GENERAL COLLEGE OPERATIONS

Faculty Handbook (100)

The *Faculty Handbook* is a summary of information concerning the University of Oklahoma and the Health Sciences Center's policies, procedures, organization, and benefits. The information contained in the *Handbook* is current at the time of publication but may change from time to time by action of appropriate segments of the University. As changes are made, they will be announced in University publications. Employees are responsible for verifying that any information to which they refer is current. Up-to-date and complete information may be obtained from the offices of the Senior Vice President and Provost and Human Resources. The complete Faculty Handbook may be viewed in its entirety at:

https://provost.ouhsc.edu/Policies-and-Procedures/HSC-Faculty-Handbook (https://provost.ouhsc.edu/Policies-and-Procedures/HSC-Faculty-Handbook/)

- Policy Date: 6/02
- Approved By: Associate Dean for Executive Affairs
- Date Revised: 08/19/2019
- Date Reviewed: 5/11/2022

Staff Handbook (101)

Revised, May 2022

The Staff Handbook has been prepared by the Office of Human Resources as an easy-to-read reference for present and prospective staff members. It contains useful information about employment policies, procedures, conditions and opportunities. For the most part, contents concerning University of Oklahoma employment policies and procedures are presented as summaries of Regents' and administrative policies and procedures as well as applicable state and federal law. The Staff Handbook may be viewed in its entirety at:

https://apps.hr.ou.edu/staffhandbook (https://apps.hr.ou.edu/staffhandbook/)

- Policy Date: 9/95
- Approved By: Executive Dean
- Date Revised: 5/6/2022
- Date Reviewed: 5/11/2022

Information Technology Policies, Standards, and Guidelines (102)

The University of Oklahoma Health Sciences Center campus wide information technology policies address in a consistent manner all areas related to computer security within the College of Medicine, to include all faculty, staff, and trainees. If you have questions and concerns related to computer security please review the areas identified in the attached link.

http://it.ouhsc.edu/policies/ (https://it.ouhsc.edu/policies/)

If you are still unable to identify an answer to your question please consult with your supervisor, your applicable Associate Dean, Course Director, or your section IT representative.

- Policy Date: N/A
- Approved By: Associate Dean for Executive Affairs
- Date Revised:
- Date Reviewed: 5/11/2022

Student Education Information Security Policy (102.1)

1. **Purpose**
   A Student Education Information Security Policy (SEISP) is necessary to provide a framework for safeguarding student education record information/data and preventing the unauthorized distribution or disclosure of confidential student education data as required by the Family Educational Rights and Privacy Act (FERPA). FERPA is a federal law that sets forth requirements regarding the privacy of student education records and provides methods for using and accessing those records. A student education record is a record that is maintained by the University and directly related to a student. For more information regarding FERPA please go to: http://admissions.ouhsc.edu/FERPA.aspx
2. **Scope**
   This policy pertains specifically to the College of Medicine ("College") and should be carried out with consideration to all applicable state and federal laws and University policies. This policy applies to all College of Medicine confidential student education data (administrative, academic and other user-defined datasets), excepting "directory information" unless the student has placed a hold on that subset of their education record, the environments in which the information resides (desktop or laptop computers, servers, portable devices, offices, cabinets, file-folders, etc.), and the media on which it is stored (electronic, CDs, printouts, etc.). This policy is applicable to all College employees and College "school officials" as that term is defined in the University's FERPA Policy.
3. **Specific Security Measures**
   Two strategies are required to successfully protect the integrity and confidentiality of student education data:
   a. modifying personnel and business practices to improve security, and
   b. properly configuring and utilizing information technologies to prevent security breaches.

Classification of Information

This policy requires that all records which contain identifiable student data shall be confidential as required by applicable law and disclosed as permitted and/or required by applicable law. This data includes, but is not limited to, Social Security Numbers, grades, financial records, disciplinary action records, medical records, disability documentation, and other data that could compromise a student's identity, privacy or reputation.

In addition, certain FERPA protected data is also considered "sensitive," as defined in accordance with OUHSC's Information Technology Policies, which may be found at: http://it.ouhsc.edu/policies (http://it.ouhsc.edu/policies/).

Controlled Access to Data

With limited exception, as provided by law, access to confidential student education data is to be restricted to only those school officials who have a legitimate educational interest. For more information regarding who is a "school official" please see: http://admissions.ouhsc.edu/FERPA.aspx. All departments and work groups should assess their needs to acquire,

manipulate and distribute confidential student education data, and assign access permissions to appropriate personnel.

Physical Security Measures

Reasonable efforts should be taken to protect computer hardware against theft and/or tampering. This includes keeping office doors locked when not occupied and securing PCs to workstations. Laptops should be secured when not in use and never left unattended, on or off-campus. College and/or departmental servers should be secured in a physically separate, enclosed space, locked, and accessible only to essential technical staff. For additional information regarding physical security measures see the OUHSC Facility Security Policy: http://it.ouhsc.edu/policies/Facility_Security.asp.

For additional information regarding the security of portable devices, which may include handheld computers, personal digital assistants (PDAs), cell phones, laptops and more, please see the OUHSC Portable Computing Device Security Policy: http://it.ouhsc.edu/policies/default.asp.

Personnel Training

All College employees whose duties include accessing confidential student data must successfully complete required on-line FERPA training.

Electronic Storage, Transfer and Sharing of Student Education Information

Employees are responsible for exercising good judgment to adequately protect the integrity and confidentiality of student education data.

