking or displaying sexually explicit materials or other behaviors that unreasonably interfere with work, academic or school-related activities. Sexual Harassment is a serious violation of this policy and is prohibited.

Harassment occurs:

- whenever submission to such conduct is based on power differentials and is made either explicitly or implicitly a term or condition of an individual’s employment, academic or school-related activities,

- whenever submission to or rejection of such conduct is used as a basis for decisions, and/or

- when such conduct is sufficiently severe, persistent or pervasive that it unreasonably interferes with an individual’s performance or creates an intimidating, hostile, or offensive work, academic or school-related environment.

**Stalking**: Engaging in a course of conduct directed at a specific person that would cause a reasonable person to fear for his or her safety or the safety of others; and/or suffer substantial emotional distress.
For the purposes of this definition course of conduct means two or more acts, including, but not limited to, acts which the stalker directly, indirectly, or through third parties, by any action, method, device, or means follows, monitors, observes, surveils, threatens, or communicates to or about, a person, or interferes with a person’s property. Substantial emotional distress means significant mental suffering or anguish that may, but does not necessarily, require medical or other professional treatment or counseling. Reasonable person means a reasonable person under similar circumstances and with similar identities to the victim.

Wisconsin law prohibits stalking under Section 940.32 Wis. Stats.

Title IX of the Education Amendments of 1972: Enforced by the U.S. Department of Education’s Office for Civil Rights, Title IX protects people from sex discrimination in education programs or activities that receive federal financial assistance. Title IX specifically states: "no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity receiving federal financial assistance."

Third Party: a Complainant or Respondent who is not an MCW faculty member, staff member or student.

Violence against Women Act (VAWA): Is a broad-based law formulated in 1994 in response to the increasing violence against women in America. In 2013, this law amended section 485(f) of the Higher Education Act of 1965, as amended (HEA), otherwise known as the Clery Act. VAWA contains provisions ranging from funding of domestic violence programs to new civil rights remedies for female victims of gender-based attacks.

VAWA provides for education, research, treatment of domestic and sex-crime victims, creation of rape crisis centers and battered women’s shelters. VAWA also authorizes additional local police, prosecutors, victim advocates, and a domestic violence hotline to check the increasing violence. It distributed funds to increase safety for women on public transportation, for shelters, and for youth education programs. Funds were also made available to provide special training for judges who hear domestic violence cases. VAWA in short expanded rape shield laws, created offenses for interstate spousal abuse, and allowed victims of gender-based crimes to sue those responsible in federal court.

Policy

MCW is committed to creating and sustaining a safe learning and working environment that recognizes and values the dignity of all members of the MCW community, which includes faculty, staff, students and visitors. In furtherance of this commitment and as more fully described herein, MCW prohibits in all work, education and other programs, sex discrimination, domestic violence, dating violence, sexual assault and stalking. To be clear, sex discrimination includes sexual harassment, sexual violence, and discrimination on the basis of sex, sexual orientation and/or gender identity.

Retaliation against any individual making a report under this policy or any individual participating in an investigation in connection with this policy is prohibited.
MCW recognizes and emphasizes that compliance with Title IX and VAWA does not constitute a violation of FERPA.

This policy applies to sex discrimination, domestic violence, dating violence, sexual assault and/or stalking that occur on campus or in connection with an MCW program or event. This policy also applies external to MCW or an MCW program or event (such as off-campus, non-MCW related activities) if continuing effects of the conduct in MCW programs, events or on MCW premises violate this policy, for example by creating a hostile environment on-campus for the Complainant or others. All MCW faculty, staff, students and visitors are subject to this policy and are encouraged to utilize the protections and processes set forth herein, regardless of their sex, sexual orientation or gender identity.

In the event MCW receives a report that a member of the MCW faculty, staff or study body is alleged to have committed a prohibited offense, and regardless of the complainant’s or respondent’s sex, gender, sexual orientation, or gender identity, MCW will promptly investigate the allegation in accordance with the MCW Investigations into Sexual Discrimination and Related Misconduct Policy (AD.CC.090). The Anti-Harassment and Non-Discrimination Policy will be used if the reported sex discrimination is made by an employee and does not involve a student.

All individuals who believe they have been subjected to or accused of sex discrimination and other related misconduct are encouraged to and have a right to seek support, utilize available resources, and report their concerns or complaint.

**Education and Prevention Programs**

MCW seeks to prevent, address and end sex discrimination and VAWA crimes by engaging in comprehensive, intentional, and integrated programming, initiatives, strategies, and campaigns that:

- Are culturally relevant, inclusive of diverse communities and identities, sustainable, responsive to community needs, and informed by research, or assessed for value, effectiveness, or outcome; and
- Consider environmental risk and protective factors as they occur on the individual, relationship, institutional, community and societal levels.

MCW has developed and implemented educational programming, consisting of primary prevention and awareness programs for all incoming students and new employees, and ongoing awareness and prevention campaigns and training for students and employees. These programs and campaigns:

1. Identify and define sex discrimination and examples thereof.
2. Identify sexual assault, dating violence, domestic violence, and stalking as conduct prohibited by MCW.
3. Define using definitions provided both by the Department of Education as well as state law as to what behavior constitutes sex discrimination, dating violence, domestic violence, sexual assault and stalking.
4. Define what behavior and actions constitute consent to sexual activity in the state of Wisconsin.

5. Provide a description of safe and positive options for bystander intervention.

6. Provide information on risk reduction. Risk reduction means decreasing potential for perpetration or bystander inaction, while increasing empowerment for victims in order to promote safety and to enable individuals and communities improve conditions that facilitate violence.

For additional information on MCW’s campus educational programs concerning sex discrimination, sexual assault, domestic violence, dating violence and stalking, contact the Title IX Coordinator, a Title IX Deputy Coordinator, the Office of Human Resources, Academic Affairs, the Graduate School and/or Public Safety. See the MCW Sexual Misconduct/Title IX Website.

**Procedure**

**After an incident**

After an incident involving a Prohibited Offense, MCW strongly recommends the victim do each of the following:

1. **Get to a safe place.**

2. **Seek medical attention as soon as possible.** For urgent medical needs, call 911 (9-911 from an MCW campus telephone), or go directly to the nearest hospital emergency room. Post-assault medical care for emergency and non-emergency cases can be performed at a local hospital emergency department.

   Many hospitals have specialized examiners who can complete an exam for victims of sexual violence. Such an exam can help the victim receive appropriate medical treatment and preserve evidence for possible future action. If victims do not opt for forensic evidence collection, health care providers can still treat injuries and take steps to address concerns of pregnancy and/or sexually transmitted diseases.

3. **Preserve physical evidence.** It is important a victim of sexual violence not bathe, douche, smoke, change clothing or clean the bed/linen/area where they were assaulted (if the assault occurred within the past 96 hours). Place items in a paper bag for possible future action. Also, keep copies of voicemail messages, text messages, instant messages, social networking pages, pictures, emails and any other relevant documents. It is important to note that as time passes, evidence of sexual assault, domestic violence, dating violence and stalking may dissipate or otherwise change to a degree it no longer serves as evidence of the crime in question. This could render investigation, prosecution, disciplinary proceedings, or obtaining legal orders for protection from abuse much more difficult.

   In instances of sexual assault, even if the victim does not want to collect
evidence or pursue a legal action against the alleged perpetrator, health care providers can still help the victim address concerns like pregnancy or sexually transmitted diseases.

**Reporting Procedures**

Responsible Employees must engage the Title IX Coordinator or a Deputy Coordinator without delay following receipt of a report of a Prohibited Offense.

Other individuals who witness or experience a Prohibited Offense (such as a bystander or victim) are strongly encouraged to report the same. Reporting procedures for all individuals are as follows:

- **Faculty, staff and students** should report to the MCW Title IX Coordinator or a Title IX Deputy Coordinator, all of whom are listed along with contact information on the [MCW Sexual Misconduct/Title IX webpage](#). The Title IX Coordinator’s contact information is: Katie Kassulke, (414) 955-8668, TitleIXCoordinator@mcw.edu.

- Faculty and staff may also report to the Office of Human Resources or to their immediate supervisor, manager and Department Administrator, Division Chief, or Department Chair.

- Students may also make a report to the Dean in the student’s school.

- **MCW Compliance Line** – 1 (866) 857-4943 (reports may but are not required to be provided anonymously)

- The Office of Civil Rights of the Department of Education (OCR) enforces Title IX. In addition to the resources above, inquiries and complaints under Title IX may be directed to ocr@edu.gov, or to the local OCR office (call 1 (800) 421-3481 for local office information).

Third Parties, including students from other institutions and individuals participating in MCW programs or on MCW premises, may report as follows:

- MCW Title IX Coordinator
- Police
- MCW Office of Public Safety
- Compliance Hotline
- OCR

See the above section and the Title IX / Sexual Misconduct webpage for contact information.

**Note:** reporting a Prohibited Offense to an individual acting in their capacity as a Confidential Resource does not constitute, and will not result in, notice of the Prohibited Offense to MCW.

Reporting parties may wish to consider carefully whether to share personally identifiable details with Responsible Employees who are not Confidential Resources, as the
Responsible Employee receiving the information must share those details with the Title IX Coordinator or a Deputy Coordinator. If a reporting party does not wish for their name to be shared, does not wish for an investigation to take place, or does not want a non-investigative resolution to be pursued, the reporting party should communicate that request to the Responsible Employee, Title IX Coordinator or a Deputy Coordinator, who will evaluate the request in light of the duty to ensure the safety of the community and to comply with federal law and institutional policies.

In cases indicating pattern, predation, threat, weapons, and/or violence, MCW may be unable to honor a request that no investigation or further action occur. In cases where a reporting party has requested no formal investigation, and the circumstances allow MCW to honor that request, MCW will work to provide support and resources to the reporting party.

MCW reserves the right in all instances to conduct an investigation as it determines appropriate, either at the time a report is received or a later point in time, in the event additional information or evaluation dictate that a formal investigation is appropriate. The role of the reporting party (bystander, victim, etc.) will be considered when evaluating whether to honor requests for confidentiality.

Reporting to a Responsible Employee, Title IX Coordinator or a Deputy Coordinator will entail privacy to the reporting party to the extent possible, and will include sharing reported information with those individuals or officials who have a need to know. The number of individuals with this knowledge will be as limited as possible to preserve the reporting party’s and/or victim’s privacy (if they differ).

An MCW employee or student may also report any allegation of dating violence, domestic violence, sexual assault or stalking to:

- Police in the case of emergencies by calling 911.
- Local law enforcement as listed on the MCW Sexual Misconduct/Title IX webpage.
- MCW Public Safety (414) 955-8299. MCW Public Safety will assist in emergent and non-emergent cases.

Retaliation against anyone involved in a report or an investigation pursuant to this policy is strictly prohibited. Reports of retaliation should be made immediately to the Title IX Coordinator or a Deputy Coordinator.

Any false information provided, or obstruction into the investigation process, by any party is considered a serious violation of this policy and may subject the non-compliant individual(s) to discipline in accordance with the applicable institutional policy/ies and Handbook(s).

Risk Reduction Strategies

With no intent to blame the Complainant and recognizing that only the perpetrators are responsible for sexual assault, the following strategies help reduce one’s risk of being in an unsafe situation including one that involves sexual assault or harassment (taken from Rape, Abuse, & Incest National Network, www.rainn.org)
1. Be aware of surroundings. Knowing where you are and who is around you may help you to find a way to get out of a bad situation.