1. Confidential student education data should never be stored on a desktop or laptop computer's hard drive or on a peripheral storage device. All confidential student education data should be stored on a designated secure University server. This information may be accessed off-site through a secure VPN or terminal services connection.
2. Only encrypted USB drives may be used to physically transport confidential student education data. The user should ensure that the student data is encrypted on the USB drive. Confidential student data should be removed from the USB drive when it is no longer required for University purposes.
3. Highly sensitive confidential information such as Social Security Numbers should never be stored outside of an OUHSC IT enterprise database or outside of the OUHSC designated Restricted Zone.
4. All College faculty and staff must use approved, functioning, and up-to-date antivirus software as defined by the OUHSC Antivirus Policy: http://it.ouhsc.edu/policies/default.asp.
5. Preclinical course directors and coordinators should use Desire-2-Learn to maintain grades for all preclinical courses. Clerkship and clinical course directors and coordinators should submit grades using the D2L/LEO system(s). If grade information must be manipulated in a separate document, it must be saved only to a secure University server, not the user's local hard drive or desktop.
6. The University's internal email system is considered secure and may be used to transmit confidential student education data to other users within the University. If confidential student education data must be sent to users outside of the University, it should be sent using the OUHSC IT's encryption process. For more information see the OUHSC Secure Email web site: http://it.ouhsc.edu/services/infosecurity/SecureEmail.asp.

When it is necessary to use campus email to transfer confidential student education data it is recommended that the document be password secured and the password provided to the recipient in a separate, follow-up phone call. Other approved mechanisms may be developed to transmit and share confidential student education data. If in doubt, contact your department head before releasing confidential student data. Department heads that have questions are encouraged to contact one or more of the following: Admissions and Records, Open Records and/or Legal Counsel.

1. In accordance with existing University Policy, all faculty, staff, students, and volunteers must participate in IT security training, education and awareness: http://it.ouhsc.edu/policies/documents/infosecurity/security%20training%20and%20awareness%20policy.pdf.
2. Confidential student education data shall not be left on public computers such as those used in lecture halls and classrooms. For example, Audience Response Systems (ARS) store student scores on the local hard drive. This information must be deleted before leaving the PC unattended.
3. Hard copies of confidential student education data may be accessed and disclosed only in accordance with the University's Policy on Access and Release of Student Records, found at: http://admissions.ouhsc.edu/FERPA.aspx.

Security Incident Reporting

In the event that a College employee has reason to believe that the security of confidential student education data has been compromised or a computer resource has been tampered with or accessed without authorization, he or she must immediately report this to the department head who will work with Information Technology and/or Legal Counsel to address the disclosure.

Accountability and Auditing

All personnel must ensure that applicable security standards as described above are adopted and adhered to.

- Policy Date: 1/24/12
- Approved By: College of Medicine Faculty Board
- Date Revised: 1/20/12
- Date Reviewed: 5/11/2022

Faculty Personnel Paperwork PeopleSoft ePaf Processing (103)

All actions relating to faculty must be processed through the Peoplesoft Electronic Personnel Action (ePaf) system. All faculty hires are approved through Faculty Affairs in the Office of the Dean.

All instructions for PeopleSoft ePaf processing are located in the ePaf Reference Guide.

https://apps.hr.ou.edu/DMS/documents/files/ePaf_Reference_Guide/ePAF_Reference_Guide_2018v2.pdf

All paid faculty ePafs will route through the COM Faculty Affairs. Copies of all paperwork are filed in the individual personnel file. Approvals are indicated by the signature of the department chair/chairs involved in the action and designees within the Dean's Office.

Types of Actions:

1. New appointment
2. Re-appointment/Re-hire
3. Primary appointment change - will be processed as a new hire ePaf in the new primary department
4. Title change
5. Status change (Change in appointment type (continuous with tenure, term tenure eligible, term tenure not eligible, temporary, part-time)
6. Salary rate change
7. Salary source change
8. Termination
9. Leave of absence
10. Correction of previous paperwork.

New Appointments - Paid Faculty Appointment

All new appointments for which compensation will be paid should include the following documentation:

- Standards for ePAF Document AttachmentPertains to the Hire and Termination ePAFs.
  A single "pdf" document will be created by scanning the pertinent documents, usually using an eCopy machine, and compiling all scans into a single document.
- The name of this document will follow this format: -.pdf
  For example, the supporting documents for processing a hire ePAF for Michael Donald Smith would be scanned into a single "pdf" named "Smithmd-hire.pdf

The pertinent documents will be in the order listed below.

1. Official Offer of Faculty Appointment (Final Provost Signature – attached by the Provost office)
2. Proposed Terms of Faculty Appointement/Ltr of Offer under 60K *
3. Curriculum Vitae
4. Personal Data Form
5. Loyalty Oath
6. Employee Role Based Access Worksheet (if applicable)

I-9 and back up documentation are process electronically through PeopleSoft.

When an ePaf notification is received, it is held pending all appropriate approvals. ePafs are approved through a designee in the Dean's office following Dean's review and appropriate signature, appointment packages are forwarded to the Provost's Office for further processing with, for example, the Equal Opportunity/Affirmative Action Office, Grants and Contracts, etc.; in the last step, the completed package is delivered to the Regents Office for final approval.

Volunteer Faculty Appointments

Volunteer faculty who are on campus must to take employee required training and will be entered into the Peoplesoft system. If a volunteer faculty member requires an ID and email account they can be processed through the ePaf system. All new volunteer Faculty appointments whether entered into Peoplesoft or handled manually should include the following documentation: 5050-A form, a current curriculum vita, a faculty application form, and Volunteer Confidentiality Agreement. Volunteer appointments are approved by the Dean's designee, logged into the Faculty Database, and a personnel file is created.

Re-Appointment

All re-appointments or re-hires follow the ePaf procedures outlined in New Appointments.

Primary Appointment Change

When faculty change from one primary appointment to another the new primary department must complete a New Appointment hire for the faculty member through the ePaf process. Volunteer paperwork once signed by the Dean or his designee, is considered "approved". Copies should be made and marked approved at this time.

Title Change

An ePaf must be completed for any title changes for existing faculty. Title changes are reviewed and approved by the Dean's office and the ePaf will be forwarded for further processing through the Provost and to the Board of Regents where applicable.

Status Change

Change of status ePafs are required for any change of status, appointment, FTE and a number of different individual situations, for example, when a faculty member has been granted tenure and is moving from a tenure eligible position to a continuous term position with tenure. Another example would be a full-time faculty member moving to part-time status or a full-time paid faculty member moving to volunteer status. A number of other circumstances call for a change of status. Documentation supporting the action is required.

Salary Rate Change

When a faculty member's salary rate changes. Any change in salary rate change requires approval by the Sr. Associate Dean for Administration and Finance and the Executive Dean. Upon approval the ePaf will be approved and forwarded to the Provost office for further processing and to the Board of Regents where applicable. Documentation supporting the action is required.

Salary Source Change

Salary source changes occur when the funds utilized for paying a faculty member are to be changed to a different funding source. An example might be the end of a funded contract that would then require the department to find state or other funds to pay the faculty member. These actions require approval of the Dean's designee through the ePaf system.

The termination of a paid faculty member requires an ePaf action initiated by the primary department. A letter of resignation must be attached to ePaf.

Leave of Absence

Leaves of absence require an ePaf with an effective date and anticipated return date along with Reason for Action selected clearly completed. Leaves are granted for a number of reasons such as sabbatical, illness, family medical leave, administrative leave, military leave and leave without pay. FMLA leave is approved through campus HR.

Correction of Paperwork

When it is discovered that there is an error in a faculty member's official record and ePaf should be completed with the corrected information and a comment to correct the record.

- Policy Date:
- Approved By: Executive Dean

- Date Revised: 07/19/2012
- Date Reviewed: 08/25/2020

Instructions - Faculty Personnel Paperwork (103.1)

The following instructions have been prepared for standardized completion of the electronic personnel paperwork (ePaf). ePaf should be initiated by the primary department only. If a secondary department requires a change, that department should contact the primary department and request that the paperwork be completed.

https://apps.hr.ou.edu/DMS/documents/files/ePaf_Reference_Guide/ePAF_Reference_Guide_2018v2.pdf

Types of Actions:

1. New appointment
2. Re-appointment
3. Primary appointment change
4. Title Change
5. Status Change (Change in appointment type)
6. Salary rate change
7. Salary source change
8. Termination
9. Leave of absence
10. Correction to record

- Policy Date:
- Approved By: Executive Dean
- Date Revised: 07/19/2012
- Date Reviewed: 08/25/2020

Post Tenure Review Policy (103.2)

All members of the faculty are expected to maintain throughout their careers the standards of excellence that are set forth in the existing College of Medicine Promotion and Tenure policies. Section 3.8 of the OUHSC Faculty Handbook indicates "Tenure implies a mutual responsibility on the part of the University and the tenured faculty member. In granting tenure to a faculty member, the University makes a commitment to the faculty member's continued employment subject to certain qualification (Section 3.16). The University expects that tenured faculty members will maintain the level of performance by which they initially earned tenure." Thus, the College of Medicine's process of Post-Tenure Review represents a supplement and a logical extension to the various systems of review that are currently in place. These include the annual evaluation of faculty members in the years prior to tenure and after, the review for promotion and/or tenure, and the reviews that occur in connection with the appointment of individuals to such leadership positions as Department Chair, Section Chief, or Endowed Chairs.

As with all of the other reviews that are conducted, the specific areas that will be evaluated during the course of Post-Tenure Review include the following:

1. Teaching;
2. Research and creative/scholarly activity; and
3. Professional and University service and public outreach.

In accordance with the provisions of Section 3.6 of the OUHSC Faculty Handbook, all faculty members are evaluated annually using established guidelines. The annual evaluation examines the faculty member's performance in light of his or her contribution to the Department or University. The annual evaluation is the core of the University's ongoing post-tenure review process. On the annual evaluation scale, the current ratings for a satisfactory performance of a tenured faculty member are 'Effective', 'Highly Effective' or 'Outstanding.' If a faculty member's previous overall performance was rated 'Improvement Needed' or 'Unacceptable' on the annual evaluation and the current overall performance has not met the conditions for improvement, the faculty member's status will be considered unsatisfactory.

When a faculty member's status becomes unsatisfactory (two consecutive annual evaluations of 'Improvement Needed' or one overall annual evaluation rating of 'Unacceptable'), a 5-member panel of tenured faculty members from current and previous members of the College's Promotion and Tenure Committee will be recommended by the current Promotion and Tenure Committee Chair and appointed by the Executive Dean to conduct a thorough review of the faculty member's performance. The Chair of the College's Promotion and Tenure Committee will notify in writing the faculty member, the Department Chair, and the Executive Dean of the proposed panel. Both the faculty member and the Department Chair (or Dean when annual evaluation is conducted at the College level) shall each have the right to challenge one member of the panel for cause (such as a perceived conflict of interest.) Such challenges must be made in writing to the Chair of the College's Promotion and Tenure Committee within 5 University business days following notification of the proposed panel. The College's Promotion and Tenure Committee shall make the final decision on panel composition. This decision is not appealable.

The Department Chair, and/or Dean, and the faculty member must supply the panel all information pertinent to its task in no more than 20 University business days after the appointment of the panel. The information shall include, but not be limited to the following:

1. Current Faculty Curriculum Vitae in standard University format, including summary statement of professional accomplishments.
2. All Annual Faculty evaluations for the faculty member.
3. Annual reports encompassing the review period (years for which the annual faculty evaluation overall score was 'Needs Improvement' or 'Unsatisfactory'.)
4. List of teaching duties and teaching evaluations.
    a. Student evaluations for the review period, including medical student, resident, fellow, and graduate student and/or other applicable groups.
    b. Peer evaluations.
5. A list of service activities
6. Applicable Department Policies
7. Any written agreements between the faculty member and the Department regarding the faculty member's role
8. All supporting documents for activities since the most recent annual evaluation.