2. Avoid isolated areas. It is more difficult to get help if no one is around.

3. Walk with a purpose. Even if you do not know where you are going, act like you do.

4. Trust your instincts. If a situation or location feels unsafe or uncomfortable, it probably is not the best place to be.

5. Try not to load yourself down with packages or bags. This can make you appear more vulnerable.

6. Make sure your cell phone is with you and charged and that you have cab money.

7. Carry a noise maker, like a whistle, and a small flashlight with you at all times (these can attach to key chains).

8. Do not allow yourself to be isolated with someone you do not trust or someone you do not know.

9. Avoid inserting music headphones in both ears so that you can be more aware of your surroundings, especially if you are walking alone.

10. When you go to a social gathering, go with a group of friends. Arrive together, check in with each other throughout the gathering, and leave together. Knowing where you are and who is around you may help you to find a way out of a bad situation.

11. Trust your instincts. If you feel unsafe in any situation, go with your gut. If you see something suspicious, contact law enforcement immediately (local authorities can be reached by calling 911 in most areas of the US.).

12. Do not leave your drink unattended while talking, dancing, using the restroom, or making a phone call. If you have left your drink alone, get a new one.

13. Do not get intoxicated or take drugs to the point of incapacitation.

14. Do not accept drinks from people you do not know and trust. If you choose to accept a drink, go with the person to the bar to order it, watch it being poured, and carry it yourself. At parties, do not drink from punch bowls or other large, common open containers.

15. Watch out for your friends, and vice versa. If a friend seems out of it, is way too intoxicated for the amount of alcohol they have had, or is acting out of character, get him or her to a safe place immediately.

16. If you suspect you or a friend has been drugged, contact law enforcement immediately (local authorities can be reached by calling 911 in most areas of the US.).
US.). Be explicit with doctors so they can give you the correct tests (you will need a urine test and possibly others).

17. If you need to get out of an uncomfortable or scary situation here are some things that you can try:

- Remember that being in this situation is not your fault. You did not do anything wrong; it is the person who is making you uncomfortable that is to blame.

- Be true to yourself. Do not feel obligated to do anything you do not want to do. "I don't want to" is always a good enough reason. Do what feels right to you and what you are comfortable with.

- Have a code word with your friends or family so that if you do not feel comfortable you can call them and communicate your discomfort without the person you are with knowing. Your friends or family can then come to get you or make up an excuse for you to leave.

- Lie. If you do not want to hurt the person's feelings, it is better to lie and make up a reason to leave than to stay and be uncomfortable, scared, or worse. Some excuses you could use are: needing to take care of a friend or family member, not feeling well, having somewhere else that you need to be, etc.

18. Try to think of an escape route. How would you try to get out of the room? Where are the doors? Windows? Are there people around who might be able to help you? Is there an emergency phone nearby?

19. If you and/or the other person have been drinking, you can say that you would rather wait until you both have your full judgment before doing anything you may regret later.

20. Tell a sexual aggressor "NO" clearly and firmly.

21. If you or someone you know is being abused, speak up or intervene.

22. Get help by seeking counseling or support services – see resources listed in this policy or contact MCW Public Safety for a list of resources.

23. Learn how to identify “red flags” in relationships so you can get out of a bad relationship and learn what to avoid in future relationships.

24. Consider reporting any abuse, assault, violence or stalking to police, MCW Public Safety, the Title IX Coordinator, a Deputy Coordinator or a Responsible Employee.

25. Consider getting a protective order from a court of competent jurisdiction.

26. Educate yourself on what behaviors constitute domestic violence, sexual assault, dating violence and stalking.
27. If you find yourself in the position of being the initiator of sexual behavior, you owe respect to your potential partner. Clearly communicate your intentions to your sexual partner and give them a chance to clearly relate their intentions to you.

28. Mixed messages from your sexual partner may be a clear indication that you should stop.

29. Do not take advantage of someone’s drunkenness or drugged state.

30. Understand that consent to some form of sexual behavior does not automatically imply consent to any other form of sexual behavior.

**Warning Signs of Abusive Behavior**

1. Being afraid of your partner, or watching what you say or do to avoid a “blow up.”
2. Feeling unworthy or feeling helpless about your relationship.
3. Feeling isolated from family and friends due to your relationship.
4. Hiding bruises or other injuries from family or friends.
5. Being prevented by your partner from working, studying, going home or using technology (including your phone).
6. Being monitored by your partner at work, home or school.
7. Being forced or pressured to do something you don’t want to do

**Active Bystander Intervention**

Bystanders play a critical role in the prevention of sexual and relationship violence. Bystanders are defined as individuals who observe violence or witness the conditions that perpetuate violence. They are not directly involved in an incident but have the choice to intervene, speak up, or do something about it. MCW promotes a culture of community accountability where bystanders are actively engaged in the prevention of violence without causing further harm.

Bystander intervention means safe and positive options that may be carried out by an individual or individuals to prevent harm or intervene when there is a risk of dating violence, domestic violence, sexual assault or stalking. Bystander intervention includes recognizing situations of potential harm, understanding institutional structures and cultural conditions that facilitate violence, overcoming barriers to intervening, identifying safe and effective intervention options, and taking action to intervene.

Ways to be an active bystander include:

1. Watch out for friends and fellow students/employees. If you see someone who looks like they could be in trouble or need help, ask if they are ok.
2. Confront people who seclude, hit on, try to make out with, or have sex with people who are incapacitated.

3. Speak up when someone discusses plans to take advantage of another person.

4. Believe someone who discloses sexual assault, abusive behavior, or experience with stalking.

5. Refer people to on or off campus resources for support in health, counseling, or with legal assistance.

Wisconsin Sex Offender Registry

The federal Campus Sex Crimes Prevention Act of 2000 requires institutions of higher education to issue a statement advising the campus community on how to obtain information provided by the State concerning registered sex offenders. It also required sex offenders already required to register in a state to provide notice, as required under state law, of each institution of higher education in that state at which the person is employed, carries on a vocation, volunteers services or is a student.

The Wisconsin Department of Corrections maintains a Sex Offender Registry website. The site contains detailed program information and an offender search capability by offender name or specific location.

References:

Sex Offender Registry
The Handbook for Campus Security and Security Reporting (PDF)
Anti-Harassment and Non-Discrimination Policy (AD.CC.050)
Medical Student Handbook (PDF)
Graduate Student Handbook
Investigations into Allegations of Sex Discrimination, Sexual Assault, Domestic Violence, Dating Violence and Stalking Policy (AD.CC.090)
Annual Campus Safety Report (PDF)
US Department of Education, Office of Civil Rights
MCW Staff Employee Handbook
MCW Faculty Handbook
MCW Sexual Misconduct Website

Attachments:

N/A

Effective Date: 07/02/2015
Revision History: 10/15/2015, 4/1/2016, 11/03/2016, 07/01/2018
Supersedes Policy: N/A
Review Date: N/A
Approved By: ________________________________
John R. Raymond, Sr., MD, President and CEO
Medical College of Wisconsin
Recruitment-Staff

Corporate Policies and Procedures: Human Resources (HR)
Recruitment-Staff

Category: Employment (EE)
Policy #: HR.EE.030
Applies to: Full-Time Exempt and Non-Exempt Staff

PURPOSE:

To ensure a consistent process of recruiting, screening, and hiring Medical College of Wisconsin (MCW) staff, ensuring that equal employment opportunity standards are met and that the best qualified candidates are hired.

MCW is committed to the tenets of Affirmative Action and dedicated to diversity and inclusion of all people and groups, specifically those represented in the communities where we serve. As an institution, we are broadly focused on diversity and inclusion, and on increasing staff numbers within the following groups: African American, Hispanic, Asian, Veterans, Differently-abled and Native American. The intention is not to designate individuals within these groups as more deserving of employment, as MCW recognizes there exist a myriad of factors that determine employment eligibility. Rather, MCW believes that, by ensuring members of these groups have opportunities to join MCW, we make MCW richer and positively impact our community.

DEFINITIONS:

See Compensation Policy HR.CM.060 for definitions.

POLICY:

It is the policy of MCW to establish and adhere to standard staff recruitment procedures. MCW determines its employment needs, including the establishment of new positions, job specifications and requirements, and staff allocation patterns using the education, research, patient care and service obligations of MCW as a guideline. It is MCW policy that the recruitment of staff positions reflects a commitment to equal employment opportunity, and is carried out in a manner consistent with the published Affirmative Action Plan adopted by the Board of Trustees. Standard recruitment procedures will be consistently applied by all departments in accordance with staff recruitment protocol and applicable federal and state guidelines.
All full and part-time non-exempt and exempt staff vacancies are covered by this policy. All positions must be posted on the MCW Careers Website for at least three business days before extending an offer.

PROCEDURE:

1. To ensure compliance with government regulations and MCW’s Affirmative Action Plan, recruitment authorization is required for all new and replacement full and part-time, Casual, and Occasional staff positions.

2. Competitively recruited positions will be announced both internally and externally by the Office of Human Resources on the MCW Careers Webpage. This enables qualified candidates, both internal and external, the opportunity to apply online for all available employment opportunities. A position must be posted on the MCW Careers Webpage for three business days before an offer may be extended.

3. Federal regulations require that original online applications and resumes be retained centrally for two years plus the current year. The Office of Human Resources Applicant Tracking System, (ATS), serves as this central location. If a candidate applies directly to a department, the department must direct the applicant to create a profile on the MCW Careers Webpage whether an internal or external applicant. This will ensure that the applicant meets the minimum qualifications for the position and that accurate records are maintained.

4. Interviewing and Selection:

   a. Only job-related questions may be asked during the interview process. Departments should utilize their Employment Consultant and the “Interviewing and Hiring Practices” class for guidance.
      i. All departmental interview notes for all candidates must be retained for at least two years from the date of the interview plus current year. These notes should be gathered from all individuals who participated in the interview process and retained by the supervisor of the position. These notes must be provided to the Office of Human Resources upon request.

   b. After selection of the top candidate(s), the Employment Office must be contacted before an offer can be extended. In conjunction with the Department, the Employment Office will determine an appropriate salary offer, conduct a criminal background check and/or a Caregiver Check and determine if appropriate references have been obtained.

   c. Minors considered for employment at MCW must be a minimum of 14 years old and must obtain a work permit. The Office of Human Resources must be contacted when a minor is being considered.
5. **References:**

   a. Documented reference checks must be conducted on the top candidate(s). The Employment Office can facilitate this process. Alternatively, the department may do so on their own; however, all documented references must be sent to the Office of Human Resources or added to a candidate’s profile in the Applicant Tracking System for storage and review. Reference inquiries must be limited only to questions relating to the candidate(s) qualifications and performance in their former or present job. Please refer to the attachments section for reference check templates that can be utilized for this purpose. References should be supervisory in nature and cover at least 10 years of work history; sufficient references must be gathered in order for the Office of Human Resources to develop a compensation offer. In addition, a reference from a current supervisor must be obtained.

   b. Before any internal candidates can be considered further for a transfer/promotion a review of the employee personnel file, either by the Office of Human Resources and a documented reference with a current supervisor is required.