The Department Chair and the faculty member shall have full access to all of the submitted information and an opportunity to comment on or rebut any of the information within 5 University business days of being notified that the panel's information is complete. During the panel's deliberations, the panel has the right to seek information from anyone pertinent to the issues, and the Department Chair and/or Executive Dean

and the faculty member shall have full access to whatever information is gathered with 5 University business days to comment on or rebut the information.

The panel first evaluates the faculty member's performance in light of his or her role within the Department or other components of the University. The panel will evaluate the faculty member in a manner consistent with the criteria outlined in the Faculty Handbook for the award of tenure which includes a demonstration of substantial accomplishment in each of the three areas (teaching, research and creative/scholarly activity, and professional and University service and public outreach) and evidence of excellence in two areas. If the panel finds that the faculty member's performance was, in fact, satisfactory during the period in question, it shall issue a report to the Department Chair and the Executive Dean delineating the reasons for its conclusion. The review is thus concluded. The Dean shall monitor the Department Chair's annual evaluations of the faculty member for the next two years.

If the panel concludes that the faculty member's performance was, in fact, unsatisfactory during the period in question, the panel shall issue a report to the Department Chair stating their conclusion of unsatisfactory performance. The panel, in conjunction with the Department Chair, Executive Dean and the faculty member will develop a two-year improvement plan intended to aid the faculty member to return to a satisfactory level of performance. This plan will include stated objective goals, agreed upon measurements of success, and negotiated resources necessary for accomplishment of the goals. This plan must be fiscally prudent and the return on investment must be positive within a reasonable timeframe.

At the end of the first year of the improvement plan, the panel will review all supporting documents related to the faculty member's performance and adherence to the plan. The panel shall issue an interim report to the Department Chair either recommending continuation of the plan through the second year, or modification of the plan. If it is evident that unsatisfactory progress has been made toward improvement, based on the panel's report, the Department Chair may determine in consultation with the Executive Dean that they initiate abrogation of tenure and/or termination for cause. Section 3.16.1 (b) indicates that one of the grounds for abrogation of tenure is "Substantial, manifest, or repeated failure to and/or refusal to fulfill professional duties and responsibilities."

At the end of the two-year plan, the panel will reconvene and again conduct a review of the faculty member's performance, using the provisions of the improvement plan and all information pertinent to the faculty member's performance during the period of the plan. If the panel finds that the faculty member's performance has been satisfactory, it reports its finding to the Department Chair and/or the Dean, and the review is complete. If the panel finds that the faculty member's performance has been unsatisfactory, the panel may issue a report to the Department Chair and/or Dean indicating that the faculty member has either failed or refused to fulfill their professional duties. The Department Chair and/or Dean will consider the panel's conclusion and determine whether to initiate proceedings for abrogation of tenure and/or termination for cause. (**Reference: OUHSC Faculty Handbook** Section 3.16.1 Grounds for Abrogation of Tenure, Termination of Employment, and Severe Sanctions (b) Substantial, manifest or repeated failure to and/or refusal to fulfill professional duties and responsibilities.)

- Policy Date:
- Approved By:
- Date Revised:
- Date Reviewed:

Staff Personnel Processing through PeopleSoft Electronic Personnel Action (104)

All Actions relating to staff, must be processed electronically through the PeopleSoft Electronic Personnel Action process. Types of Actions:

1. New appointment
2. Re-appointment
3. Change of Status: Re-classification, promotion, demotion, change of pay source only, probationary increase, other.
4. Termination
5. Leave of Absence
6. Name Change

All Staff Personnel Actions - Instructions and processes for all ePaf entries are contained in the ePaf Reference Guide located at the following link:

https://apps.hr.ou.edu/DMS/documents/files/ePaf_Reference_Guide/ePAF_Reference_Guide_2018v2.pdf

I-9 processing is now electronic. Instructions are included in the following link:

https://apps.hr.ou.edu/dms/documents/files/Electronic_I-9_Reference_Guide/Electronic_I9_Reference_Guide_1-2017v2.pdf

- Policy Date:
- Approved By: Executive Dean
- Date Revised: 07/01/2012
- Date Reviewed: 08/25/2020

Emergency Response Plan (105)

The College of Medicine Emergency Response Plan follows the University of Oklahoma Health Sciences Center Emergency Operations Plan, revised October 2021. The complete plan may be viewed at: http://www.ouhsc.edu/police/EmergencyManagement/EmergencyOperationsPlan.aspx

Students of the College of Medicine and Residents in Graduate Medical Education programs shall adhere to the University plan unless on a clinical rotation or assignment. In those situations the policies of the affiliated entities as specified within the affiliation agreements shall apply and take precedence.

Residents in training programs will find supplemental information in the University of Oklahoma College of Medicine policy number 720.0 entitled Administrative Support for residents in the Event of Disaster.

Faculty members involved in the care of ambulatory patients will find supplemental information in the specific clinic emergency plan authored through OU Health.

In the event that a state of emergency extends beyond the University of Oklahoma Health Sciences Center, the College

of Medicine response will be guided by the Oklahoma State Department of Health's Oklahoma Public Health and Medical System Emergency Response Plan, approved October, 2019 (https://www.ok.gov/health/Prevention_and_Preparedness/Emergency_Preparedness_and_Response/Emergency_Response/). The entire Oklahoma State Plan may be viewed at: https://www.ok.gov/health2/documents/FINAL%20OSDH%20ERP.%20V11%202019.pdf

- Policy Date: Feb. 19, 2008
- Approved By: Executive Dean
- Date Revised: October 2021
- Date Reviewed: 5/11/2022

COM HIPAA Compliance Enforcement (106)

The purpose of this policy is to establish sanctions to address HIPAA violations by any College of Medicine faculty or staff members. It is understood that all College of Medicine employees are expected to maintain the highest level of compliance with the OUHSC HIPAA policies and procedures.

The scope of this policy includes all College of Medicine employees, including both faculty and staff members. With respect to College of Medicine faculty members, the sanctions identified in this policy must be administered in conformance with the **OUHSC Faculty Handbook, more specifically, Section 3.16 "Abrogation of Tenure, Termination of Employment, Severe Sanctions; Summary Suspension; and Other Disciplinary Actions Imposed for Failure to Comply with The University Compliance Program, Professional Practice Plan Billing Compliance Policy, or Other Federal or State Mandates."**

It is not possible to anticipate each type of HIPAA violation that may occur. The offense classes below provide guidance on categorizing offenses but are not intended to be all-inclusive or limiting. All HIPAA violations shall be reported and investigated in compliance with the OUHSC HIPAA policy.

Definitions

Health Information. Any information, whether oral or recorded in any form or medium, that:

1. is created or received by a Health Care Provider….employer…school or university…
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. 45 C.F.R. & 160.103.

HIPAA. Abbreviation used for the Health Insurance Portability and Accountability Act. The Standards for Privacy of Individually Identifiable Health Information ("Privacy Rule") established, for the first time, a set of national standards for the protection of certain health information. The U.S. Department of Health and Human Services ("HHS") issued the Privacy Rule to implement the requirement of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The Health Information Technology for Economic and Clinical Act passed on February 17, 2009.

Protected Health Information (PHI). Individually identifiable health information that is transmitted by, or maintained in, electronic media or any other form or medium. Protected Health Information excludes individually identifiable health information in:

1. education records covered by the Family Educational Rights and Privacy Act (FERPA); and
2. employment records held by the University in its role as employer.

Offenses

Class I offenses, include but are not limited to:

1. Accidentally or unintentionally accessing protected health information (PHI) that you do not need to access to do your job;
2. Leaving your computer unattended while you are logged into a PHI program or record containing PHI;
3. Sharing PHI in violation of University HIPAA policies;
4. Copying PHI or co-mingling of multiple PHI in violation of University HIPAA policies;
5. Modifying PHI in violation of University HIPAA policies;
6. Failure to report known or suspected HIPAA violation;
7. Discussing PHI in a public area or in an area where an unauthorized individual is likely to overhear the conversation;
8. Discussing PHI with an unauthorized person (verbal disclosure of PHI);
9. Failure to cooperate with the Privacy Official or OUP HIPAA Coordinator or his/her designee;
10. Failure to comply with University HIPAA policies and procedures.

Class II offenses, include but are not limited to:

1. Second offense of any Class I offense (does not have to be the same offense);
2. Unauthorized use or disclosure of PHI to others (paper or electronic form);
3. Using another person's computer access codes (user name and password);
4. Sharing your computer access codes (user name and password) with others or using another employee's computer user name and password.

Class III offenses, include but are not limited to:

1. Intentionally accessing PHI that you do not need to access to do your job;
2. Third offense of any Class I offense (does not have to be the same offense);
3. Second offense of any Class II offense (does not have to be the same offense);
4. Obtaining PHI under false pretenses;
5. Using and/or disclosing PHI for commercial advantage, personal gain, or malicious harm

Sanctions: Any offense in any class may result in termination. Other sanctions may include but are not limited to:

Class I offense sanctions may include, but are not limited to:

1. Termination of employment;
2. Suspension of employee (in reference to suspension period) generally minimum of one day/maximum of three days;

3. Retraining on the proper use of internal forms and HIPAA required forms;
4. Retraining on HIPAA policies and procedures;
5. Written reprimand maintained in employee's personnel file;
6. Verbal reprimand.

Class II offense sanctions may include, but are not limited to:

1. Termination of employment;
2. Suspension of employee (in reference to suspension period) generally minimum of one day/maximum of three days;
3. Retraining on proper use of internal forms and HIPAA required forms;
4. Retraining on HIPAA policies and procedures;
5. Written reprimand maintained in employee's personnel file

Class III offense sanctions may include, but are not limited to:

1. Termination of employment

Prior to any termination or suspension, the supervisor shall first consult with Human Resources and the College of Medicine Dean's Office. Lesser sanctions may be imposed in extraordinary circumstances with prior review and approval by the Executive Dean, or his designee.

- Policy Date: 1/29/2013
- Approved By: Executive Dean
- Date Revised:
- Date Reviewed: 5/11/2022

Facility Access Control Policy PHI (107)

1. **Purpose**
   Establish policies and procedures that limit physical Access to electronic Information Systems and to protect Facilities within the College of Medicine, Office of the Dean, where PHI/ePHI is stored from unauthorized physical access, tampering, and theft.
2. **Policy**[1]
   The College of Medicine, Office of the Dean, will control and monitor physical access to the areas where PHI/ePHI is maintained.
3. **Procedure**
   a. The College of Medicine, Office of the Dean, through the Human Resources Manager will maintain the following:
      i. A current Role-Based Access Worksheet on each Workforce Member.
      ii. A list of Workforce Members who have been given a key, key card, or access code that gives them access to Facilities or areas where PHI/ePHI is maintained. This must be updated when Workforce Members leave the College of Medicine, Office of the Dean, or work functions change.
      iii. A list of when non-Workforce service providers or individuals who need regular or recurrent, non business hours access to areas or Facilities where PHI/ePHI is maintained. Logs should include name of service provider, date, purpose of access, and any other relevant details.
      iv. HIPAA breach and violation investigation documents shall be maintained in a locked cabinet in the Human Resource Manager's office, which shall be locked when unattended. Electronic versions shall be maintained on HIPAA secure servers, products or devices.
   b. The College of Medicine, Office of the Dean, required access control procedures include the following:
      i. Entrances and exits to areas where PHI/ePHI is maintained and that are not monitored or attended must remain locked at all times. Doors must not be propped open unless required by fire codes.
      ii. Workforce Members with access to restricted areas must not allow unauthorized individuals access to those restricted areas and should report to their supervisor any unidentified persons who have gained, or seek to gain, access.
      iii. If entrances, exits, windows, strategic areas of the building, and other means of Access into the building have alarms, the alarms must be armed after hours per University site security procedures. Building access is restricted to those with accessibility after hours and on weekends.
4. **References**
   a. HIPAA Privacy Policy, Safeguards
   b. Information Technology Information System Workstation and Use Policy

[1] Capitalized terms are defined in the HIPAA Security Definitions and Privacy Definitions policies.