6. **Background Checks:**

   a. MCW conducts a full background investigation to include a criminal background check. All external and internal applicants must complete a Background Information Disclosure (BID) form (HFS-64). Applicants for Caregiver positions must also undergo a Caregiver Background Check.

   b. All applicants being considered for hire must have completed a BID form and have a successful background check prior to the extension of an offer and beginning employment. In cases where a business necessity is determined, an offer may be extended if the applicant has submitted a “clean” BID form and an official offer letter has been sent by the Office of Human Resources. The New Hire may work no more than 60 days without the results of the criminal background check.

   c. Applicants cannot begin employment if they (1) are barred from employment under the Caregiver Background Check Law; (2) were convicted of a crime the circumstances of which the Director of Talent and Faculty Affairs or Vice President of Human Resources and Faculty Affairs determine are substantially related to the circumstances of the position; or (3) are subject to a pending criminal charge, the circumstances of which the Director of Talent and Faculty Affairs Vice President of Human Resources and Faculty Affairs determine are substantially related to the circumstances of the position.

7. **Recruitment Activity Record (RAR):**
a. To finalize the recruitment process, the Recruitment Activity Record (RAR) must be completed in the Applicant Tracking System no later than the date the candidate begins their employment with MCW or in their new position.

8. **New Hire Forms:**
The following forms must be completed by the employee and submitted to the Office of Human Resources as noted:

a. Employment Eligibility Verification Form (I-9) - Must be completed, by law, within three (3) business days of the employee's start date. I-9's at MCW are completed electronically in the TALX I-9 Express System. A link to the form will be provided in Virtual New Employee Orientation (VNEO) and within offer letters for Exempt staff. Failure to complete this form will result in suspension and/or termination of the new employee.

b. Employee's Withholding Allowance Certificate (W-4) - Must be completed on or before the employee's start date.

c. Direct Deposit form - Must be completed on or before the employee's start date.

d. *Employee Handbook Acknowledgement and Agreement Form* - Must be electronically signed via the Virtual New Employee Orientation presentation.

e. Code of Conduct Acknowledgement and Agreement Form - Must be electronically signed via the Virtual New Employee Orientation presentation

9. **Specific Laboratory Safety Training for Medical College Technical Employees:**

MCW provided information in Virtual New Employee Orientation to all new employees about potentially dangerous, health affecting agents routinely used in the workplace. An acknowledgement form must be completed by the employee, who may be in contact with hazardous chemicals, radioactive materials, and infectious agents, within the Virtual New Employee Orientation platform.

REFERENCES:

[Compensation Policy HR.CM.030](#)
[Caregiver Law Policy HR.EE.020](#)

ATTACHMENTS:

[Reference Check Template Forms](#)
Staff Conflict Resolution

Corporate Policies and Procedures: Human Resources (HR)
Staff Conflict Resolution

Category: Employee Relations (ER)
Policy #: HR.ER.080
Applies to: Current exempt and non-exempt employees who have completed six continuous months of employment and who have successfully completed an initial trial period.

PURPOSE:

To provide a fair, consistent, and effective process to resolve conflict situations, and thereby promote the work of the College.

DEFINITIONS:

Not Applicable

POLICY:

There are times when differences of opinion will arise from the interpretation of policies or matters relating to daily work responsibilities. All parties benefit from the prompt and orderly resolution of such concerns. The Medical College of Wisconsin (MCW) promotes positive working relationships which depend on effective communication and understanding among people. Good relationships are easier to achieve when people feel that their problems and opinions can be discussed freely and honestly. The majority of misunderstandings can and should be resolved through open discussion between people.

Issues subject to the staff conflict resolution process (appeal process) may include such things as corrective action and termination from employment. The staff conflict resolution process may not be used to contest department guidelines or MCW policies, budgetary programs, benefit programs, or performance reviews. The appeal process provides a prompt, orderly means of receiving and responding to employee concerns.

Eligibility:

Employees are eligible to use the appeal process after successful completion of their initial trial period and up to fourteen (14) calendar days following their date of employment termination. A newly transferred or promoted employee is eligible to use the appeal process.
Presentation of a complaint or problem will, in no way, prejudice the interest and good standing of an employee. Reprisal or retaliation against an employee for using this process will not be tolerated.

Terminology:

Levels of supervision and management mentioned in the appeal process may be identified by various titles within MCW. The Office of Human Resources will help employees and leaders understand the appropriate appeal path if questions arise.

PROCEDURE:

Appeal Procedure:

NOTE: In situations where an employee may feel undue duress if required to talk with the supervisor involved in a situation, the employee may discuss the matter with either the Department Administrator or the Office of Human Resources, who will decide if there is legitimate reason to approve a modification of the appeal process or if some other method of problem resolution is more appropriate. The employee is required to meet the appeal process deadlines in all situations.

Step One - Initial Problem Solving Step

To initiate Step One of the Staff Conflict Resolution process, the employee must submit a formal written Staff Conflict Resolution Form (available from the Office of Human Resources or via the Human Resources intranet website) to the Office of Human Resources within seven (7) calendar days following the decision or reasonable knowledge of the decision being appealed.

When appealing a termination, the terminated employee must submit a formal written Staff Conflict Resolution Form to the Office of Human Resources within fourteen (14) calendar days following the date on which they were informed of the termination from employment.

The written appeal using the Staff Conflict Resolution Form must contain a description of the specific situation or management action being appealed and the specific action(s) being requested as a result of the appeal. The appeal must also identify all known facts about the situation.

The Staff Conflict Resolution Form that is completed by the employee in Step One is the form that will be used throughout all subsequent steps of the process. Employees will not complete and submit new Staff Conflict Resolution Forms or other documents in subsequent steps of the process unless requested.

A meeting will be scheduled for the employee to meet with the supervisor who made the decision being appealed. Following the meeting, the supervisor will consider the information presented, investigate further if necessary, consult with and inform the Office of Human Resources of the recommended response. The
supervisor will respond to the employee in writing within seven (7) calendar days following the meeting and forward a copy of the written reply to the Office of Human Resources.

If the Department Administrator is the supervisor who made the decision being appealed, skip Step One and proceed directly to Step Two. On rare occasions when both the immediate supervisor and Department Administrator were equally involved in making the decision in question, Step 1 and Step 2 may be combined in one meeting.

**Step Two - Formal Written Appeal to Department Administrator**

If the matter is not settled satisfactorily through Step One of the appeal process, the employee may proceed to Step Two by contacting the Office of Human Resources within seven (7) calendar days of the date listed on the supervisor’s written response.

The Department Administrator will meet with the employee during the investigation of the appeal and provide the employee a written decision within fourteen (14) calendar days of meeting with the employee. A copy of the appeal and written reply must be provided to the Office of Human Resources by the Department Administrator.

**Step Three - Appeal to the Vice President of Human Resources**

If the matter is not settled satisfactorily through Step Two, the employee may appeal to the Vice President of Human Resources by contacting the Office of Human Resources within seven (7) calendar days of the date listed on the Department Administrator’s written response. The Vice President of Human Resources will meet with the employee to learn more about the employee’s appeal, complete any other investigation as determined appropriate, and respond with a final written decision to the employee within fourteen (14) calendar days of meeting with the employee, marking the end of the appeal process.

**Process and Timeframes:**

A. The staff conflict resolution process is a guideline to follow to resolve employee complaints in a fair and consistent manner. On occasion, the Office of Human Resources may need to modify the process and/or timelines, depending on the situation, and any changes made by Human Resources are ineligible for appeal.
   1. If a written response is provided to the employee outside of the timeline designated by the policy, this does not imply that the decision is found in the employee’s favor. Rather, the employee is eligible to present the appeal to the next step in the process.
   2. The timelines stated within the appeal process may be modified in advance of any step by mutual agreement.
3. Any failure by the employee to process the appeal within the otherwise stated timeframes will be considered a withdrawal of the appeal and acceptance of the most recent management level decision.

4. All appeal meetings will take place in-person. The Office of Human Resources reserves the right to make alternate arrangements for good cause on a case-by-case basis. Employees will not be permitted to bring outside counsel or any other parties to any staff conflict resolution meetings.

B. When an employee accepts a decision at any step of the appeal process, formally withdraws the appeal, or does not process the appeal timely, the appeal will be considered settled. If/When an action requested by the employee is granted, the appeal will be considered settled. An appeal is not subject to reinstatement at a later date.

C. When staff use multiple forums to contest actions that they believe unfair and/or discriminatory (as defined by state and federal laws), MCW may designate one forum to be the primary forum appropriate for final resolution of the situation.

D. When staff members use the staff conflict resolution process to report alleged discriminatory behavior, the Office of Human Resources will first conduct an immediate investigation into the allegations, before commencing the staff conflict review process.

E. Current staff members utilizing the staff conflict resolution process will be provided a reasonable amount of release time from work duties without a loss of pay to attend meetings. Release time for the meetings should not interfere with the employee's work responsibilities and require approval of the appropriate supervisor.

NOTE: The Staff Conflict Resolution Appeal policy is not intended to replace the MCW Anti-Harassment and Non-Discrimination policy (AD.CR.050), but merely supplement it.

REFERENCES:

Not Applicable

ATTACHMENTS:

Staff Conflict Resolution Form

Effective Date: 04/02/1980
Supersedes Policy: Formerly Policy # 3.11
Review Date: N/A
Approved By: ____________________________
John R. Raymond, Sr., MD, President and CEO
Medical College of Wisconsin
Use of Electronic Equipment
Corporate Policies and Procedures: Information Technology (IT)
Use of Electronic Equipment

Category: Information Services (IS)
Policy #: IT.IS.030
Applies to: All Employees

Purpose:
To define inappropriate use of the Medical College of Wisconsin’s (College) electronic resources.

Definitions:
Not applicable

Policy:
The College provides electronic resources for use by College employees in connection with the performance of their job duties. The use of such electronic resources, including without limitation; telephones, copy machines, facsimile transmission machines, computers, email, voice mail, local area network or other shared computer access, and Internet access, must comply with all policies of the College, including but not limited to policies relating to sexual harassment, rules of employee conduct, protection and use of College equipment, software, conflicts of interest and protection and use of confidential information. The following activities are inappropriate uses of the College's electronic resources and are prohibited:

- use of the College's electronic resources to send threatening or harassing content or messages or to view, download, retransmit, distribute or otherwise communicate content or messages that may violate the MCW Anti-Harassment and Non-Discrimination Policy
- use of the College’s electronic resources to intentionally display, hold, send, view, print, download, retransmit, distribute or otherwise communicate content which the College may deem to be indecent, obscene, sexually explicit, or pornographic absent a legitimate academic, research or medical purpose
- private use or use other than for Medical College of Wisconsin purposes, except in cases of emergency or use which does not interfere with the College employee's performance of work, provided such use otherwise complies with all other policies of the Medical College of Wisconsin
- any use which could result in damage or corruption of College equipment or facilities or the data or software used in connection with such equipment or facilities, such as running destructive software or viruses
• any use of software not licensed to the College, software not licensed to an individual, or violations of the software license agreements including freeware or shareware; see Software Policy for details.
• any unauthorized access to restricted or confidential information, or any use of another user's information services account, or any action which would facilitate an unauthorized access or use by another person

Personal passwords are issued to enhance the protection of College confidential information, not to permit private use of College electronic resources. The College reserves the right, consistent with the College's purposes, policies, and procedures to monitor use of College electronic resources by College employees. Specifically, computer software audits will be regularly conducted; other audits will be carried out as needed.