- Policy Date: 03/27/2015
- Approved By: Executive Dean
- Date Revised: 8/5/2015
- Date Reviewed: 5/11/2022

Willed Body Program Responsibilities and Oversight (108)

The Willed Body Program (Program), under the authority of the University of Oklahoma College of Medicine (College) and acting as an Agent of the Oklahoma State Anatomical Board (Board), is responsible for:

1. The collection, preservation, storage, distribution, delivery, and recovery from authorized users, of all deceased human bodies and body parts issued through the Program for health sciences education, training, and research. In addition, through an interlocal agreement with the Board, the Program is also responsible for appropriate cremation and final disposition of such remains.
2. The procurement, distribution, and final disposition of human cadaveric specimens provided to other educational and research entities for their training, educational, and research programs. It provides a combination of fully embalmed, unfixed and lightly embalmed cadaveric specimens to approved users for approved purposes. Uses of these specimens may include teaching, research, and applied educational activities such as training on new surgical procedures.
3. Approval and oversight of the use of all cadaveric specimens by any College of Medicine program or employee in an educational, training, or research activity, including activities that may procure specimens through another willed body program or human tissue program outside of the Program. This oversight assures, among other things, that all College and Program polices related to the proper and safe uses of cadaveric specimens are followed.

The College's responsibilities related to the Program include program administration and oversight, review and approval of policies and procedures, and programmatic review and recommendation.

Willed Body Program Oversight Committee Composition and Responsibilities

The Willed Body Program Oversight Committee (Committee) shall be established by the Executive Dean of the College of Medicine (Dean), who shall appoint the membership as follows: There will be five (5) members to include: one (1) designee each from the Office of the Senior Vice President and Provost, HSC Office of Legal Counsel, and the College of Allied Health; and two (2) designees from the College of Medicine, one of whom shall be appointed to serve as the Committee Chair. All members shall serve at the pleasure of the Dean for a period of time that he/she shall deem as appropriate. The Program Director shall serve the Committee in an ad hoc, non-voting capacity. The Committee is the designated oversight entity that works with Program administration and a wide variety of liaisons from other departments, colleges, and institutions to assure that appropriate resources and management are in place and that the Program effectively carries out its responsibilities. The Committee is also responsible for overseeing the policy and contractual matters related to the Program. By virtue of its enumerated functions, the Committee reports to both the COM and to the Board, which has statutory jurisdiction over all the functions carried out by the Program.

Committee Meetings

The Committee will meet at least annually (each Fall) and will maintain written minutes. Interval meetings can also be set as needed for the purpose of entertaining new business and/or effecting policy changes as required. The primary reasons for the annual meetings will be to:

1. Review the Program's activities and make recommendations, as needed, to the Dean.
2. Review relevant policies, procedures, and contracts and address needed changes.
3. Address Program management issues and concerns that require the consideration and input of the Committee.
4. Assure ongoing assessment and oversight by the Program's management in the areas of Program activities, quality and safety initiatives, and programmatic improvement efforts.
5. Review and accept the Administrator's Annual (AY) Report before the Program provides it to the Dean and the Board.
6. Report matters of concern or consequence to the Dean as they arise, and if required, to the Board.

Willed Body Program Areas of Responsibility

The Program will assure that all College policies and procedures related to the Program are implemented and followed for the purpose of safe and effective day-to-day management and operations of the Program. The specific responsibilities of the Program and its management include, but are not limited to the following:

1. **Arranging for Pick-up, Transportation, and Preservation of Bodies Donated for Issue by the Program**
   In accordance with state law and applicable requirements of the Board, the Program will work with all entities and individuals that provide donated human bodies to the Program or to any College of Medicine program or employee to assure that appropriate procedures are followed for the collection, pick-up, transportation, preservation, testing, and/or embalming of those bodies as required for anatomical specimen use. (Note: The costs related to the pick-up, transportation, and preservation of donated bodies may or may not be the responsibility of the Program.)
2. **Receipt of Cadavers and Cadaveric Specimens from Any Source**
   In accordance with state law and applicable requirements of the Board, the Program will assure appropriate receipt of and accounting for all human cadavers and cadaveric specimens donated to the Program and of those acquired by any College of Medicine program or employee and will assure that all appropriate College and Program policies and procedures for receipt, accounting, housing, and storage of such are followed.
3. **Documentation and Management of Cadaveric Specimens**
   In accordance with state law and applicable requirements of the Board, the Program will be the designated entity to work with all entities providing human cadaveric specimens to College of Medicine programs and employees for educational, training, and research purposes to assure that appropriate documentation is maintained, and that specimens are received, managed, and used in accordance with all College and Program policies and procedures for the appropriate receipt, housing, use, and storage, if necessary, of cadaveric specimens.
4. **Blood Testing of Unfixed (Non-Embalmed) and Lightly Embalmed Cadavers**
   In accordance with state law, applicable requirements of the Board, and College and Program policy, the Program will assure that all required serologic testing is completed for all of its own unfixed and lightly embalmed cadaveric specimens so as to assure the safety of specimen users. The Program will also work with all entities that provide human cadaveric specimens to any College of Medicine program or employee for educational, training, or research purposes so as to assure that testing required by the College or Program been done prior to the use of the specimen by any such program or employee.
5. **Distribution of Cadaveric Specimens**
   In accordance with State law and applicable requirements of the Board, the Program will work with external educational, research, and training entities that use human cadaveric specimens to provide appropriate cadaveric specimens to those entities, when available, and to assure that appropriate College and Program policies and procedures are followed for the collection, pick-up, transportation, preservation, use, and disposition of those cadaveric specimens.
6. **Final Disposition of Cadaveric Specimens**
   In accordance with State law and applicable requirements of the Board, the Program will assure that appropriate College and Program policies and procedures are followed for the proper disposition of cadaveric specimens by cremation and distribution of cremains in accordance with applicable state and federal laws. In addition, the Program will maintain appropriate records of specimens it cremates and the disposition of cremains of cadavers and cadaveric specimen issued by the Program.

Relevant Authority

- **63 Okl. Stat. 91-109,**
- **63 Okl. Stat. 2200.1A - 2200.27A**
- **74 Okl. Stat. 1008A**
- **OAC Title 50**

Program Policies: http://hippocrates.ouhsc.edu/policy/default.cfm

- Policy Date: 04/25/2016
- Approved By: Executive Dean
- Date Revised: 6/20/2019
- Date Reviewed: 5/11/2022

College of Medicine Academic Office Building Multi-Purpose Rooms (109)

The scheduling and utilization of the three (A, B, and C) multipurpose rooms located on the first floor of the Andrews Academic Tower will be managed through the Dean's office. The following will identify the layouts and available equipment for each room, outline the procedures for scheduling, the expectations and the requirements of those entities utilizing the space:

The Venue: (click here for room layouts)

There are three separate multi-purpose rooms available.

1. The "A" room is set up classroom style and will hold 30 comfortably.
2. The "B" room is set up classroom style and will hold 40 comfortably
3. The "A" & "B" rooms are separated by an accordion door which can be opened to accommodate 70 comfortably.
4. The "C" room is set up in a horseshoe shape and seats 24 around the tables with room for an additional 29 seats on either wall, providing a total of 53 seats.

All three rooms have state-of-the-art technology packages which include:

1. Lectern that includes:
   a. Built in Computer with USB connections to load your presentations to be used with the projection/video-conference/ recording systems.
   b. HDMI and VGA connections to connect your own device to the projection/video-conference/recording systems.
   c. Crestron touch-panel to allow you to control the room equipment from a central location
2. HD Projection to a 109" screen
3. 16 Ceiling Speakers built into the Reinforced Sound System
4. 2 Wireless Handheld and 2 Lapel Microphones
5. Polycom H.323 Video Conference System
   a. 2 60" HD monitors for Far site viewing, 1 located at the Front and 1 located at the Back of room
   b. 2 HD Cameras for transmission to Remote location, 1 located at the Front of the room to view the audience and, 1 located at the Back of room to view the presenter f. Media Site Conference Room Web Streaming/Recording system that operates seamlessly with existing equipment.
6. Media Site Conference Room Web Streaming/Recording system that operates seamlessly with existing equipment.

Scheduling of the Venues

All scheduling for the multi-purpose rooms will be accomplished through the Dean's Office utilizing Meeting Room Manager software. Scheduling will be accomplished on a first-come, first-serve basis (keeping in mind that College of Medicine entities will have priority). In the event of a potential conflict, every effort will be made to accommodate all parties but a final decision may come down to prioritization of need as well as numbers that need to be accommodated in the venue. The 2nd thru 9th floors of the new building will also have large conference rooms that can hold at least 30 people (these are managed, maintained, and utilized by the corresponding department on that floor).

1. Scheduling may be done up to a year in advance (please reference above pertaining to prioritization and potential conflicts).
2. Normal hours for the multi-purpose rooms will be from 8:00 a.m. to 5:00 p.m., Monday thru Friday. If you have need for the multi-purpose room(s) in the early morning, evening, or on weekends you'll need to make special arrangements with the scheduler in the Dean's office.
3. Any event outside of normal work hours will have to be staffed by personnel from the requesting party and that department will be responsible for scheduling any needed access to the building/rooms. If audiovisual is required, training can be provided to ensure there is access to the specific needed equipment.

Expectations/Requirements for Utilization

Parties utilizing the multi-purpose rooms will be responsible for any set up of the rooms that will take the room away from its standard set-up. If there are changes to the room the utilizing party will also be responsible for returning the room to its standard set-up following use.

1. The point of contact during the scheduling of the room will be the responsible party for the room throughout the length of the event.
2. Food and drink is authorized in the multi-purpose rooms, and individuals are expected to clean up after themselves.
3. If food is brought in for the event, the group will be responsible for set-up, and cleanup of the venue. (For most events there is a 30 minute space both before and after the meeting to provide this time).
4. Audio-visual support can be provided IF it is scheduled in advance. Training can also be provided so the party using the room can provide their own support. Audiovisual personnel are always on call in case of any unforeseen technical problems.
5. Following cleanup of the room, 1Call will be notified if trash needs to be removed.

The multipurpose rooms are an additional benefit provided by our new College of Medicine Academic Office building and may be utilized by all members of the College of Medicine. With outstanding facilities it becomes incumbent for all to follow the proper steps to assure that the facilities stay clean and fresh and well taken care of.

Failure to abide by the standards outlined may result in termination of use of the multi-purpose rooms by organizations/departments that are not in compliance.