Violation of this policy may result in appropriate disciplinary action, up to and including termination. Certain violations of this policy may constitute violations of state and/or federal law; the College reserves the right to report such conduct to state and/or federal authorities.

Procedure:

Not applicable

References:

Not applicable

Attachments:

Not applicable

Effective Date: 07/1997
Supersedes Policy: Formerly Policy 3.27
Review Date: N/A

Approved By: ________________________________
John R. Raymond, Sr., MD, President and CEO
Medical College of Wisconsin
Relevant Froedtert Hospital Corporate Policies and Procedures
Froedert Cellular Phones and Other Transmitting Devices Policy

Name: Cellular Phones and Other Transmitting Devices  
Last Review Date: 01/01/2016  
Next Review Date: 01/01/2019  
Policy Number: SP3.001  
Origination Date: 06/01/2006

Purpose: To regulate, in order to maintain the safe environment of care, the use of cellular phones, Personal Digital Assistants (PDAs) and other wireless technology capable of transmitting information electronically; mitigate possible interference with electronic medical equipment; and provide guidelines for the use of such equipment on hospital owned / controlled property.

Definitions: Cellular phone means any portable telephone, analog or digital, that is not specifically designed for low power (< 100mW) use, or which has not been tested and found to be safe in the immediate patient vicinity by the Biomedical Engineering Department. Cellular phones which incorporate immediate contact functions (e.g. two-way / "walkie-talkie") are considered to be cellular phones.

Personal Communication Devices means all devices regulated by this policy.

Personal Digital Assistant (PDA) means any device (e.g. pocket PCs, PDAs, Blackberries, etc.) which incorporates wireless connection capabilities.

Transmitting device means any instrument with the ability to transmit voice or data over a wireless path using radio frequencies. (Note: Some pagers also contain the ability to transmit information; however most only receive information and, therefore, are not regulated by this policy.)

Policy:  
1. Froedert Hospital reserves the right to control / restrict, at any time and at any location on hospital owned or controlled property, the use of cellular phones, PDAs, transmitting devices, or any other devices that may interfere with medical electronic equipment, or that jeopardizes the safe environment of care, or violates patient confidentiality regulations.

2. Personal communication devices are allowed to be used in any area of the hospital except those posted to the contrary. Untrained staff, patients, visitors, and outside personnel may not use personal communication devices any closer than three (3) feet from any electronic medical device or electronic diagnostic / laboratory medical equipment. Two-way radio communication devices must maintain a distance of ten (10) feet from medical electronic equipment. Two-way radio devices may be used by Security Officers, and other trained individuals, in exigent circumstances in any area of the hospital.

3. Control of two-way radio systems in use by hospital departments is
the responsibility of the Security Department. Hospital Departments considering use of a two-way radio system must receive authorization from the Security Department. In times of crisis management all hospital two-way radio systems and communication devices may be appropriated / controlled by the Incident Command Center for use in facilitating resolution of the event.

4. Hospital and medical staff, patients, visitors, or other guests of the hospital are required to immediately comply with the directives of Security Officers, nursing staff, Biomedical Engineering staff, or safety officials in regards to the use and control of cellular phones, PDAs, and all other transmitting devices even if these directives are contrary to the tenets of this policy.

5. Hospital and medical staff may use cellular phones, PDAs, and other transmitting devices only in the performance of their duties as prescribed by their department managers and approved by the hospital. Use of these devices during working hours by hospital staff for personal reasons is prohibited.

6. Any occurrence of interference in medical electronic equipment caused by or suspected to be caused by a personal communication device will be reported to the Biomedical Engineering Department and documented on an incident report form.

Procedure: 1. Areas where personal cellular phones, wireless technology devices, and all other unapproved transmitting devices are prohibited, and the devices must be turned OFF include:

MICU Surgical Suites Emergency Department (treatment/exam areas)  
SICU Cardiac Cath Lab Trauma Center  
NICU PACU Nursery & Surgical Suites (Birth Center @ CHW)  
CVICU Radiology Suites Eye Institute Bldg., 5th floor

2. All hospital staff will assist in enforcing the tenets of this policy by confronting individuals using cellular phones, PDAs, and other transmitting devices in restricted areas or in incidences where the device is causing interference with medical equipment, or jeopardizing the safe environment of care, or violating confidentiality policies; and by advising the users to cease operation and to power off the device.

3. The use of cell phones and PDAs by hospital and medical staff must be authorized by the department manager in accordance with other hospital policies. Transmitting devices used by hospital staff members must be approved by the department manager and by Biomedical Engineering because of the increased potential for interference due to their high power output.

4. The use of two-way radio systems by hospital departments must be
reviewed by the Security Manager (or designee) prior to system installation & use. Departments using such two-way systems may be required, at the department’s expense, to add their frequency to the dispatch console in the Security Operations Center in order to facilitate the optimum use of the radio system. Departments may also be required to add, at their expense, other hospital frequencies to their portable radios to facilitate use during emergency events. Staff using two-way radio devices must undergo education relating to the proper use of such devices in the hospital environment due to their increased potential for interference.

5. Staff who do not comply with the tenets of this policy or directives of authorized individuals relating to the use of these devices or use such devices for personal reasons may be referred for disciplinary action. Patients, visitors, or other guests of the hospital who fail to comply with authorized directives may be directed to leave hospital property.

6. If an incident occurs where a personal communication device causes interference or is suspected of causing interference with a medical electronic device that adversely impacts patient outcomes or negatively affects the reliability / performance of the equipment, or in any way compromises the safe environment of care, the hospital staff member noting the event will immediately contact the Biomedical Engineering Department. The staff member will also complete an incident report detailing the circumstances of the event.

Collaborators: Martin Busack
Distribution: Froedtert Memorial Lutheran Hospital
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Froedtert Code of Business Conduct

Double click the pamphlet below for full access.

Please note that the Code of Business Conduct does not create any contract of employment, express or implied, between Froedtert Health or any of its affiliated organizations and any individual.
Froedtert Code of Corporate Ethics

Name: Code Of Corporate Ethics
Last Review Date: 02/27/2017
Next Review Date: 02/27/2020
Description: Code of Corporate Ethics, Compliance, Code of Conduct, Staff Behavior, Staff Conduct, Patient Rights, Conflict Resolution
Policy Number: FH-COM.032
Origination Date: 11/01/2011
Supersedes: CPA.0096, 80100-071
Purpose: To set forth a code of ethical behavior designed to help improve patient outcomes by respecting each patient’s rights and conducting business in an ethical manner.
Definitions: A. Froedtert Health affiliate means for purposes of this policy: Froedtert Memorial Lutheran Hospital, Inc.; Community Memorial Hospital of Menomonee Falls, Inc.; St. Joseph’s Community Hospital of West Bend, Inc.; Froedtert & The Medical College of Wisconsin Community Physicians, Inc., West Bend Surgery Center, LLC, and Froedtert Surgery Center, LLC. Any other entity that becomes controlled by FH after adoption of this policy also may be considered an affiliate.

B. Staff of a Froedtert Health Affiliate – For the purposes of this policy, means individuals employed by a Froedtert Health Affiliate or credentialed members of the medical staff of a Froedtert Health Affiliate.

Policy: General Principles
A. Everyone working at, or for a Froedtert Health Affiliate has the responsibility to act in a manner consistent with the ethical principles outlined in this policy.
B. Everyone working at, or for a Froedtert Health Affiliate must perform their duties with integrity, honesty, fairness, and diligence; and adhere to the highest principles of dignity and respect.
C. Everyone working at, or for a Froedtert Health Affiliate will follow all laws, rules, regulations, policies and procedures that apply to their job duties.
D. Everyone working at, or for a Froedtert Health Affiliate will treat individuals with courtesy, honor and respect. Individuals shall not be harassed or discriminated against on the basis of: race, color, national origin, age, disability and sex, including discrimination based on pregnancy, gender identity and sex stereotyping.
E. Everyone working at, or for a Froedtert Health Affiliate will perform and
fulfill all duties consistent with the principles, values and obligations established in our Code of Business Conduct

F. Staff of a Froedtert Health Affiliate will perform and fulfill all duties consistent with the principles, values and obligation established in our Rules of Conduct/Corrective Action Policy.

G. Staff of a Froedtert Health Affiliate will declare any conflicts of interest and make appropriate arrangement to assure that those with a material interest are not involved in the decision making process.

H. Reporting business performance should be undertaken in such a way that senior leadership is fully and properly informed of the business' actual performance, risks and opportunities in a timely manner.

I. Everyone working at, or for a Froedtert Health Affiliate will promptly report all ethical or compliance violations to the Froedtert Health Compliance Office.

**Patient Care Principles**

A. Everyone working at, or for a Froedtert Health Affiliate will respect and honor the rights, dignity, well-being, and privacy of all patients.

B. Everyone working at, or for a Froedtert Health Affiliate will respect and protect the emotional vulnerability of all patients and refrain from encouraging, developing, fostering, or maintaining intimate or other inappropriate personal employee/patient relationships.

C. Everyone working at, or for a Froedtert Health Affiliate will protect all patients from any form of abuse, neglect, or exploitation.

D. Everyone working at, or for a Froedtert Health Affiliate will maintain the highest level of patient confidentiality at all times.

E. Everyone working at, or for a Froedtert Health Affiliate will encourage and include, whenever possible and to the extent possible, the family or designated others in the treatment of the patient.

F. Everyone working at, or for a Froedtert Health Affiliate recognizes and accepts the autonomy of patients and the right of those with capacity to make their own health care decisions, including refusal of treatment.

G. Everyone working at, or for a Froedtert Health Affiliate, in accordance with applicable policies and procedures, will honor and respect patients advance directives and durable powers of attorney regarding their health care wishes and decisions.

H. Everyone working at, or for a Froedtert Health Affiliate will be sensitive, responsive, and respectful in the care of individuals who are at the end of life by fostering the individual’s comfort and dignity while
addressing the treatment of primary and secondary symptoms, effectively managing pain and responding to the individuals’ and their family’s specific psychosocial, spiritual, and cultural needs and concerns.

I. Froedtert Health will respect the right of all patients and staff to refuse to participate in any research without first obtaining legally adequate consent and make sure that care is not compromised for refusal to participate.

J. When a patient makes a request for a referral to a physician, or other healthcare service provider, such as home health, staff should provide a list of several physicians/providers who are qualified in the specialty for which the referral is sought. This will avoid the appearance of favoritism or potential influence over the decisions of the patients.

K. Everyone working at, or for a Froedtert Health Affiliate will provide treatment in the most efficient and effective manner possible and refrain from unrealistic lengths of stay or inappropriate provisions of services to our patients.

L. Everyone working at, or for a Froedtert Health Affiliate will make decisions about admissions, discharges, and transfers of patients with purely the best interest of the patient in mind.

M. Everyone working at, or for a Froedtert Health Affiliate will make sure that the integrity of clinical decision making shall be protected and not compromised regardless of any consideration related to the compensation between the facility, its leadership, physicians, and/or any other business/vendor.

**Administrative Principles**

A. Froedtert Health recognizes our position of public trust and will represent our services and capabilities fairly and accurately to the public.

B. Froedtert Health will advise patients at their request about their financial responsibility to the hospital and/or clinic, if any, and provide assistance to them in accessing possible resources, while never denying a medical screening exam for emergency medical conditions.

C. Froedtert Health will perform all billing and reimbursement activities with integrity, accuracy and in compliance with all laws, regulations and organizational policies and procedures.

D. Froedtert Health will refrain from contractual agreements with organizations or individuals where there is a potential for conflicts of interest.

E. Froedtert Health will refrain from doing business with organizations and individuals that do not share the same values and integrity as we have. As a result we will not do with business with any businesses or
individuals that can not participate in federal or state health care programs.

F. Froedtert Health staff and members of the medical staff, vendors, and contractors must obtain and maintain all appropriate licensure and/or certifications required for their job responsibilities or contracts.

**Conflict Resolution Principles**

A. Froedtert Health will respect the right of staff members to not participate in any treatment, procedure, or activity approved by the facility that is in violation of, or in conflict with, their specific and identifiable cultural, religious, or ethical beliefs.

B. Froedtert Health will promptly and courteously investigate and resolve all complaints from staff, our patients, the public, or others regarding any aspect of our service delivery.

C. Froedtert Health will not retaliate against a patient or staff member or any other person who, in good faith, raises a concern about non-compliance.

D. If an individual feels his/her concern has not been addressed, he/she should direct these concerns to any member of the Senior Leadership Team and/or the Vice President, Chief Compliance and Risk Officer.

E. If the individual continues to feel his/her concern is not being properly addressed by internal parties, he/she has the right to report his/her concerns to the appropriate government agency.

F. Staff of a Froedtert Health Affiliate will accept no gifts from patients, their families or friends, vendors, or from any other source associated with the performance of our duties that has any potential to influence or creates a perception of influence.

**Other Principles**

A. Outside activities of staff members are generally a personal matter. In general, staff members are encouraged to participate and accept leadership roles in professional and educational groups, as well as community, cultural and charitable activities. Whether such activities are subject to indemnification by Froedtert Health depends upon Wisconsin law and the individual Froedtert Health Affiliate’s indemnification policy. When a staff member serves as a director of an entity at the request of Froedtert Health, any fees for such service accrue to Froedtert Health. Other directors’ fees may be retained as personal income.

B. Borrowing money or items from vendors, consultants or any other individuals or organizations doing business with Froedtert Health is strictly prohibited. Personal borrowing needs of staff should be confined to banks or other financial institutions.
C. Froedtert Health encourages voluntary support of political activities and candidates for public office. However, the use of Froedtert Health funds or other Froedtert Health property as donations or to engage in such activities for such purposes is strictly prohibited.

D. Froedtert Health’s communication with elected officials regarding public policy matters is regulated by the state Government Accountability Board, the federal Lobbying Disclosure Act and the Internal Revenue Service. Froedtert Health resources, including staff time and the e-mail system, may be used for advocacy or lobbying purposes without authorization from the Froedtert Health President, CEO or Director of Government Relations. Staff members authorized to use Froedtert Health’s e-mail or other property for these purposes must report such activity to the Director of Government Relations.

Issuing Authority: FH Corporate Policy Committee
Distribution: Froedtert Health
Reference Type: Content Details
URL: http://fhpolicy.s1.fchhome.com/d.aspx?d=21C57571FCX4
Expiry Date: 2/27/2067 12:00:00 AM
Froedtert Confidentiality Policy

Name: Confidentiality Policy
Last Review Date: 05/23/2018
Next Review Date: 05/23/2021
Description: Confidentiality, Compliance, PHI, Confidential, Confidentiality Policy
Policy Number: FH-COM.062
Origination Date: 07/01/2014

Purpose:
A. To outline the responsibility, expectations and accountability for all Workforce Members to maintain and protect the confidentiality of patient, workforce and other business information at Froedtert Health (FH).

B. To describe the consequences for failing to comply with the rules, and expected behaviors or actions.

Definitions:
A. Confidential Information - For purposes of this policy, confidential information includes any information not publicly available that belongs to FH or is related to FH business operations.
1. Patient’s Protected Health Information (PHI): Any individually identifiable health information, whether oral, written, electronic, transmitted, or maintained in any form or medium that:
   I. Is created or received by a health care provider, a health plan, or a health care clearinghouse; and
   II. Relates to an individual’s past, present, or future physical or mental health condition, health care treatment, or the past, present or future payment for health care services to the individual; and
   III. Either identifies an individual (for example, name, social security number or medical record number) or can reasonably be used to find out the person’s identity (address, telephone number, birth date, email address, and names of relatives or employers)
   IV. Protected health information excludes individually identifiable health information contained in employment records held by a covered entity in its role as employer; in addition to any person who has been deceased for more than 50 years.
2. Information Pertaining to Workforce: Examples include salaries, benefits/claims, employment records, corrective actions, social security numbers, workforce health, occupational health, and payroll information, etc.
3. Business Information: Examples include FH financial, strategic, operations, contracts, research, internal communications or other proprietary information or information not publicly available.

B. Froedtert Health Affiliate (FH Affiliate) - For purposes of this policy, Froedtert Health Affiliate refers to: Froedtert Memorial Lutheran Hospital, Inc.; Community Memorial Hospital of Menomonee Falls, Inc.; St. Joseph’s Community Hospital of West Bend, Inc.; Froedtert & The Medical College of Wisconsin Community Physicians, Inc.; West Bend Surgery Center, LLC; Froedtert Surgery Center, LLC; Waukesha
Policy:

A. All Workforce Members have a legal and ethical responsibility to protect and secure the privacy and confidentiality of information regarding our patients, staff and business activities.

B. A Workforce Member may be granted access to Confidential Information as necessary to fulfill the requirements of his/her defined role and responsibility.

C. A Workforce Member who has access to, or comes into contact with any Confidential Information is only authorized to acquire, access, use, disclose, remove, copy, alter, or destroy information within the scope of our policies and only for the sole purpose of carrying out his/her approved and legitimate job duties and never for personal reasons, curiosity, malicious use, unethical motivation or for any other unapproved purpose.

D. Workforce Members are prohibited from accessing, reviewing, using, copying, printing, disclosing or removing his/her own PHI. The approved methods for obtaining access to one’s PHI is to contact the health provider directly, request copies of the medical information from the Health Information Management Department, or by accessing information through the MyChart portal. It should be noted that appointment information, provider schedules and billing information is considered PHI.

E. Workforce Members are prohibited from accessing, reviewing, using, copying, printing, disclosing or removing the PHI of any family members, friends, co-workers, neighbors, patients in the media, VIPs, or any other individual for any personal reason or other non-legitimate job duty related purposes. It should be noted that appointment information, provider schedules and billing information is considered PHI.

F. Workforce Members do not have any individual rights to or ownership of any information accessed or created by the workforce member during his/her employment or relationship with FH.
G. FH employees are provided proper training and education regarding the confidentiality rules, regulations and expected behaviors and are required to complete all mandatory education within the specified timeframe. A Confidentiality Agreement must be signed by each FH employee upon hire and as required throughout his/her employment. Signed Agreements for employees are retained in the Human Resources Department.

H. A Confidentiality Agreement must be signed by each FH volunteer, student, temporary worker, medical staff member, resident and others when obtaining an identification badge from FH Affiliate Security Department. Signed agreements will be forwarded to the FH Compliance Department.

I. Department leaders are required to validate that a signed Business Associate Agreement is in place when applicable and prior to any access, use or disclosure of PHI and in accordance with the HIPAA Business Associate Agreements Policy FH-SC.035. Additionally, department leaders may decide to request certain contractors or other on site vendors to sign the FH Confidentiality Agreements due to the sensitive information they may come into contact with during their business engagement. Those agreements are to be stored in the departmental files and retained for 6 years after the engagement has ended.

J. Workforce Members have an obligation and responsibility to immediately report to the FH Compliance Department (FH Compliance) any activities that may compromise the privacy and/or security of our staff, business and/or patient information. FH will not retaliate against individuals who, in good faith, bring forth information of non-compliance. For more information on the reporting policy and procedures, refer to Corporate Policy FH-COM.025 Compliance Reporting, Hotline and Non-Retaliation.

K. FH Compliance is responsible for and will investigate and respond as appropriate to all reported concerns related to privacy and confidentiality. If a breach of our patient's Confidential Information has occurred, FH Compliance will follow all applicable rules and regulations regarding breach notification which are outlined in the Corporate Policy: FH-COM.006 Notification of Breach of Protected Health Information.

L. Routine auditing and monitoring of system use and access may be conducted at any time and without notice. A Workforce Member’s system access may be revoked at any time.

M. FH will administer appropriate and consistent sanctions and will take corrective action against those Workforce Members who do not follow the rules, regulations and expected behaviors or actions.
Procedure: A. Only the Minimum Amount of Confidential Information should be acquired, accessed, used or disclosed when carrying out any given task. For example:
1. Workforce Members must not access, use or disclose information beyond the scope of his/her job responsibilities and are only authorized to access the data elements necessary to carry out his/her legitimate job duties. Staff who are unsure of the scope of their job duties or authorization to access PHI are required to seek immediate clarification from their leader.
2. Social Security Numbers will not be acquired, accessed, used or disclosed unless it is required to fulfill a business need. This includes having Social Security Numbers on reports or other documents when it is not needed or required.
3. Electronic security access is granted in accordance with the Workforce Members role and responsibility and in accordance with FH Information Technology policies and procedures.
4. Reports, spreadsheets and databases will only contain the data elements necessary to fulfill the business purpose and will be stored in a secure environment and for the appropriate length of time.

B. Disposal of Confidential Information must be done in a manner that ensures that the information cannot be identified, recovered or reconstructed and done in accordance with Corporate Policy: FH-COM.030 Disposal of Protected Health Information and Other Confidential Information. Workforce Members are required to use the locked/secure recycle bins or other authorized manner of disposal for the disposal of all Confidential Information. Confidential Information must never be discarded in regular trash bins or dumpsters.

C. Storing of Confidential Information must be done in a location (both physically and electronically) that is only accessible to those that require the information. Only store the information as long as required and in accordance to the Record Retention policies and regulatory requirements. For example:
1. Confidential Information in electronic format should not be stored on a shared or public drive, local hard drive, non-encrypted USB, mobile device, personal device or any other device that is not in compliance with FH Information Technology policy and procedures.
2. Departments should not indefinitely store data, internal reports, spreadsheets or other databases that are used for a specific departmental use to track productivity, quality monitoring or for other internal purposes. (Unless required by law or other requirement, or is specifically addressed in a FH Affiliate record retention policy) Departments should perform regular maintenance of their electronic and physical space to assure that only the necessary data and information is retained.

D. Physical Environment Protections:
1. Keep all Confidential Information, devices or equipment that contain confidential information physically secure to prevent any
Unauthorized person from gaining access.
a. Areas that do not have the capability of being locked during off
hours must have an established process to assure that Confidential
Information is not left easily viewable or accessible by others.
b. Workforce Members that are in roles where removal of
Confidential Information from the facility is authorized, are
responsible for the security of the information in his/her possession.
Confidential Information, including laptops, should never be left in an
unlocked vehicle or in plain sight, or left unattended in a public
location where others may steal, view or access it.
c. Confidential Information should not be left carelessly in conference
rooms, restrooms, dining locations, photocopiers or other publicly
accessible locations. Any Workforce Member who discovers
Confidential Information in a public location, is responsible for
securing the information (e.g. disposing in the locked/secure recycle
bins, or delivering to the owner, when known.)

E. Careful Dissemination of Confidential Information is critical in
preventing errors and mishandling of information.
1. When disseminating or handing out documents or other
information which contain PHI or other Confidential Information,
Workforce Members must validate that they have the correct
information prior to dissemination. For example, Workforce
Members must:
a. Positively identify the patient or staff member by validating
identifiers (name and date of birth) prior to distributing any
information.
b. Validate each page of the documents or information that is to be
distributed to ensure that all the correct information is enclosed and
that no other information has been accidentally included.
2. When mailing information, verify that all of the correct papers are
enclosed and match the name addressed on the envelope prior to
sealing the envelope. Ensure that the envelope is properly
addressed and select the appropriate type of envelope or sturdy
packaging to ensure it will safely secure the documents during the
mailing process.
3. When emailing Confidential Information within Froedtert Health,
validate that the correct recipients have been selected to receive the
email. If the email is going to another organization outside of
Froedtert Health, (this does not include emails to/from MCW), type
SECURE in the subject line to force the email to be encrypted. For
additional information regarding emailing of confidential information,
refer to the Email and Internet and Usage Policy FH-IT.025.
4. When routing Confidential Information throughout the health
system, information must be protected to the extent possible to
maintain its confidentiality. For example, only use the approved inter-
office envelopes and complete all of the fields of information required
on the outside of the envelope so it is properly delivered.
a. If Confidential Information is misdirected and the recipient is
unaware of who the owner or intended recipient is, the recipient may
either dispose of the information in a locked recycle bin, or forward the information to the FH Compliance Department for proper identification or disposal.

5. When faxing PHI or other Confidential Information, Workforce Members must validate that they have the correct fax number, and to use caution when entering the number in the fax machine to prevent errors. Appropriate fax cover sheets must always be used and the Corporate Faxing Policy FH-HIM.010 must be followed.

6. When a Workforce Member receives a complaint or they discover that Confidential Information was mishandled or accidently released to an unintended recipient, they must immediately report the incident to his/her Leader and to the FH Compliance Department.

F. Computer and other Electronic Security

1. Workforce Members must secure the computer workstation when it is left unattended. They must also:
   a. Alert other Workforce Members when they discover their workstations not properly secured.
   b. Notify Department Leader and/or FH Compliance if non-compliant practices continue.

2. Each Workforce Member is responsible for all activity and access that occurs under his/her UserID/password and will be held accountable for any inappropriate activities that may occur.
   a. Never share unique computer UserID/password information or share ID badges with anyone.
   b. User must never allow anyone else to use a computer that they are logged into.
   c. Never write your password down and leave it in a public or unsecure area where others may have access to it.
   d. Never access a computer network, application or any other electronic information under another individual's UserID/password.

3. Workforce Members will not email Confidential Information to any personal web email accounts. For any exceptions, discuss with your immediate Supervisor or the Compliance Department.

4. Workforce Members with mobile devices that contain access to Confidential Information must follow the FH Information Technology approval process, proper remote access policies and all other policies and procedures, in addition to wiping confidential information from the mobile device prior to end of employment.

5. Workforce Members may not make any unauthorized transmissions, inquiries, modifications or purging of Confidential Information and will not modify the workstation configuration, or use or add software to workstations without prior authorization from the FH Information Technology Department and the appropriate Leader.

6. If Workforce Members are provided direction or instruction that is in opposition with computer and/or electronic security policies or rules, or if they become aware of a situation that compromises the security of our systems or unique UserID/passwords, Workforce Members are responsible to immediately report the incident to the
FH Information Technology Department.
7. Workforce Members should not send in-basket messages to staff members who are receiving care as a patient. Any patient who happens to be a staff member should receive communication in the same manner as all other patients. (i.e. MyChart, phone calls, etc.)
8. Workforce Members will not post any patient information, including photographs or videos, on any Social Media Site.

G. Paging/Messaging Confidential Information
1. When necessary to deliver timely information to care providers, it is acceptable to include limited patient identifiers when sending messages through pagers. The intent is to provide necessary information to assist with safe and efficient care to patients. Workforce Members must:
   a. Use caution when sending messages to prevent improper disclosures.
   b. Never include mental health, HIV, sexually transmitted disease, or other highly sensitive information or diagnosis information.
   c. Provide the minimum amount of information that is necessary.
   d. Examples of acceptable elements for messaging: Patient full name, date of birth, medical record number, room number, non-sensitive results, description of complaint or reason for message.

H. Verbal Disclosures of Confidential Information requires Workforce Members to comply with the following guidelines:
1. Never discuss confidential business, workforce, or patient information with others that do not have a business reason to know; this includes family members/friends. Examples include:
   a. Do not share interesting or unusual patient situations with others who do not have a business need to know the information. This also includes inappropriate and unprofessional comments or gossip about patients, co-workers or others.
   b. Do not share staff members’ salary, corrective actions or other confidential employment/benefit/claims related information with others.
   c. Do not share confidential business information, transactions, trade secrets or other proprietary information or information not publicly available with others.
2. Care teams must take precautions when talking to patients about his/her health, care and treatment in the presence of others. Request patient visitors to step out of the inpatient room prior to discussing Confidential Information with the patient.
3. Speak softly in public areas, check-in areas and waiting rooms to prevent others from overhearing the information.
4. Close doors when possible to prevent others from overhearing information they do not require and to maintain the patient's overall privacy.
5. Use caution when having conversations in public areas such as elevators, dining locations, hallways and restrooms to prevent others
from overhearing the conversation.
6. Care teams should be aware of surroundings when discussing patient information in the space directly outside of patient rooms.
7. Professional discretion and judgment should be used when discussing patient information with patient’s family or friends. When possible, obtain patient’s verbal consent prior to disclosing relevant information. In the event the patient is unable to consent, use professional judgment and keep the patient’s best interest in mind by sharing information only with family or friends who are currently involved in the patient’s care and by limiting the information to what they need to know about the current episode of care.
8. Information relevant to a patient’s insurance claim or detailed bill may be discussed with the guarantor on the patient’s account.
9. Voice messages may be left for patients and should generally include very basic information. Do not leave messages with specific health information on a voice message. Examples of acceptable information to be left on a voice message are:
   a. Name of the facility calling
   b. Name of the individual calling
   c. Contact information
   d. General comment or statement which describes the purpose of the phone message.
   e. Information about an appointment may include instructions the patient needs to know to be prepared for the appointment and to avoid the appointment from being cancelled. (i.e. eating, drinking, medication restrictions)

I. Reporting Suspected or Known Non-Compliance
1. It is the responsibility of each Workforce Member to immediately report any knowledge or suspicion of non-compliance to the FH Compliance Department. For further details on reporting, please refer to corporate policy- FH-COM.025 Compliance Reporting, Hotline and Non-Retaliation.

J. Sanctions for Breach of Confidentiality
1. Any Workforce Member who fails to comply with the confidentiality rules, policies and/or laws is subject to corrective action up to and including immediate termination of employment or business relationship.
2. Other actions such as remediation education, root cause analysis or other activities may be assigned to the leader and/or Workforce Member, depending upon the incident and severity of the violation.
3. Depending on the violations, reporting to applicable state licensing boards, law enforcement, affected parties and/or other external agencies may apply.
4. Upon completion of an investigation, a severity level is assigned to the incident based on the facts, circumstances, risk and severity of the incident. The following are common examples of privacy violations and what severity level they may fall into, depending upon the circumstances involved.
a. Level 1 Severity: Generally involve lower risk infractions that are typically accidental or careless acts that result in non-compliance or breach of confidentiality. This may include patterns of failure to validate information, such as patient identifiers prior to distributing, mailing, faxing or handing out patient information or other confidential information. Any of these examples may escalate to a higher level severity infarction depending upon the particular facts and circumstances involved.
   (i) Patterns of accidental or careless actions, disregard of policy and procedures or overall poor performance by a workforce member will result in corrective action. Root cause analysis and re-education may be required.

b. Level 2 Severity: Moderate risk or severity of infractions which are prohibited acts, where despite training, an individual does not follow policies. Typically these incidents are not accidental in nature and may be viewed as a more egregious action that results in non-compliance or breach of confidentiality. This may include actions such as accessing patient information beyond the scope of defined job role; but not deemed as curiosity or for personal reasons, accessing provider schedules, removing PHI or other confidential information from the facility for legitimate purpose but it is subsequently lost or stolen, disclosing patient information or location when the patient has opted out of the patient directory, computer username/password violations Any of these examples may escalate to a Level 3 Severity, depending upon the particular facts and circumstances involved.
   (i) FH will hold staff member accountable by following the Corrective Action Policy, which may include corrective action or termination of employment or business relationship. Root cause analysis and re-education may be required.

c. Level 3 Severity: Higher risk or severity infraction which involve willful intent, unethical actions, reckless and/or irresponsible acts or complete disregard of the rules. This may include actions such as the use, access or disclosure of patient or confidential information without a legitimate business purpose/job duty. Some examples include: snooping in records, reviewing records for personal reasons, curiosity, inappropriately disclosing confidential information to others that do not require the information, gossiping about patients or others, unethical acts or malicious actions such as identity theft, fraud, personal gain, custody battles, defamation of character, and estranged relationships
   (i) FH has no tolerance for these actions or behaviors and will take immediate corrective action, including the termination of employment or business relationship. Root cause analysis and re-education may be required.

5. Breaches of confidentiality that constitute violations of HIPAA are subject to civil and criminal penalties. The tiered civil money penalties range between $100 and $50,000 per violation, and potentially may be in excess of $1,500,000 for identical violations in a calendar year, determined based on the nature and extent of the
violation, the nature and extent of the harm resulting from the violation, and the history of prior non-compliance and the level of culpability.

Related Policies: Compliance Reporting, Hotline and Non-Retaliation
Corrective Action
Disposal of Protected Health Information (PHI) and Other Confidential Information
E-mail and Internet Usage Policy
Faxing of Protected Health Information (PHI)
HIPAA Business Associate Agreements
HIPAA Privacy Definitions
Information Integrity
Notification of Breach of Protected Health Information

Issuing Authority: FH Corporate Policy Committee
Distribution: Froedtert Health
Reference Type: Additional Attachments: Confidentiality Agreement.docx
Content Details URL: http://fhpolicy.s1.fchhome.com/d.aspx?d=74ZD4a6098f8
Constant Content File URL: http://fhpolicy.s1.fchhome.com/d.aspx?c=74Z04a76Ec3b
Expiry Date: 5/23/2068 12:00:00 AM
Froedtert E-mail and Internet Usage Policy

Name: E-mail and Internet Usage Policy
Last Review Date: 10/05/2016
Next Review Date: 10/05/2019
Policy Number: FH-IT.025
Origination Date: 04/14/2011
Supersedes: CPA.0047, SJH.ADM.018, 87400-004

Purpose: To define appropriate uses, processes and controls to protect Froedtert Health, its staff and its resources from the risks associated with use of the Internet, Intranet and e-mail systems.

Definitions:
A. eCAR: Electronic Computer Access Request – required to grant access to systems via the Access Controls policy.
B. Protected Health Information – Any individually identifiable health information, whether oral, written, electronic, transmitted, or maintained in any form or medium that:
   1. Is created or received by a health care provider, a health plan, or a health care clearinghouse; and
   2. Relates to an individual’s past, present, or future physical or mental health condition, health care treatment, or the past, present or future payment for health care services to the individual; and
   3. Either identifies an individual (for example, name, social security number or medical record number) or can reasonably be used to find out the person’s identity (address, telephone number, birth date, e-mail address, and names of relatives or employers).

Policy: Froedtert Health will provide e-mail capability and will allow access to its Intranet and to the Internet for applicable staff for business-related purposes, in accordance with the following conditions and guidelines:

SECTION I: E-Mail and Internet Usage
A. General Use

1) The internet is to be used in a responsible, ethical and legal manner, and in accordance with the stated objectives of a staff member’s job function.
2) All patient information sent via an e-mail system is subject to the confidentiality requirements outlined by federal and state laws. By sending e-mails under this requirement, the sender agrees to adhere and comply with these laws.
3) Access to the Internet/Intranet will be granted based on completion of the Froedtert Health Computer Access Request (eCAR) form.
4) Failure to adhere to this policy and the guidelines listed below may result in suspension and/or termination of the offender’s privilege of network or internet access as well as possible corrective action.
Persons who make use of the resources of Froedtert Health to access
the Internet do so as guests of Froedtert Health and are expected to conduct themselves accordingly. Conduct which adversely affects the ability of others to use the Internet or which is harmful to others will not be permitted.

5) Froedtert Health reserves the right to monitor its computing resources to protect the integrity of its computing systems, workstations and Information Technology facilities.

6) Froedtert Health staff agree to send/receive internal patient identifying e-mails between the hospitals and MCW based on the users/recipient need to know. By sending/receiving e-mails, Froedtert Health staff agree not to share any patient identifying information to individuals who do not have a need to know or who are not part of the care or services of the patient or do not need the information to perform his/her job.

B. Specific Use – The E-Mail System and the Internet are used to support the following objectives:

1) Provide for the information needs of Froedtert Health leaders, physicians and staff to carry out his/her job functions, as well as the Medical College of Wisconsin (MCW) Physicians and students.

2) Enhance the remote learning potential of the Internet to physicians, leaders and staff.

3) Develop the information access skills and knowledge of physicians, leaders and staff.

4) Support the professional development needs of physicians, leaders and staff and enhance communication between them and their professional colleagues.

C. Personal Use - The E-mail and Internet system is to be used to facilitate only Froedtert Health business. Confidential business information is not for personal use and must not be shared outside the organization, without authorization at any time. Staff will not conduct personal business using the Company computer or email account.

D. Prohibited Use - Froedtert Health's E-mail/Internet system may not be used in any of the following ways:

1) to harass, intimidate or threaten,

2) to access or distribute obscene, abusive, libelous or defamatory material,

3) to distribute chain letters,

4) to participate in religious or political debate,

5) to conduct any type of personal solicitation or solicitation in any form not related to work or job responsibilities.

6) to send patient identifiable information or confidential information to non-business related entities without prior authorization from your leader.

7) to send patient identifiable or other confidential information to your personal email account without prior authorization from your leader.
8) To communicate or conduct personal business such as income tax forms, credit disputes, loan applications, etc.

E. Electronic Transmission of PHI or other Confidential Information - All confidential information sent outside the organization (this does not include emails to MCW) must be encrypted using approved industry standard security measures supported by the Froedtert Health Information Technology (IT) Department. Froedtert staff are advised to type the word “SECURE” in the subject line to force the email to be encrypted.

SECTION II: E-Mail/Internet Ownership, Monitoring, and Special Access

A. Property / Ownership - All electronic information, materials and communications stored or transmitted within the Froedtert Health infrastructure are the property of Froedtert Health.

B. Monitoring E-mail & System Usage

1. Information Technology, a manager or other designated individual, when properly authorized, may access and read any message sent or received via the hospital's e-mail system at any time, whether of a personal or business nature. Information contained in e-mail messages may be revealed to authorities to document staff misconduct or criminal activity.

2. To ensure appropriate use and successful operation of Froedtert Hospital's IT systems and the information they contain, it is sometimes necessary for authorized personnel to access and monitor their contents. Statistical information about each user and other measures of system performance, such as number and size of messages sent and received, time spent using the e-mail system, etc., are routinely collected and monitored by system administrators. While the goal of this type of monitoring is to evaluate and improve system performance, any evidence of violations of this electronic communications policy discovered in the course of this type of monitoring will be reported to the appropriate Froedtert Health leaders.

C. Internet Access Exceptions - Generally, access to internet sites unrelated to the business of healthcare will be restricted, including social networks and web based email accounts. Exceptions can be granted to such restrictions based on compelling business or clinical reasons with executive level approval.

Related Policies: Electronic Access Policy

Reference Details: HIPAA Privacy Policy Regarding Transmission of known ePHI

HIPAA Security Policy for Auditing and also for ePHI Technical Safeguards

HIPAA Security Rules: §164.308(a)(4) and §164.312(b)
Froedtert Equal Employment Opportunity Policy

Name: Equal Employment Opportunity

Last Review Date: 07/31/2017
Next Review Date: 07/31/2020
Policy Number: FH-HR.010
Origination Date: 06/01/2010

Purpose: The purpose of this policy is to provide guidelines for the equitable and non-discriminatory recruitment, hiring, and administration of Human Resource policies and procedures.

Definitions:
A. EEO - Equal Employment Opportunity
B. FH - Froedtert Health and its affiliates includes all entities within the health system.
C. Bona fide occupational qualifications (BFOQ) - any situation in which religion, sex or national origin is reasonably necessary to carry out a particular job function in the normal operations of an organization.

Policy:
A. FH is committed to its affirmative action policies and practices in employment programs to achieve a balanced workforce.

B. FH will provide equal opportunity to all individuals, regardless of their race, creed, color, religion, sex, age, national origin, disability, military and veteran status, sexual orientation, gender identity, marital status or any other characteristics protected by state or federal law.

Procedure:
A. All recruitment, hiring, training, education, promotion, demotion, transfer, reduction in force, corrective action, performance appraisal, compensation and other employment related programs are provided fairly to all persons on an equal opportunity basis without regard to race, creed, color, religion, sex, age, national origin, disability, military and veteran status, sexual orientation, gender identity, marital status or any other characteristic protected by state or federal law.

B. The only exceptions to these guidelines being:
   a) bona fide occupational qualifications (BFOQ).
   b) instances where reasonable accommodations cannot be made.

C. The Senior Vice President/Chief Human Resources Officer, has overall responsibility for assuring compliance with this Policy. This includes a commitment to review employment policies, practices and procedures periodically and to apply every good faith effort to rectify any identified problem areas.
and take appropriate action on any investigation findings. Any questions should be directed to the Operational Vice President or Administrator of the department, the site Human Resources leader, Corporate Compliance or the Senior Vice President/Chief Human Resources Officer.

D. Staff members and applicants will not be subjected to harassment, intimidation, threats, coercion or discrimination because they have exercised any right protected by law. All staff members are responsible for supporting the concept of EEO and assisting in meetings its objectives and affirmative action goals.

E. During the life of any contract with the State of Wisconsin, FH will comply with Wis. Stats. section 16.765, state regulations, and federal laws relating to equal employment opportunities and affirmative action.

F. Internal Process - FH utilizes internal means of communication and training which may include; intranet posting of policy, orientation, in-service education and training, publications and bulletin boards. External Process - FH utilizes external means of communication and advertising (including the phrase "EEO") which may include; publications, newspapers, other media, employment applications and postings.

Issuing Authority: FH Corporate Policy Committee
Distribution: Froedtert Health
Reference Type:
Content Details URL: http://fhpolicy.s1.fchhome.com/d.aspx?d=bzb3g07WB43f
Expiry Date: 8/1/2067 12:00:00 AM
Froedtert HIPPA Privacy Definitions

Name: HIPAA Privacy Definitions
Last Review Date: 12/15/2015
Next Review Date: 12/15/2018
Description: HIPAA Privacy Definitions, Definitions, Compliance, Compliance Definitions
Policy Number: FH-COM.031
Origination Date: 11/01/2011

Purpose: A. To provide a listing of definitions that will be consistently used throughout all Froedtert Health Policies related to HIPAA Privacy.

Definitions: A. Administrative Safeguards - administrative actions, and policies and procedures, to manage the selection, development, implementation, and maintenance of security measures to protect electronic protected health information and to manage the conduct of the covered entity’s or business associate’s workforce in relation to the protection of that information.

B. Affiliated Covered Entity – Legally separate covered entities that are affiliated through common ownership or control that designate themselves as a single covered entity for purposes of HIPAA compliance.

C. Breach - Unauthorized acquisition, access, use, or disclosure of Protected Health Information (PHI) in a manner not permitted under the Privacy Rule which compromises the security or privacy of the PHI.

D. Business associate – A person or entity who, other than as a member of the workforce, creates, receives, maintains, or transmits PHI for a function or activity (e.g., claims processing or administration, data analysis, utilization review, quality assurance, patient safety activities, billing, benefit management, practice management, and repricing) or provides legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for such covered entity that involves the disclosure of, or access to, PHI.

E. Correctional institution – Any penal or correctional facility, jail, reformatory, detention center, work farm, halfway house, or residential community program center operated by, or under contract to, the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe,
for the confinement or rehabilitation of persons charged with or convicted of a criminal offense or other persons held in lawful custody. Other persons held in lawful custody includes juvenile offenders adjudicated delinquent, aliens detained awaiting deportation, persons committed to mental institutions through the criminal justice system, witnesses or others awaiting charges or trial.

F. Covered entity (CE) – A health plan, health care clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a transaction covered by HIPAA.

G. Designated record set – A group of records maintained by or for a covered entity that is:

1. The medical records and billing records about individuals maintained by or for a covered health care provider;
2. The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or
3. Used, in whole or in part, by or for the covered entity to make decisions about individuals.
4. As applied to this term, the word record means any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for a covered entity.

H. Direct treatment relationship – A treatment relationship between an individual and a health care provider that is not an indirect treatment relationship.

I. Disclosure – Means the release, transfer, provision of, access to, or divulging in any other manner of information outside the entity holding the information.

J. Domestic partner – An individual who has signed and filed a declaration of domestic partnership in the office of the register of deeds of the county in which he or she resides.

K. Employer – The Privacy Rule adopts the definition in 26 U.S.C. 3401(d): The person for whom an individual performs or performed any service, of whatever nature, as the employee of such person, except that:

1. If the person for whom the individual performs or performed the services does not have control of the payment of the wages for such services, the term
“employer” means the person having control of the payment of such wages.

L. Family Member - means, with respect to an individual:

1. A dependent (as such term is defined in 45 CFR 144.103), of the individual; or

2. Any other person who is a first-degree, second-degree, third-degree, or fourth-degree relative of the individual or of a dependent of the individual. Relatives by affinity (such as by marriage or adoption) are treated the same as relatives by consanguinity (that is, relatives who share a common biological ancestor). In determining the degree of the relationship, relatives by less than full consanguinity (such as half-siblings, who share only one parent) are treated the same as relatives by full consanguinity (such as siblings who share both parents).

M. Financial Remuneration - Direct or indirect payment from or on behalf of a third party whose product or service is being described. Direct or indirect payment does not include any payment for treatment of an individual.

N. Genetic information - with respect to an individual, information about:

1. The individual’s genetic tests;
2. The genetic tests of family members of the individual;
3. The manifestation of a disease or disorder in family members of such individual; or
4. Any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by the individual or any family member of the individual.
5. The genetic information of:
   a. A fetus carried by the individual or family member who is a pregnant woman; and
   b. Any embryo legally held by an individual or family member utilizing an assisted reproductive technology.

O. Genetic services - A genetic test; Genetic counseling (including obtaining, interpreting, or assessing genetic information); or Genetic education.

P. Genetic test - an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, if the analysis detects genotypes, mutations, or chromosomal changes.

Q. Group Health Plan – An employee welfare benefit plan of the Employee Retirement Income and Security Act of 1974,
including insured and self-insured plans, to the extent that the plan provides medical care, including items and services paid for as medical care, to employees or their dependents directly or through insurance, reimbursement or otherwise:

1. Has 50 or more participants; or
2. Is administered by an entity other than the employer that established and maintains the plan.

R. Health care – care, services, or supplies related to the health of an individual. Health care includes, but is not limited to, the following:

1. Preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to the physical or mental condition, or functional status, of an individual or that affects the structure or function of the body; and
2. Sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription.

S. Health care operations – Any of the following activities of the covered entity to the extent that the activities are related to covered functions:

1. Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; patient safety activities (as defined in 42 CFR 3.20); population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment;

2. Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities;

3. Except as prohibited under 164.502(a)(5)(i), underwriting, enrollment, premium rating, and other
activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance), provided that the requirements of § 164.514(g) are met, if applicable;

4. Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;

5. Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies; and

6. Business management and general administrative activities of the entity, including, but not limited to:
   a. Management activities relating to implementation of and compliance with the requirements of this subchapter;
   b. Customer service, including the provision of data analyses for policy holders, plan sponsors, or other customers, provided that protected health information is not disclosed to such policy holder, plan sponsor, or customer.
   c. Resolution of internal grievances;
   d. The sale, transfer, merger, or consolidation of all or part of the covered entity with another covered entity, or an entity that following such activity will become a covered entity and due diligence related to such activity; and
   e. Consistent with the applicable requirements of § 164.514, creating de-identified health information or a limited data set, and fundraising for the benefit of the covered entity.

T. Health care provider – A provider of medical or health services and any other person who bills, or is paid for health care in the normal course of business.

U. Health oversight agency – Federal, state, local, territorial, or tribal government agency or authority, or person or entity acting under grant of authority from or contract with such agency, and employees or agents of such agency or of its contractors, authorized by law to oversee the public or private health care system or government programs for which health information is needed to determine eligibility or
compliance, or to enforce civil rights laws for which health information is relevant. Examples are: state insurance commissioners, state health professional licensure agencies, federal inspector general offices, Justice Department.


W. Hybrid entity – Means a single legal entity
1. That is a covered entity;
2. Whose business activities include both covered and non-covered functions; and
3. That designates health care components.

X. Indirect treatment relationship – A relationship between an individual and a health care provider in which:
1. The health care provider delivers health care to the individual based on the orders of another health care provider; and
2. The health care provider typically provides services or products, or reports the diagnosis or results associated with the health care, directly to another health care provider, who provides the services or products or reports to the individual.

Y. Institutionally related foundation – A foundation that qualifies as a nonprofit charitable foundation under section 501(c)(3) of the Internal Revenue Code and that has in its charter statement of charitable purposes an explicit linkage to the covered entity. An institutionally related foundation may, as explicitly stated in its charter, support the covered entity as well as other covered entities or health care providers in its community.

Z. Individual – For purposes of this policy, it refers to the person who is the subject of protected health information.

AA. Individually identifiable information – Information that is a subset of health information, including demographic information collected from an individual, and:
1. Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and
2. Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future
payment for the provision of health care to an individual; and
a. That identifies the individual; or
b. With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

BB. Inmate – A person incarcerated in or otherwise confined to a correctional institution.

CC. Law enforcement official. An officer or employee of any agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, who is empowered by law to:

1. Investigate or conduct an official inquiry into a potential violation of law; or
2. Prosecute or otherwise conduct a criminal, civil, or administrative proceeding arising from an alleged violation of law.

DD. Legal Representative – See Person Authorized by the Individual.

EE. Marketing - includes any communication about a product or service that encourages recipients of the communication to purchase or use the product or service or an arrangement between a FH Affiliate and any other entity whereby the FH Affiliate sells or otherwise receives indirect or direct remuneration for disclosing PHI to make a communication about its own product or service that encourages recipients of the communication to purchase or use that product or service. 45 C.F.R. § 164.501. See Disclosures and Use of Protected Health Information for Marketing Purposes for more detail.

FF. Mental Health Treatment Records - The registration and all other records that are created in the course of providing services to individuals for mental illness, developmental disabilities, alcoholism, or drug dependence and that are maintained by the department; by county departments under s. 51.42 or 51.437 and their staffs; by treatment facilities; or by psychologists licensed under s. 455.04 (1) or licensed mental health professionals who are not affiliated with a county department or treatment facility. Treatment records do not include notes or records maintained for personal use by an individual providing treatment services for the department, a county department under s. 51.42 or 51.437, or a treatment facility, if the notes or records are not available to others.
GG. Minimum necessary – The minimum amount of protected health information necessary to accomplish the intended purpose of the use or disclosure.

HH. Patient Representative - See Person Authorized by the Individual.

II. Payment – Activities undertaken by a health care provider or health plan (except as prohibited under 164.502(a)(5)(i)) to obtain or provide reimbursement for the provision of health care. Examples of activities include but are not limited to:

1. Determinations of eligibility or coverage;
2. Risk adjusting amounts due;
3. Billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess of loss insurance) and related health care data processing;
4. Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;
5. Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services; and
6. Disclosure to consumer reporting agencies of any of the following PHI relating to collection of premiums or reimbursement:
   a. Name and address
   b. Date of birth;
   c. Social security number;
   d. Payment history;
   e. Account number; and
   f. Name and address of the health care provider and/or health plan.

JJ. Person authorized by the individual (Legal Representative, Patient Representative, Personal Representative) – A parent or legal guardian of a minor child; the guardian of an incompetent adult; the health care agent designated in an incapacitated patient’s health care power of attorney; any person authorized in writing by the individual, or the personal representative, spouse, or domestic partner of a deceased patient. If no spouse or domestic partner survives a deceased patient, “person authorized by the individual” also means an adult member of the deceased patient’s immediate family.

KK. Personal Representative - See Person Authorized by the Individual.
LL. Physical Safeguards - are physical measures, policies, and procedures to protect a covered entity's or a business associate’s electronic information systems and related buildings and equipment, from natural and environmental hazards, and unauthorized intrusion.

MM. Protected Health Information – Any individually identifiable health information, whether oral, written, electronic, transmitted, or maintained in any form or medium that:

1. Is created or received by a health care provider, a health plan, or a health care clearinghouse; and
2. Relates to an individual’s past, present, or future physical or mental health condition, health care treatment, or the past, present or future payment for health care services to the individual; and
3. Either identifies an individual (for example, name, social security number or medical record number) or can reasonably be used to find out the person’s identity (address, telephone number, birth date, e-mail address, and names of relatives or employers).

Protected health information excludes individually identifiable health information in employment records held by a covered entity in its role as employer; and regarding a person who has been deceased for more than 50 years.

NN. Psychotherapy Notes – Notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual’s medical record. Psychotherapy notes exclude medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

OO. Required by law - A mandate contained in law that compels an entity to make a use or disclosure of protected health information and that is enforceable in a court of law. Required by law includes, but is not limited to, court orders and court-ordered warrants; subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information; a civil or an authorized
investigative demand; Medicare conditions of participation with respect to health care providers participating in the program; and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits.

PP. Reasonable cause – an act or omission in which a covered entity or business associate knew, or by exercising reasonable diligence would have known, that the act or omission violated an administrative simplification provision, but in which the covered entity or business associate did not act with willful neglect.

QQ. Reasonable diligence – the business care and prudence expected from a person seeking to satisfy a legal requirement under similar circumstances.

RR. Research – Systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge.

SS. Subcontractor - a person to whom a business associate delegates a function, activity, or service, other than in the capacity of a member of the workforce of such business associate.

TT. Technical Safeguards - The technology and the policy and procedures for its use that protect electronic protected health information and control access to it.

UU. Treatment – The provision, coordination, or management of health care and related services by one or more health care providers, including the coordination and management of health care by a health care provider with a third party. Treatment includes consultation among providers, nursing assistance by telephone, and referrals of patients from one provider to another. Services that may be provided specifically for the purposes of a clinical research trial are not included in this definition of treatment.

VV. Treatment facility – Any publicly or privately operated facility or unit thereof providing treatment of alcoholic, drug dependent, mentally ill or developmentally disabled persons, including but not limited to inpatient and outpatient treatment programs, community support programs and rehabilitation programs.

WW. Unsecured Protected Health Information - Protected health information that is not rendered unusable, unreadable,
or indecipherable to unauthorized persons through the use of a technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2) of Public Law 111-5.

XX. Use – Means, with respect to individually identifiable health information, the sharing, employment, application, utilization, examination, or analysis of such information within a covered entity that maintains such information.

YY. Willful neglect – Conscious, intentional failure or reckless indifference to the obligation to comply with the administrative simplification provision violated.

ZZ. Workforce – Means employees, volunteers, trainees (excluding residents, fellows, and medical students), and other persons whose conduct, in the performance of work for a covered entity or business associate, is under the direct control of such entity or business associate, whether or not they are paid by the covered entity or business associate.

Policy: Not applicable.
Issuing Authority: FH Corporate Policy Committee
Distribution: Froedtert Health
Reference Type: Content Details
URL: http://fhpolicy.s1.fchhome.com/d.aspx?d=72MX0AE0bA3y
Expiry Date: 12/15/2065 12:00:00 AM
Froedtert Non-Discrimination Policy

Name: Non-Discrimination Policy

Last Review Date: 03/01/2017
Next Review Date: 03/01/2020
Policy Number: CP CR2.4
Origination Date: 08/01/2010

Policy: The CP Board of Directors and CP Credentialing Committee members shall not make credentialing and re-credentialing recommendations or decisions based solely on an applicant’s race, ethnic/national identity, gender, age, sexual orientation or the types of procedures (i.e. Abortion) or patients (i.e. Medicaid) in which the practitioner specializes.

Procedure: 1. A Non-Discrimination Statement (Attachment 1) shall be signed by all members of the CP Credentialing Committee.

2. The Committee Chair shall facilitate discussion and decision processes to assure that all decisions are made in a non-discriminatory manner.

3. On a monthly basis the CP credentialing staff will compile a summary of complaints related to credentialing decisions that allege discrimination. Any complaints will be included as an agenda item on the monthly CP Credentialing Committee agenda.

4. On an annual basis by December of each calendar year, CP will conduct a random audit of ten (10) credentials files and review all decisions related to that file to assure none involve discrimination. The Committee Chair will review the annual audit summary.

Issuing Authority: CP Administration
Distribution: Community Physicians

Additional Attachments: 
CP CR2.4 Attachment 1 Nondiscrimination Statement.doc
CP CR2.4 Attachment 2 Non-Discrimination Audit Form.doc

Content Details URL: http://fhpolicy.s1.fchhome.com/d.aspx?d=1a86CncCc421
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