- Policy Date: 9/2016
- Approved By: Executive Dean
- Date Revised:
- Date Reviewed: 09/08/2016

College of Medicine Academic Office Building
Multi-Purpose Rooms Layouts

Continuous Quality Improvement (110)

The University of Oklahoma College of Medicine engages in ongoing quality improvement activities to ensure that the school fulfills educational program goals by maintaining compliance with accreditation standards. In accordance with guidance from the Liaison Committee on Medical Education (LCME), the college has established an LCME Compliance Committee and an associated review process. The committee will be staffed by an individual tasked with coordinating the ongoing quality improvement activities (including managing the CQI Monitoring Instrument, collecting and assembling compliance data for meetings, preparing meeting agendas, and working with designated individuals to follow-up on tasks), the Senior Associate Dean, the Senior

Associate Dean for Academic Affairs, and other individuals selected by the chair. The Executive Dean will appoint the chair of the committee.

The committee identifies the LCME elements that require ongoing monitoring. One or more of the following criteria are used to select elements for monitoring:

- New elements
- Elements that include language that monitoring is required or involve a regularly occurring process that may be "prone to slippage"
- Elements where LCME expectations have evolved
- Standards/elements that were cited in the school's previous full survey visit
- Elements internally identified as potentially at-risk

The committee monitors compliance using a regularly updated CQI instrument. This instrument includes the following items:

- Element Title
- Timing and frequency of monitoring
- Data sources used for monitoring
- Individuals/groups receiving results
- Individuals/groups responsible for taking action
- Issues/tasks
- Notes/progress
- Date element last reviewed
- Compliance status

The committee meets approximately weekly to monitor data and evaluate compliance. It makes recommendations to selected individuals or groups as appropriate to maintain compliance. The CQI Monitoring Instrument is used to track and monitor progress toward compliance for monitored elements.

Updates and recommendations are shared with the Faculty Board and the Executive Dean. Other groups may be included as necessary.

- Policy Date: 9/19/2017
- Approved By: Faculty Board; Executive Dean
- Date Revised: 4/01/2021
- Date Reviewed: 8/26/2020

Activity Insight Data Governance Policy (112)

Policy Purpose

The purpose of the Activity Insight Data Governance Policy is to outline standards and procedures relating to the use of the Activity Insight system in the OU College of Medicine. Activity Insight users must adhere to the standards and procedures outlined here and in the OUHSC data system policies linked below.

Security, Backups, and System Requirements

See p. 2 of the Faculty User Guide and Resources for more information regarding data security, backups, and system requirements within the Digital Measures system.

http://hippocrates.ouhsc.edu/comweb/ai/Activity%20Insight%20Guide.pdf

Access to University Data Policy (OUHSC)

This policy states that access to OUHSC's non-public data requires prior authorization. Processes must be in place for the authorization, establishment, review, modification, and removal of access to OUHSC's non-public data.

https://it.ouhsc.edu/policies/documents/infosecurity/Access%20to%20University%20Data%20P olicy.pdf

Access Authorization Policy and Procedure (OUHSC)

OUHSC Information Security Services/Information Technology requires an Access Authorization Policy and Procedure for the College of Medicine's administration of Activity Insight. This policy identifies signature authority for user roles, defines access levels, and outlines processes for setting up and maintaining user access to data in the Activity Insight system.

Parties requesting data will be notified with an adjudicated reply.

Parties receiving data approved and released by the College of Medicine must acknowledge that the data in the Activity Insight system is faculty-reported, that it does not come from a system of record, and that it is not warranted by the College of Medicine to be complete or accurate for external purposes.

Faculty Access to Their Own Data

Faculty with accounts in the Activity Insight system may access, extract (via custom and ad-hoc reports,) and disseminate their personal data at their own discretion.

- Policy Date:
- Approved By: College of Medicine Executive Committee: February 13, 2020
- Approved By: College of Medicine Faculty Board: March 31, 2020
- Date Revised:
- Date Reviewed:

Appointment of Advanced Practice Providers (APPs) (114)

Advanced practice providers (APPs) are highly valued members of the College of Medicine. APPs will be appointed as staff members in the College of Medicine unless they meet criteria listed below for consideration of faculty status.

- Responsible for providing specific educational content to medical students, PA students, graduate students or residents to assist these learners in achieving specific learning objectives
- Participates significantly in educational and/or research programs and projects (i.e. Curriculum development, oversight and administration)
- Performs or contributes significantly in other scholarly work products (publications, presentations, etc.) beneficial to the College of Medicine

The appropriate faculty pathway and rank will be determined by the degree of involvement in the education and research programs and educational degree attained. In order to achieve greater consistency, APPs hired and appointed as limited-term faculty prior to the issuance of this policy will be assigned the rank of Associate. APPs should have the standardized rank of Associate unless they are part of the core PA

Program. APPs that are core faculty members of the PA professional programs will be appointed as consecutive-term faculty.

- Policy Date: March 31, 2020
- Approved By: Executive Committee of the Faculty Board: February 13, 2020
- Date Revised: March 31, 2020
- Date Reviewed: 08/25/2020

Policy on Policies (115)

The University of Oklahoma College of Medicine develops and maintains policies that support the college's missions and administrative functions. College policies safeguard organizational integrity, promote operational consistency, and ensure compliance with applicable laws, university policies, and accreditation standards. Policies are developed, approved, and updated by appropriate college administrative and academic entities. New policies may be developed at any time and all policies are subject to change.

As a rule, the college does not grant policy exceptions. However, in rare cases and for extraordinary reasons, the Executive Dean (or their authorized campus-based academic executive) may authorize an exception to a policy or policies after thorough review. Policy exceptions are not appropriate solutions for problems that may have been avoided or resolved through personal responsibility.

College policies use a standardized format and are publicly available on the College of Medicine web site.

- Policy Date: 6/11/2020
- Approved By: Executive Committee of the Faculty Board; Executive Dean
- Date Revised:
- Date Reviewed: