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**POLICY**

- The Designated Institutional Official (DIO) has the authority and responsibility for oversight of Kaiser Permanente Southern California (KPSC) independent residency programs and assurance of compliance with the Accreditation Council of Graduate Medical Education (ACGME) Institutional Requirements.

- The DIO will be responsible to the Medical Director of Quality and Clinical Analysis.

- The DIO will act as chairperson for the Institutional Graduate Medical Education Committee (IGMEC).

- The DIO or designee will review and co-sign all program information forms and any correspondence or document submitted to the ACGME by program directors that either addresses program citations or requests changes in the programs that would have significant impact, including financial, on the program or institution.

- The DIO shall present an annual report to the Governing Board of the Southern California Permanente Medical Group (SCPMG) and the governing bodies of the Joint Commission for the Accreditation of Hospital Organizations (JCAHO) – accredited Hospitals in which the institutional programs are conducted.
STATEMENT
The Sponsoring Institution and Major Participating Sites that are hospitals will be accredited by JCAHO or recognized by another entity with reasonably equivalent standards.

POLICY
• Kaiser Foundation Hospitals will maintain JCAHO accreditation.

• Hospitals that serve as major participating sites for KPSC GME Program shall maintain JCAHO accreditation.
KPSC established the Institutional Graduate Medical Education Committee (IGMEC) to provide oversight of GME programs. The IGMEC establishes and implements policies and procedures regarding the quality of education and the work environment for residents in all departments.

**POLICY**

- Composition of IGMEC
  - Voting members
    1. Designated Institutional Official (DIO)
    2. Program directors
    3. Peer-nominated residents
    4. Regional GME Administrator
  - Non-voting members
    1. Select assistant program directors
    2. Other administrative staff
    3. Residency coordinators

- The IGMEC will meet quarterly and maintain written minutes.
POLICY

SECTION:

INSTITUTIONAL STRUCTURE FOR EDUCATIONAL OVERSIGHT

TITLE:

IGMEC Responsibilities

POLICY

IGMEC responsibilities include:

Oversight of:

- the ACGME accreditation status of the Institution and its ACGME-accredited programs;
- the quality of the GME learning and working environment within KPSC, its ACGME-accredited programs, and its participating sites;
- the quality of educational experiences in each ACGME-accredited program that lead to measurable achievement of educational outcomes as identified in the ACGME Common and specialty/subspecialty-specific Program Requirements;
- the ACGME-accredited programs’ annual evaluation and improvement activities; and,
- all processes related to reductions and closures of individual ACGME-accredited programs, major participating sites, and the Sponsoring Institution

Review and Approval of:

- institutional GME policies and procedures;
- annual recommendations to KPSC Community Benefit regarding resident/fellow stipends and benefits;
- applications for ACGME accreditation of new programs;
- requests for permanent changes in resident/fellow complement;
- major changes in ACGME-accredited programs’ structure or duration of education;
- additions and deletions of ACGME-accredited programs’ participating sites;
- appointment of new program directors;
- progress reports requested by a Review Committee;
- responses to Clinical Learning Environment Review (CLER) reports;
- requests for exceptions to duty hour requirements;
- voluntary withdrawal of ACGME program accreditation;
- requests for appeal of an adverse action by a Review Committee; and,
- appeal presentations to an ACGME Appeals Panel.
IGMEC must demonstrate effective oversight of the institution’s accreditation through an Annual Institutional Review (AIR).

- IGMEC must identify institutional performance indicators for the AIR which include:
  - results of the most recent institutional self-study visit;
  - results of ACGME surveys of residents/fellows and core faculty; and,
  - notification of ACGME-accredited programs’ accreditation statuses and self-study visits.
- The AIR must include monitoring procedures for action plans resulting from the review.
- The DIO must submit a written annual executive summary of the AIR to the Governing Body.

IGMEC must demonstrate effective oversight of underperforming programs through a Special Review process.

- The Special Review process must include a protocol that:
  - establishes criteria for identifying underperformance; and,
  - results in a report that describes the quality improvement goals, the corrective actions, and the process for GMEC monitoring of outcomes.
KPSC residents and fellows are eligible for the following benefits:

**Vacation**
Residents will receive three weeks of paid vacation and one paid week of educational time per program approval.

**Educational Stipend**
Residents and fellows are eligible for the following reimbursements:

- USMLE/COMLEX Step 3 Exam
- California Medical License Application
- California Medical License & Renewal
- DEA
- Up-to-Date Annual Subscription
- MedStudy Board Review Books
- Travel Reimbursement for research presentations at national society meetings

Residents are also eligible to receive a $500 reimbursable allowance for educational materials. In the final year of training, residents can receive a week of educational time leave and $1,000 professional conference allowance. Per program director approval.

**Malpractice Coverage**
Medical malpractice insurance is provided by the Southern California Permanente Medical Group.

**Meals**
A meal allowance is provided which covers the cost of most meals.

**Coats and Parking**
Both are provided at no expense to resident.

**Sleeping Rooms**
Private rooms are provided when on call.

**Moonlighting**
Licensed residents can earn additional income moonlighting within our medical centers with approval by the Program Director.
For detailed information regarding medical, dental, life insurance, and other applicable benefits, please refer to Kaiser Permanente **Benefits in Brief** for Southern California Region Resident Physicians.

The salary structure for the 2014-2015 academic year is as follows:

- PGY-1 $50,311.38
- PGY-2 $52,072.68
- PGY-3 $53,894.75
- PGY-4 $55,780.68
- PGY-5 $57,733.56
- PGY-6 & 7 $59,754.42
STATEMENT
KPSC and each of its residency programs are committed to establishing and maintaining educational and work environments conducive to the provision of the highest quality learning within a healthful atmosphere. This includes:

- Establishing expectations that physicians appear rested and fit to provide the services required by their patient.
  - Each program educates faculty and residents to recognize signs of fatigue and sleep deprivation and the means to manage these circumstances.

- Development of a forum in which residents can communicate as well as raise issues in a confidential and protected manner.
  - KPSC ensures the confidential communication of resident issues such that: each resident has access to a support group whose proceedings are confidential and anonymous and each program director engenders an environment in which individual residents may raise concerns without fear of retaliation. The institution will validate this through the annual ACGME and Institutional resident surveys as well as the Internal Review Process.
  - KPSC residents are encouraged to utilize avenues within their programs to raise issues related to their education or the work environment. Such avenues include but not limited to:
    - Program Director/Asst. Program Director
    - Chief Resident
    - Other Local GME Administrative Leadership
    - Mentor/Faculty Member
    - House Staff

If the resident perceives that an issue has not been resolved despite multiple efforts, residents are encouraged to escalate the issue to the Graduate Medical Education Compliance Line, 1-866-413-1577. Concerns reported will be evaluated and investigated by persons with the proper competency. Severe allegations will be reported to the Designated Institutional Official (DIO) and Institutional Graduate Medical Education Committee (IGMEC).

In accordance with Kaiser Permanente’s “Principles of Responsibility”, residents are protected by the Confidentiality, Anonymity and Non-Retaliation provisions. Residents who would like to be contacted regarding their concern may voluntarily disclose their contact information solely for follow-up purposes. Reports of compliance and ethics concerns are monitored and tracked by reporting volume and allegations.
**INSTITUTIONAL RESOURCES**

**TITLE:**
Resident Education and Work Environment

- Provision of a health care delivery system in which the residents’ work is focused on their programs’ educational goals and objectives rather than other service-based tasks.
  - KPSC maintains extensive patient support services with respect to establishing peripheral intravenous access and obtaining phlebotomy, transportation, laboratory and radiology services.
  - KPSC maintains an electronic medical record – HealthConnect – which integrates ambulatory and inpatient care services, including all diagnostic and referral reports available across the Region at all times.

- Maintaining an environment that promotes resident safety and support resident.
  - Each medical center provides residents with access to food services at all times.
  - Each site provides residents with call rooms that are safe, clean, quiet, and private.
  - Security personnel and safety measures are available at all locations.
STATEMENT
The Joint Commission and the Accreditation Council for Graduate Medical Education require all health care providers to implement a standardized approach to handoff communications and maintain formal educational structure in handoff and care transitions.

PURPOSE
To provide guidance on and expectations for the development and implementation of a standardized process for communication that ensures effective information transfer among providers during the handoff with the overarching goal of minimizing the potential for medical errors. The primary objective of handoff communication is to provide accurate information about a patient’s care, treatment and services, current condition and any recent or anticipated changes.

SCOPE/COVERAGE
This policy and procedure covers all Kaiser Permanente Southern California faculty members, residents and fellows who have responsibility for patient care in the clinical environment.

DEFINITIONS
Communication: process by which information is exchanged between individuals and groups. In order to be effective, the communication should be complete, clear, concise and timely.

Handoff: the transition of responsibility and accountability for patient care across the continuum from one health care professional to another which can occur within health care settings, between health care settings, across levels of care and between providers.

Sign-out: the act of transmitting information about a patient during a handoff or transition of care.

Transitions of care: a broad range of services designed to ensure health care continuity and promote the safe and timely transfer of patients and responsibility for patients from one level of care to another or one type of setting to another or from one care provider to another.
PROVISIONS/PROCEDURES

It is understood that specific handoff procedures will vary from one specialty/practice site to another. This policy outlines general principles and expectations of patient handoff, with the adoption of specific process and form to be determined by each program and site which shall include the following:

- Interactive communication between the giver and receiver of patient information, including an opportunity for the receiver to ask for clarification of any issues or items presented.

- A system for providing updated information regarding each patient’s condition, treatment and anticipated needs during the coverage period.

- A strategy to minimize interruptions during handoff procedure.

- Each program’s handoff process will include:
  - To whom each resident will sign out and whether handoff includes on-call phone or pager
  - Location that will minimize interruptions and prevent any risks to patient confidentiality or other compliance violations as well as provide access to necessary materials to support the handoff, i.e. access to electronic clinical information
  - Standardized handoff content which includes at a minimum:
    - Identification of patient name, medical record number, age
    - Identification of supervising/consulting physician(s)
    - Diagnosis/current status/condition/acuity of patient
    - Recent events, including changes in condition or treatment, current medication status, recent lab tests, allergies, anticipated procedures and actions to be taken
    - Outstanding tasks – what needs to be completed in the near future
    - Outstanding labs/studies; what needs to be followed up during shift
    - Changes in patient condition that may occur requiring interventions or contingency plans
• interventions or contingency plans
• any special family or communication/language issues

• Any written documentation of handoff process must be maintained in a confidential manner

• Other expected standards include:
  • Each training program will include the transition of care process in its curriculum such that development for faculty and residents is provided
  • Resident demonstration and written evaluation of competence in handoff procedure
  • Program assessment of effectiveness of handoff procedure
STATEMENT
Residency training is based on graduated responsibility that culminates in a high level of individual accountability achieved by graduation. Throughout training, residents become more competent to make judgments of increasing complexity and perform procedures of increasing difficulty. A supervisory relationship exists between residents and faculty, such that the beginning resident has limited independence and progresses to assume increasing responsibility for patient care. KPSC directs each training program to demonstrate that the appropriate level of supervision is in place for all residents at all times.

DEFINITIONS
Supervision – The crucial responsibility that an attending physician has to enhance the knowledge of the resident and to ensure the quality of care delivered to each patient. It includes imparting knowledge, skills and attitudes by the attending to the resident and ensuring that patient care is delivered in a timely, appropriate, and effective manner.

POLICY
• All patient care is delivered under the ultimate supervision of qualified faculty.
• Each residency develops a program specific clinical grid, or Supervision Grid, which delineates levels of supervision for common patient care activities.
• Supervision Grids, updated each year, are available to nursing staff in all areas either in hard copy or uploaded to online systems.
• The resident is responsible to communicate in an effective and timely manner with the supervising physician regarding findings of the evaluation, physical examination, interpretation of diagnostic tests, and intended interventions.
• The attending physician on an inpatient service will review and co-sign the following entries:
  o Admitting history and physical
  o Operative report
  o Procedure notes
  o Discharge summary
  o Other medical record entries as necessary
• The attending physician in the ambulatory setting will review a substantive portion of entries in the medical record.
• Any entries made by non-licensed residents will be co-signed by the attending physician.
• Supervision can be exercised through a variety of methods, depending upon the circumstances and experience of the resident. These methods include:
  o Direct Supervision
    ▪ Physical presence of the faculty member.
    ▪ Presence of a fellow or senior resident.
  o Indirect Supervision
    ▪ Immediate availability of supervising faculty or senior resident, either within the institution or via telephone.
It is essential to the education, health and well-being of residents/fellows and the safety of patients that faculty and residents alike develop awareness of the symptoms and dangers of physician fatigue. It is a requirement of the ACGME for all residency programs to educate faculty and residents concerning alertness and fatigue, require that faculty and residents participate in such educational experiences, and to document and monitor such participation.

Evidence based literature indicates that fatigue impacts resident/fellow learning and well-being. Duty hour requirements are part of the solutions, but such requirements do not address all issues relevant to alertness and fatigue. Research indicates that most people do not realize they are sleepy until they are extremely fatigued.

Causes of fatigue include:
- Too little sleep. Most adults require an average of 8.2 hours of sleep per night.
- Fragmented sleep. When sleep is interrupted, a person may not have sufficient time spent in the deeper, restorative stages of sleep.
- Circadian Rhythm disruption. Circadian rhythms are the body’s internal biological clock, managing system functions throughout a 24-hour period. Frequent disruption of sleep schedules, as in extended duty hours or shift changes can result in fatigue and sleep deprivation.
- Other conditions, including anxiety, depression, medication, and physical illness.

Sleep debt can occur with as little as 2 hours less sleep than usual. Incidents of less than optimal sleep time over several nights will increase the deficit. Sleep debt requires several consecutive nights of optimal sleep for recovery.

Symptoms of sleepiness/fatigue include:
- Repeated yawning and “nodding off” at inappropriate times
- Microsleep – a few seconds of sleep that an individual may not even recognize
- Increased tolerance for risk
- Inattention to details
- Decreased cognitive functions
- Increased errors
- Accidents, especially automobile accidents
In the interest of the health and well-being of residents and patient safety, the IGMEC requires:

- Educational experiences must be developed in all programs to educate both faculty and residents to recognize the causes, symptoms and remedies for sleep deprivation, including recognition of impairment in others and their personal responsibility to be well-rested and alert when on duty.

- Participation in sleep deprivation educational experiences must be documented and monitored by each program.

- In accordance with duty hours and transition of care requirements, each program must have a process in place to ensure continuity of care in the event that a resident may be unable to perform patient care duties due to fatigue, illness, or other impairments.

- Faculty, residents, and other health care personnel must be trained in the process of recognizing fatigue, illness, or other impairments in their colleagues and encouraged to intervene when necessary to maintain the health and well-being of their colleagues and the safety of patients.

- Residents must be educated concerning possible short-term strategies for counter-acting sleep deprivation symptoms, including napping and occasional moderate use of caffeine.

- Residents must be educated as to their personal responsibility for their own health and well-being by careful management of their time before, during and after duty hours.

- Accurate and timely reporting of duty hours is mandatory.

- Each program must make sure that adequate sleep facilities/on-call rooms are available for their residents. Each program must ensure that residents know the location and scheduling of the sleep facilities/on-call rooms. These facilities are available before, during, and after a resident’s duty hours.

- To enable residents with the opportunity for safe transportation home in the event of fatigue, illness, or other impairment, each resident will be given a voucher to use for a taxicab ride home. The resident is responsible for returning the receipt for the service in a timely manner, including documentation of the reason for the transportation. (This process is in development at this time and updates will be provided to IGMEC as soon as details are determined.)
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**STATEMENT**

The recruitment and selection of new residents is a multi-layered process that takes place at both the Regional Recruitment Department as well as at the residency program’s medical center. See also Resident Recruitment and Eligibility.

**DEFINITIONS**

NRMP: The National Residency Matching Program is an independent non-profit organization that provides an impartial venue for matching applicants’ and programs’ preferences for each other. It provides uniform appointment of applicants to positions in graduate medical education.

USMLE: The United States Medical Licensing Exam. Steps I and II are taken in medical school; Step III is taken during the PGY-1 or -2 year. All three steps must be passed in order for the resident to be eligible for medical licensure in the state of California.

**POLICY**

- KPSC ensures that its ACGME-accredited programs select from eligible applicants on the basis of residency program-related criteria such as preparedness, ability, academic credentials, aptitude, communication skills, and personal qualities (i.e. motivation and integrity). Programs do not discriminate with regard to sex, race, age, religion, color, national origin, disability or veteran status, or any other legally protected status.
- KPSC accepts residency applicants who meet qualifications outlined in the ACGME Institutional Requirements and participate in the NRMP, where such is available.
- All KPSC residencies eligible for the Match will follow the NRMP guidelines.
- Residency programs accepting a resident at the second postgraduate year or higher must obtain a letter from the resident’s previous program director outlining his/her prior performance based on the six care competencies.
- Appointment to the residency program is initiated by the Program Director.
- The effectiveness of the resident selection process is periodically evaluated based on retention and board pass rates.
- The Regional Residency Recruitment Department or the residency program director (or designee) reviews the documents verifying eligibility for appointment to create an applicant pool from which the KPSC programs select to fill openings.
The initial screening documentation include:
  o Satisfactory Dean’s Evaluation;
  o USMLE Part I and Part II scores;
  o Passing grades in medical school;
  o Recommendation from medical school faculty;
  o Assessment of KPSC residency program compatibility from personal statement
    (suitable applicants are scheduled for interview with program director, faculty,
    and current residents).

All applicants are assessed post-interview and given a rating score, which will assist the
Program Director in assembling the NRMP rank list.

Each program applies its own unique selection process to the pool of screened
applicants, based on the criteria outlined in the ACGME Institutional Requirements and
the organization’s priorities.
The KPSC GME Program seeks to recruit qualified resident applicants.

**DEFINITIONS**

**LCME:** The Liaison Committee on Medical Education, responsible for the accreditation of all medical schools in the United States.

**POLICY**

- The SCPMG Residency Recruitment Department is responsible for the development, planning, and implementation of recruitment activities based on input from program directors, the IGMEC, and organizational leadership. This responsibility includes creation of marketing plans, the identification of targeted, appropriate medical student activities for promotion of residency program, and the provision of support for all ERAS activities.

- Program directors develop criteria by which designated staff initially screens all applicants.

- Program directors and faculty maintain ultimate oversight of candidates selected for interview.

- Recruitment staff support candidate interview scheduling, in collaboration with local department staff members. Conduct of interview-day activities is managed by either regional recruitment or local staff.

- Applicants with one of the following qualifications are eligible for appointment to a KPSC independent residency program:

  - Graduates of medical schools in the United States and Canada accredited by the LCME.
  - Graduates of colleges of osteopathic medicine accredited by the American Osteopathic Association (AOA).
  - Graduates of medical schools outside the United States who meet one of the following qualifications:
    - Have received a currently valid certificate from the Educational Commission on Foreign Medical Students prior to appointment, and
    - Have a valid Postgraduate Training Authorization Letter (PTAL) from the Medical Board of California.
• KPSC provides each resident with a written agreement of appointment/contract outlining the terms and conditions of their appointment to a program.

• The resident is appointed for a duration of one year.

• Resident promotion to the next postgraduate level shall be based on program director recommendation and contingent upon many factors including the resident’s successful completion of the current postgraduate year of training.

• Reappointment to a subsequent postgraduate level shall be for a one-year term.
POLICY

INSTITUTIONAL POLICIES AND PROCEDURES

TITLE: Non-Renewal of Agreement of Appointment

POLICY

• In instances when a resident’s appointment is not going to be renewed, the program director will provide the resident with a written notice of intent not to renew no later than four months prior to the end of the current agreement.

• If the decision for the non-renewal occurs within the final four month period, the program will provide the resident with written intent not to renew with as much notice as the circumstances will reasonably allow.

• Residents may implement the grievance procedure if they have received a written notice of intent not to renew their appointments.
STATEMENT
KPSC residency programs support an environment for faculty to provide residents with the opportunity to improve performance within an established, step-wise structure.

POLICY
• Residency programs will conduct formative evaluations at the end of rotations or at specified intervals throughout longitudinal schedules.
• Summative evaluations are conducted no less than on a semi-annual basis. These functions afford program directors and faculty the opportunity to identify trends in performance that would benefit from formal corrective interventions.

See attached documents for descriptions and format of the disciplinary process.
(Program Name) Residency/Fellowship Program

Date:

TO: (Resident's name)

FROM: (Program Director's name)

RE: Meeting to discuss needed improvement in residency performance

This memorandum is to document our meeting on (date) attended by (names of those present) to discuss (state problem behavior). The goal of our meeting was to (describe desired positive outcome).

Program Director's description of problem:

Resident's understanding of the problem:

At the end of the meeting it was agreed that (resident's name) would:

To support (resident's name) in this effort, (Program Director's name) will:

If improvement is not noted by (date), a remediation action plan will be put in place to provide additional structure for the remediation of this problem.
Step 1: Formal verbal warning with documentation

- A number of reports (usually emails) have been received by the PD regarding poor behavioral or academic performance
- PD and an additional faculty member (or GME director) meet with resident
- Concerns presented to resident
- Resident viewpoint / explanation elicited and understood
- Desired improvements described
- Resident agrees to make necessary improvements
- Meeting is documented in memo format with resident and PD approval of content (may be email approval)
- Memo removed from resident file when resident graduates

Step 2: Written remediation action plan with behavioral objectives and a timeline

- Poor behavioral or academic performance continues
- PD and an additional faculty member (or GME director) meet with resident to create a written remediation action plan
- Plan includes behavioral targets, completion dates, and faculty member who will verify completion of each action item
- HR representative reviews plan
- Resident and PD sign plan
- Progress reviewed on specified dates
- Satisfactory remediation is documented and plan removed from resident file at graduation OR
- Resident moved to probation

Step 3: Formal probation with written action plan & a timeline

- PD and additional faculty member(s) update failed action plan
- GME Directors, HR representative, and DIO review and approve plan
- Plan specifies behavioral targets, completion dates, and faculty member who will verify completion
- Resident, PD, HR representative and GME Director meet with resident to review, discuss, and sign probation plan
- Resident is informed that lack of successful completion will result in termination
- Progress reviewed on specified dates
- Satisfactory remediation documented and resident removed from probation
- Resident unwilling/unable to meet behavioral targets, probation failure is documented, and the termination process is initiated
- Probation documentation (whether remediated or failed) remains part of the resident file

Step 4: Termination
Resident name: 
Residency program: 

Program Director: 
Date: 

**Action Item 1**

A. Specific indicator(s) / measure(s) of successful change:

B. Faculty mentor(s) / monitor(s):

C. Progress check date(s):

D. Target completion date:

E. Successful completion (date/signatures of resident and program director):

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<th>Resident</th>
<th>Date</th>
<th>Program Director</th>
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**Action Item 2**

A. Specific indicator(s) / measure(s) of successful change:

B. Faculty mentor(s) / monitor(s):

C. Progress check date(s):

D. Target completion date:

E. Successful completion (date/signatures of resident and program director):

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**Action Item 3**

A. Specific indicator(s) / measure(s) of successful change:

B. Faculty mentor(s) / monitor(s):

C. Progress check date(s):

D. Target completion date:
E. Successful completion (date/signatures of resident and program director):

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**Action Item 4**

A. Specific indicator(s) / measure(s) of successful change:

B. Faculty mentor(s) / monitor(s):

C. Progress check date(s):

D. Target completion date:

E. Successful completion (date/signatures of resident and program director):

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<th>Program Director</th>
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**Action Item 5**

A. Specific indicator(s) / measure(s) of successful change:

B. Faculty mentor(s) / monitor(s):

C. Progress check date(s):

D. Target completion date:

E. Successful completion (date/signatures of resident and program director):

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<th>Resident</th>
<th>Date</th>
<th>Program Director</th>
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I understand that unsatisfactory performance on any of the above action items may result in my being placed on formal probation which will remain as a component of my residency file and which precedes involuntary termination.

Resident Signature ______________________________ Date ______________

Program Director Signature ______________________________ Date ______________
Resident name:  
Residency program:  

Program Director:  
Date:  

Action Item 1  
A. Specific indicator(s) / measure(s) of successful change:  
B. Faculty mentor(s) / monitor(s):  
C. Progress check date(s):  
D. Target completion date:  
E. Successful completion (date/signatures of resident and program director):  

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Action Item 2  
A. Specific indicator(s) / measure(s) of successful change:  
B. Faculty mentor(s) / monitor(s):  
C. Progress check date(s):  
D. Target completion date:  
E. Successful completion (date/signatures of resident and program director):  

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<th>Date</th>
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Action Item 3  
A. Specific indicator(s) / measure(s) of successful change:  
B. Faculty mentor(s) / monitor(s):  
C. Progress check date(s):  
D. Target completion date:  
E. Successful completion (date/signatures of resident and program director):  

| Resident | Date | Program Director | Date |
Action Item 4
A. Specific indicator(s) / measure(s) of successful change:
B. Faculty mentor(s) / monitor(s):
C. Progress check date(s):
D. Target completion date:
E. Successful completion (date/signatures of resident and program director):

Resident  Date  Program Director  Date

Action Item 5
A. Specific indicator(s) / measure(s) of successful change:
B. Faculty mentor(s) / monitor(s):
C. Progress check date(s):
D. Target completion date:
E. Successful completion (date/signatures of resident and program director):

Resident  Date  Program Director  Date

I understand that unsatisfactory performance on any of the above action items may result in involuntary termination.

Resident Signature  Date

Program Director Signature  Date

Reviewed and confirmed by:

Physician Director, Center for Medical Education  Date

Designated Institutional Official  Date

Human Resources Representative  Date
STATEMENT

KPSC provides residents with fair, reasonable, and readily available guidelines for pursuing grievance and due process.

The purpose of this policy is to facilitate the fair and timely resolution of issues concerning a resident’s academic or professional performance. As of its effective date, and as amended thereafter, the policy sets out the exclusive internal administrative procedures by which a resident may obtain review of a decision which directly concerns his or her academic or professional performance. This policy shall supersede any prior policies, bylaws, rules or regulations addressing Resident’s academic and professional appeals processes, including the Professional Staff Bylaws. Residents do not have a right to the Informal Review or the Formal Appeal and Hearing Procedure for actions taken against Residents acting in any other capacity, e.g. in his/her capacity as a “moonlighter.”

INFORMAL REVIEW POLICY

Scope:

- Informal Review is the process available to the resident to appeal Decisions that do not fall under the definition of an Adverse Decision. Decisions subject to Informal Review include, for example, routine assessments of the resident’s performance or progress, letters of warning, letters of probation, suspensions for medical record delinquencies pending completion of the records where the period(s) of suspension total less than 30 calendar days in a twelve month period, and Administrative Suspensions or Dismissals, e.g., for failure to obtain a California physician’s license in the requisite time period.

Procedure:

- When the resident disagrees with a Decision, the resident has the right and the responsibility to meet and address the disputed matter with his/her program director within 30 calendar days of the Decision. The program director shall meet with the resident to discuss his/her concerns, and provide the resident with a written response within 14 calendar days of the meeting. All written documentation about the disputed matter shall be made part of the resident’s residency program file (“File”). If the Resident fails to discuss a Decision with his/her Program Director within 30 calendar days, he/she waives any right to Informal Review of the Decision.
If the resident is dissatisfied with the outcome of the program director’s review of the matter, the resident may submit a written statement to the DIO, or the designee, if the DIO is the resident’s program director. The written statement must describe the resident’s concern(s), the reasons why the resident believes the matter remains unresolved, and the resolution the resident is seeking. The DIO shall meet with the resident to discuss his or her concerns, and provide a written response within 14 calendar days of the meeting. All written documentation shall be made part of the Resident’s File. The resident has no further right to review of the matter, and the DIO’s decision is final.

FORMAL APPEAL AND HEARING POLICY

Scope:
- This Formal Appeal and Hearing Procedure is the process available to a Resident to appeal an Adverse Decision.

Procedure:
- **Notice of Adverse Decision and Right to Request Hearing:** A resident who is subject to an Adverse Decision shall be notified in writing. The written notice shall advise the resident of his/her right to request a hearing before an Ad Hoc Review Panel and the time limit for requesting the hearing. The written notice shall be hand-delivered to the affected resident or, if the resident makes herself/himself unavailable, sent by certified or registered mail, return receipt requested to the Resident’s last known address on file in the GME Office. It is the resident’s responsibility to keep the Office informed of his/her current mailing address.

- **Time to Request Hearing:** To obtain a hearing, the resident must submit a written statement of the dispute with the DIO within 30 calendar days of the written notice to the resident of the Adverse Decision. The written statement must describe the resident’s concern(s), the reasons why the resident believes the matter remains unresolved, and the resolution the resident is seeking. The statement must specify the action or inaction taken by the program the resident disputes and how the action or inaction directly and adversely affects the individual resident.

- **Failure to Timely Request a Hearing—Effect:** The resident’s failure to submit a timely written statement for the hearing shall constitute waiver of his/her right to a hearing and acceptance by the resident of the Adverse Decision.
• Pre-Hearing Procedure:
  o Within 14 calendar days of receipt of the resident’s written statement, the DIO shall arrange for the hearing. This responsibility includes such matters as scheduling a hearing date, appointing the Ad Hoc Review Panel, and notifying the parties of the names of the Ad Hoc Review Panel members and the date, time, and place of the hearing. The hearing shall be scheduled to begin no more than 60 calendar days of receipt of the resident’s request.
  o The Ad Hoc Review Panel membership shall consist of:
    ▪ Two faculty members, one of whom shall act as Chairperson (“Chair”);
    ▪ One resident
    ▪ The Ad Hoc Review Panel members must not have acted as accusers, fact finders, or initial decision-makers in, or previously taken an active part in, the matter contested. One Panel member may be in the same specialty as the affected resident. Where feasible, the other members shall be from a different department than the resident requesting the hearing.
  o Within 14 calendar days after receipt of the resident’s written request for a hearing, the program director shall prepare a brief written statement setting forth the Adverse Decision and the reasons for the Decision, including the acts or omissions with which the resident is charged. A copy of the statement shall be hand-delivered or sent to the resident by certified or registered mail, return receipt requested, at his/her last known address on file in the GME Office, with a copy to the DIO.
  o As soon as reasonably practicable after receipt of the request for a hearing, each party shall have the right to inspect and copy relevant documents of the other party, subject to applicable privileges. The right of inspection and copying does not extend to confidential information referring solely to individually identifiable practitioners other than the affected resident. The Chair shall consider and rule on any request for access to information and may impose any safeguards that the protection of the hearing process, patient confidentiality, and justice require.
  o At least 14 calendar days before the scheduled hearing date, each party shall distribute the following items to the other party and to the Chair of the Ad Hoc Review Panel (“Chair”):
    ▪ A list and copies of the documents which the party intends to introduce;
    ▪ A list of the party’s witnesses with a summary of the subject matter about which each witness will be testifying and the relevance of that witness’ testimony to the matters at issue in the hearing.
  o The Chair shall address any other pre-hearing procedural disputes. Objections to any prehearing decision may be made at the hearing.
• **Rights of the Parties at the Hearing**: During the hearing, both parties shall have the following rights:
  o To be provided with all information made available to the Ad Hoc Review Panel;
  o To call and examine witnesses;
  o To present and rebut evidence determined to be relevant by the Chair;
  o To submit a written statement at the close of the hearing;
  o To be accompanied at the hearing by an advisor. If the resident’s advisor is an attorney, the residency program shall also be represented by an attorney. The resident must notify the DIO, the Chair of the Ad Hoc Review Panel, and the program director in writing at least 15 calendar days before the scheduled hearing date whether he or she will be represented at the hearing by an attorney. If the resident chooses not to be represented by an attorney, an attorney shall not represent the residency program at the hearing.

• **Resident’s Failure to Personally Appear and Proceed—Effect**: The resident’s failure to personally appear and proceed at the hearing without good cause shall constitute a waiver of the right to a hearing and acceptance by the resident of the Adverse Decision.

• **Procedure at the Hearing**
  o The Chair of the Ad Hoc Review Panel shall preside at the hearing and assure that all parties are heard and given an adequate opportunity to present relevant evidence and arguments.
  o The Chair shall also rule on any challenge to the impartiality of any Ad Hoc Review Panel member. Such challenges must be raised at the start of the hearing, unless the challenging party did not know the information on which the challenge was based at the start of the hearing, and could not have known with reasonable diligence.
  o Order of presentation:
    ▪ Each party may make an opening statement.
    ▪ After each party has made or waived its opening statement, the program director shall present, including any witness(es) he/she intends to call.
    ▪ The resident shall present second, including any witness(es) the Resident intends to call.
  o The hearing shall be closed and informal. Rules of evidence or judicial procedure need not be followed. Testimony, however, shall be under oath.
  o On conclusion of the presentation of evidence and arguments, the Chair shall declare the hearing closed.
  o Thereafter, the Ad Hoc Review Panel shall deliberate privately and reach a decision based on the evidence presented at the hearing, including oral testimony, written statements, and other documents, including medical record information, introduced at the hearing.
Within 14 calendar days of the close of the hearing, the Ad Hoc Review Panel shall issue its report and decision in writing to the Chief Operating Officer and the DIO. The report shall include findings of fact and a conclusion stating the connection between the evidence produced at the hearing and the decision reached. The report, which shall constitute the final decision of the Ad Hoc Review Panel, shall make findings as to whether the Adverse Decision was warranted or unwarranted. The Chair shall have a copy of the report sent to the resident by personal delivery or registered or certified mail, with a copy to the program director.

The decision of the Ad Hoc Review Panel is final, and neither party has any further right to review of the matter.

The report and decision of the Ad Hoc Review Panel shall be made part of the resident’s File.

Other Hearing Issues:

- **Burden of Persuasion**: The program director or other decision making body which made the Adverse Decision shall initially come forward with evidence in support of the decision concerning the resident. Thereafter, the burden will shift to the resident to come forward with evidence to establish the decision was improper. The Ad Hoc Review Panel will evaluate the evidence presented. The decision of the program director or other decision making body will be upheld unless the Ad Hoc Review Panel finds upon review of the evidence presented that by clear and convincing proof the disputed action was arbitrary or capricious.

- **Fees and Costs**: Each party shall bear its own legal fees and other costs.

- **Recording the Proceeding**: If requested by either party, the Chair shall arrange to have the hearing audio taped. The Chair shall provide a copy of the tape(s) to a party, on the request and at the expense of the requesting party. The GME Office shall retain the original tapes. A party shall not be permitted to independently audio or videotape, or otherwise record the proceedings. A party requesting the use of a court reporter rather than a tape recording must pay for the court reporting. The cost of a transcription of the matters reported by the court reporter shall be borne by the party requesting the transcription. A party requesting a copy of a transcription shall pay the cost of the copy.
STATEMENT
KPSC provides an internal grievance and problem solving procedure for Residents to utilize in resolving individual resident complaints or problems fairly and promptly through a series of steps which are to be followed in sequence.

POLICY
• KPSC provides an internal process for residents to resolve individual complaints or problems; it is not a means for disputing the content of overall hospital policies affecting residents in general, or a means for addressing issues of performance. Refer to “Resident’s Professional And Academic Grievance Process.”
• KPSC provides assistance to residents who wish to discuss a complaint or problem freely and in confidence with the program director and/or the DIO.
• KPSC ensures that a resident’s appointment is not in any way jeopardized because the resident has requested a discussion of his/her complaint or problem.
• KPSC provides the opportunity to resolve minor complaints and problems before they become major problems or cause discontent.

PROCEDURE
First Step
• Problems should be addressed early before they become unmanageable. If informal discussions do not resolve the issue, the resident shall submit his/her concern(s) in writing to the program director’s attention, with a copy to the DIO, within 10 business days of the incident.
• Written concerns should give a detailed description of the complaint and the specific remedy requested by the resident in order to resolve the problem or complaint.
• The program director shall respond to the resident’s complaint/grievance in writing, with a copy to the DIO, within 7 business days of receipt of the written concern.

Second Step
• If the program director’s answer is unsatisfactory to the resident, the resident shall send his/her concern(s) in writing to the DIO within 7 business days of receipt of the program director’s written response. The written concerns should give a detailed description of the complaint and the specific remedy requested by the resident in order to resolve the problem or complaint.
• Upon receipt of the complaint, the DIO shall acknowledge the receipt of the concern/grievance to the resident in writing within 7 business days.
Third Step
- The DIO shall meet with the Program Director and the resident in an attempt to resolve the issue. If a consensus can be reached, the resolution shall be documented in writing and signed by all parties.
- If a consensus cannot be reached by the DIO, the program director, and the resident, then the matter shall be referred to the Assistant Medical Center Administrator whose written recommendation shall be binding.

GRIVANCES WITH THE DEPARTMENT OF ACADEMIC AFFAIRS or THE ADMINISTRATIVE OFFICE OF THE TRAINING PROGRAM

- If a resident’s grievance is with the DIO or the GME Office, the above steps shall be placed in effect with the DIO fulfilling the role of the program director, and the Assistant Medical Center Administrator fulfilling the role of the DIO. The “Third Step” referral would be to the Area Medical Director.

LIMITATIONS
- This policy and procedure is not to be invoked for matters which relate to resident’s performance (academic progression, job performance, or professional issues), but is intended to address complaints or concerns related to training issues, conditions of employment, educational policies, and support.

Reference:
Resident’s Professional And Academic Grievance Process
Residents enrolled in KPSC sponsored residency programs are employees of Kaiser Foundation Hospitals (KFH), and as such are entitled to employee benefits, including leave benefits, in compliance with federal and state laws. Residents may refer to Benefits in Brief for a full description of time off benefits.

The maximum allowable time off for a KFH employee may conflict with requirements for successful completion of a residency program. Therefore, residency program directors will provide residents with a written policy in compliance with program specific requirements concerning the effects of leave of absence on satisfying the criteria for completion of a residency program.

When desired leave exceeds a specified amount of time, the resident will need to apply to the residency program director for an extension of residency training to meet the criteria for successful completion of the residency program.

**DEFINED LEAVES**

**Education Leave:** Residents in an independent Kaiser Permanente training program in their final year of required training may be granted up to five days, at the Program Director’s discretion.

**Family Leave:** After one year of service and working 1,250 hours, Residents are eligible for up to 12 weeks per year either to care for a newborn or foster/adopted child, or a close family member who is seriously ill.

**Sick Leave:** Residents will accrue 8 hours of sick leave per month for a total of 12 days per year.

**Bereavement Leave:** Residents may be eligible for up to 3 days (up to 5 days if one-way travel of more than 300 miles is required) of paid bereavement leave in the event of the death of an eligible family member or domestic partner.

**Vacation:** Residents are provided with four weeks of vacation at the beginning of the academic year. If a resident becomes an SCPMG physician at the conclusion of the residency program, up to 10 days of vacation may be transferred to one’s account with the Medical Group.

**Jury Duty:** Kaiser Permanente provides paid leave.

**Other Leave types:** Other unpaid leaves include: personal, medical, military, occupational injury or illness.
POLICY

INSTITUTIONAL POLICIES AND PROCEDURES

TITLE:

Resident Counseling and Support Services

POLICY

• KPSC facilitates resident access to the same confidential counseling and employee assistance program that it provides for the SCPMG physicians.

• Residents may seek services from providers within the Medical Group or they may alternatively seek service from external providers using their health plan benefits.

• Residents suspected of substance abuse problems are referred to the appropriate counseling program(s) for physician impairment.
The following Kaiser Permanente National H.R. Policy, “Commitment to Harassment-Free Work Environment” is applicable to KPSC residents and fellows.

**STATEMENT**
Consistent with the Principles of Responsibility, Kaiser Permanente (KP) is committed to sustaining a work environment that encourages employees to treat each other with dignity and respect and is free from discrimination/harassment. In keeping with this commitment, KP strongly disapproves of, and will not tolerate, any kind of harassment (as defined below) of employees or applicants for employment by anyone, including any manager, supervisor, physician, coworker or non-employee.

**SCOPE/OVERAGE**
This policy applies to all employees and applicants for employment with any of the following entities (collectively referred to as “Kaiser Permanente”):

- Kaiser Foundation Hospitals and Kaiser Foundation Health Plan, Inc. (together, KFH/HP);
- KFH/HP’s subsidiaries;
- The Permanente Medical Group (TPMG) [NOTE: This policy does not apply to physicians, podiatrists or Vice Presidents of TPMG, who are covered by separate TPMG policies]; and
- Southern California Permanente Medical Group (SCPMG) [NOTE: This policy does not apply to physicians of SCPMG].

**PROVISIONS**

**Harassment Definition**
- This policy prohibits harassment, whether verbal, physical, or visual, that is unwelcome and based upon a person’s race, color, religion, sex (including pregnancy), gender identity, national origin, age, physical or mental disability, veteran status, sexual orientation, genetic information, or other status protected by applicable federal, state, or local laws, or by corporate policy. (See Protected Status by State Addenda.)
- One type of harassment prohibited by this policy is sexual harassment. Sexual harassment is defined, generally, as unwelcome sexual advances, requests for sexual favors, and other physical, verbal, or visual conduct of a sexual nature, or based on sex/gender, which affects an employee’s terms and conditions of employment or creates an intimidating, hostile, or offensive work environment. Such conduct is a violation of federal law when:
- Submission to the conduct is made either explicitly or implicitly a term or condition of employment;
- Submission to or rejection of the conduct is used as the basis for an employment decision; and/or
- The conduct has the purpose or effect of unreasonably interfering with an individual’s work performance or creating an intimidating, hostile, or offensive work environment.

Sexual harassment takes many different forms and may be overt or subtle. It involves behavior that is not welcome, is personally offensive, that fails to respect the rights of others, or otherwise interferes with work effectiveness. Sexual harassment may occur between persons of the same or different genders. Both men and women are protected by the law and this policy, regardless of whether a male or female is the harasser or the victim, or the harassment involves individuals of the same sex. An employee may also be a victim of sexual harassment where sexual harassment is pervasive in the work environment, even if no sexual harassment is directed specifically at that employee. Sexual harassment prohibited by this policy includes offensive or hostile conduct based on gender regardless of whether the conduct is sexual in nature.

The same legal standards used to define hostile environment sexual harassment are applicable to other forms of unlawful harassment.

Conduct Prohibited by this Policy
- In order to prevent unlawful harassment from occurring in KP’s workplace, this policy prohibits any conduct of a sexual nature or based on sex/gender or the other protected status categories outlined in the Policy Statement above that could reasonably be perceived to be offensive to others in the workplace.
- Employees are prohibited from harassing other employees whether or not the incidents of harassment occur on company premises and whether or not the incidents occur during working hours, if the conduct is related to any of the participant’s employment or adversely affects KP’s operations.
- Anyone engaging in conduct that violates this policy is subject to corrective/disciplinary action up to and including discharge, and, if such conduct involves a violation of law, also may be personally subject to civil and criminal legal liability. The level of corrective/disciplinary action will depend on the nature, severity and frequency of the conduct.
Some examples of sexual or sex/gender based conduct prohibited by this policy include:
- Sexual propositions, stating or implying that sexual favors are required as a condition of employment or continued employment, preferential treatment or promises of preferential treatment to an employee for submitting to sexual conduct; repeated unwanted sexual flirtations, advances, or invitations
- Unwanted physical contact, such as touching, pinching, grabbing, kissing, patting, or brushing against another’s body
- Verbal conduct, such as sexually oriented or suggestive jokes, comments, teasing, or sounds; comments about a person’s body, questions about or discussions of another person’s or one’s own sexual experiences; sexually derogatory or stereotypical comments; verbal abuse of a sexual nature or based on sex/gender; sex/gender-based hostility
- Offensive leering, flirtatious eye contact, staring at parts of a person’s body, sexually oriented gestures
- Displays or distribution of offensive, sexually suggestive pictures or objects, drawings, cartoons, graffiti, calendars, posters, printed material, or clothing containing sexually oriented language or graphics
- Inappropriate electronic mail usage and transmissions, including sexually explicit messages, cartoons, jokes, and unwelcome propositions; as well as accessing or viewing pornographic websites

Some examples of other conduct based on protected status that is forbidden by this policy include:
- Racial, ethnic, or religious slurs, epithets, or jokes
- Derogatory or stereotypical comments based on race, religion, national origin, age, disability, sexual orientation, gender identity, or other protected status
- Abusive or hostile treatment or similar offensive and unwelcome conduct based on an individual’s protected status
- Inappropriate use or transmission of electronic mail or other electronic communication equipment, or inappropriate access or viewing of websites including those with ethnic or racial cartoons, jokes, or any other message that may offend, disparage, or harass an individual based on the protected status categories outlined above
Reporting Obligation

- Any employee or applicant for employment who is subjected to, witnesses, or has knowledge of any actions or conduct in violation of this policy or that could be perceived as sexual harassment or any other form of harassment prohibited by this policy should report it promptly to an appropriate management official, such as a supervisor or the local Human Resources representative. Individuals also may choose to use the EEO Internal Complaint Procedure or the KP Compliance Hot Line. However, an employee is not required to complain to his or her supervisor or manager, particularly if the supervisor or manager is the individual who is engaging in the prohibited conduct.

- Employees should understand the importance of informing, and are encouraged to inform, individuals engaged in behavior that may be perceived as violating this policy that their behavior may be unwelcome, inappropriate or offensive.

- Any physician, manager, supervisor, or other exempt professional or management employee who witnesses or has knowledge of sexual harassment or other forms of harassment or conduct prohibited by this policy is obligated to promptly report such behavior to an appropriate representative in Human Resources so that it can be appropriately investigated. Failure of management or other exempt personnel to promptly report or otherwise address incidents of harassment or conduct forbidden by this policy that are either reported to them or that they witness may result in corrective/disciplinary action, up to and including termination of employment.

Investigations and Remedial Action

All reports of violations of this policy will be promptly and objectively investigated and to the maximum extent possible, investigations will be conducted so as to protect the confidentiality and privacy of the parties involved (see NATL.HR.004, EEO Internal Complaint Procedure). If an investigation confirms that a violation of this policy has occurred, appropriate corrective/disciplinary action will be taken, up to and including termination of employment, and any other remedial action will be taken as is necessary to assure a workplace free of harassment.

5.5 No Retaliation

Kaiser Permanente policy, as well as applicable federal and state laws, prohibit retaliation, intimidation or reprisal against applicants, employees, and independent contractors who file complaints and/or who cooperate with or participate in any procedures or investigations related to complaints of discrimination, including complaints of sexual harassment and other forms of harassment. Therefore, employees should object to sexual and other forms of harassment and report violations without fear of reprisal or retaliation. If it is determined that an employee has committed acts of retaliation in response to the actual or perceived filing of a complaint or participation in the investigation of a complaint under this policy, that person will be subject to corrective/disciplinary action, up to and including termination of employment.
Protected Status
In California, discrimination/harassment is prohibited on the basis of the following protected status:
• Race
• Color
• Religion
• Sex (including pregnancy, *childbirth or a related medical condition, and *breastfeeding or medical conditions related to breastfeeding)
• Gender identity (and gender expression*)
• National origin
• Age
• Physical or mental disability
• Veteran status
• Sexual orientation
• Genetic information
• Ancestry*
• Marital status*
• Medical condition*
• Religious creed*
• Other status protected by applicable federal, state, or local laws, or by corporate policy

*Additional protected status under California state law
STATEMENT
To comply with the requirements of both the federal Americans with Disabilities Act (ADA) and applicable state laws, Kaiser Permanente (KP) provides reasonable accommodation to qualified individuals with disabilities who are employees or applicants for employment and need assistance to perform essential job functions, unless to do so would cause undue hardship.

PURPOSE
The purpose of this policy is to facilitate reasonable job accommodations for qualified individuals with disabilities and to describe the interactive process for determining reasonable job accommodations.

SCOPE/COVERAGE
This policy applies to all eligible applicants and employees who are employed by any of the following entities (collectively referred to as “Kaiser Permanente”):
- Kaiser Foundation Health Plan, Inc. and Kaiser Foundation Hospitals (together, KFHP/H);
- KFHP/H’s subsidiaries;
- The Permanente Medical Group (TPMG) [NOTE: This policy does not apply to physicians, podiatrists or Vice Presidents of TPMG, who are covered by separate TPMG policies]; and
- Southern California Permanente Medical Group (SCPMG) [NOTE: This policy does not apply to physicians of SCPMG].

DEFINITIONS
Eligible applicants and employees – Individuals who:
- have a known physical or mental disability for which accommodation is both necessary and reasonable to enable satisfactory performance of essential job functions; and
- are considered “qualified” for a position because they satisfy the requisite skills, experience, education, and other job-related requirements of the position and can perform the essential functions of the job, with or without reasonable accommodation.
The “essential functions” of a job are determined by showing that:

- The position exists to perform the function;
- There are a limited number of employees available to perform the function; or
- The function is highly specialized.

The work experience of past and current employees in the position is an important factor in determining whether a function is essential.

**PROVISIONS**

**Job Accommodations**

- KP provides reasonable job accommodations for individuals with disabilities. An accommodation is “reasonable” if it would be feasible to implement and would be effective in allowing the individual to perform essential job functions. Accordingly, a job accommodation is not reasonable if it would change or remove essential job functions. Also, job accommodations are not required if they would impose an undue hardship (as defined in section below) on KP’s operations.
- In general, an accommodation is any change to the work environment or job application process or in the way work is performed that enables a qualified individual with a disability to perform the essential functions of the job. Accommodations may include:
  - Making facilities accessible.
  - Acquisition of assistive devices (e.g., telephone amplifier, specialized computers or keyboards) or modification of work environment or equipment (e.g., ergonomic workspace, modifications to lighting or sound equipment, raised or lowered desks).
  - Job restructuring (i.e., reallocating nonessential job functions or altering when or how an essential function is performed if this permits the individual to perform the essential functions of the job). Job restructuring for union represented employees must be in accordance with applicable collective bargaining agreements.
  - Modification of work schedule and/or non essential job duties.
  - Leave of absence or extension of leave for a definite period of time when an employee is currently unable to perform the essential functions of the position (e.g., to allow employee to receive medical treatment or recover from a medical condition and return to work).
Reassignment to a vacant position. (Reassignment is only available to current employees, not job applicants, when there is no other reasonable accommodation that will enable the employee to perform the essential job duties of his/her current job. Reassignment for union-represented employees must be in accordance with applicable collective bargaining agreements.)

- A determination that an accommodation would impose an undue hardship must be based on an individualized assessment of current circumstances that show that a specific accommodation would cause significant difficulty or expense, or would be unduly disruptive to other employees’ ability to work or to provide patient care or would change the nature of the operation of the business. Since it is difficult for any employer to establish undue hardship, the question of whether a proposed accommodation would create an undue hardship must be carefully evaluated on a case-by-case basis and requires review by Legal Counsel.

Interactive Process

- When an employee/applicant requests an accommodation for a disability, or when KP otherwise knows that a disabled employee needs a reasonable accommodation, KP will engage in an interactive process to determine if the disability can be reasonably accommodated. The interactive process is an ongoing, timely dialogue between the individual and the manager/supervisor/recruiter/appropriate KP Human Resources representative to clarify the individual’s needs in performing essential job functions and identify the appropriate reasonable accommodation. Both KP and employee/applicant have a duty to cooperate in good faith in the interactive process.

- The interactive process should be initiated promptly when an employee/applicant gives notice of a disability and desire or need for an accommodation or KP knows about a disability and/or KP recognizes the need for an accommodation. A request for accommodation can be made orally or in writing by the employee, or by someone (e.g., a family member, friend, health professional) on his/her behalf.

If the disability and need for accommodation are obvious, and an accommodation that will assist the employee/applicant perform the essential job duties is not difficult or costly to implement, the manager should go ahead and provide the accommodation. In such circumstances, no further steps in the interactive process are required. However, the manager must notify Human Resources/the regional EEO Coordinator of the
accommodation so that it can be appropriately documented. [NOTE: Examples of accommodations that managers could easily implement include relocation/movement of office furnishings; and acquisition of assistive devices, such as telephone headset, document holder, glare shield for monitor.] A manager should not alter or eliminate the essential functions of a position as an accommodation.

- The purpose of the interactive process is to identify and discuss: (1) the essential functions of the position(s) in question; (2) the nature of the individual’s physical and/or mental limitations and the impact of those limitations on the performance of the essential job duties; and (3) potential accommodations.

- When an accommodation is requested and the manager has not already provided a non-difficult or inexpensive accommodation as indicated, the manager/supervisor/recruiter should promptly contact Human Resources, which will be responsible for meeting with the employee/applicant and conducting and documenting the interactive process. This includes the following actions:
  - Analyze the job and determine the essential job functions and skills and attributes required to perform those functions.
  - In consultation with the employee, determine the individual’s job-related functional limitations and their impact on the performance of essential job functions.
  - Ask individual what specific accommodation is needed and consider requested accommodation.
  - Determine if a requested accommodation is related to the performance of essential job functions and is reasonable (will enable the individual to perform the essential job functions and is feasible to implement).
  - Consider the accommodation preferred by the individual, but if there is more than one reasonable accommodation, select the accommodation that best serves the needs of the individual and KP.
  - Document all steps in the interactive process and any reasonable accommodation that is considered and/or implemented. This includes taking and preserving notes of each meeting or call, maintaining copies of relevant documents, recording efforts to identify accommodations, sending letters/memos to employee/applicant confirming discussions, agreements, any failure to cooperate and/or next steps.
INSTITUTIONAL POLICIES AND PROCEDURES

Title: Accommodation for Disabilities

- Monitor the effectiveness of the reasonable accommodation. If a selected accommodation is not effective or no longer effective, the interactive process should be resumed to identify possible alternatives, or additional accommodations.

Medical Documentation

- The employee/applicant is responsible for cooperating with KP in providing medical documentation to assist in assessing the extent of the employee/applicant’s functional limitations and facilitate the interactive process to determine possible reasonable accommodations. If an employee/applicant fails to fully cooperate and provide necessary information during the interactive process, KP will no longer have an obligation to continue the interactive process.

- KP may request the employee/applicant to provide written documentation from the employee’s/applicant’s health care provider regarding functional limitations when the disability and/or need for accommodation is not obvious.

- If medical information provided by the employee/applicant’s treating physician is insufficient to enable KP to evaluate the functional limitations and possible accommodations, KP should explain to the individual why the documentation is insufficient and allow the individual a reasonable period of time to provide the missing information. If the individual fails to provide the necessary information, KP may request that the employee/applicant consent to a medical examination conducted by a physician selected by KP.

Any job accommodation issues for selected applicants which arise in conjunction with preplacement Health Screening are administered in accordance with applicable national and regional policies.
The KPSC GME program is committed to promoting patient safety and resident well-being. It assumes responsibility for oversight of and compliance with all ACGME duty hours requirements.

DEFINITIONS
Duty Hours – All clinical and academic activities related to the training program, including patient care (both inpatient and outpatient), administrative duties related to patient care, in-house call, provision for transfer of patient care, and scheduled academic activities such as conferences.

POLICY
• Each program develops and adopts the duty hour policies for its specialty.
• Duty Hours are limited to a maximum of 80 duty hours per week, including in-house call and moonlighting, averaged over four weeks.
• Residents are given one full calendar day out of seven free from all clinical and educational responsibilities, averaged over four weeks, inclusive of call.
• PGY-2 and above residents are not scheduled for in-house call more than once every three nights, averaged over four weeks.
• Duty periods of PGY-2 residents and above are scheduled to a maximum of 24 hours, although residents may remain on duty for four additional hours to transfer patients, maintain continuity or care, conduct outpatient activities, or participate in educational activities. Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.

In unusual circumstances, residents at their own initiative may remain beyond scheduled duty period to continue to provide care to a single patient. Justification is limited to:
• Required continuity for a severely ill or unstable patient
• Academic value of event transpiring
• Humanistic attention to patient/family needs

Under such circumstances, the resident will:
• Hand over care of all other patients to the team
• Document reasons for remaining and submit to program director
• Program director will review such submissions and track individual and program episodes.
• PGY-1 residents are given 10 hours for rest and personal activities between daily duty periods and after in-house call.
• Intermediate-level residents should have 10 hours and will have 8 hours between scheduled duty periods. They will have at least 14 hours free of duty following 24 hours.
of in-house duty.

- When residents are called into the hospital during at-home call, the hours spent in-house must be counted toward 80 hour work limit.
- Duty periods for PGY-1 residents do not exceed 16 hours.
- Residents are not to be scheduled for more than six consecutive episodes of night float. Hours spent on at-home call do not contribute to duty hour calculations unless the resident is called into the hospital, in which circumstance the hours count toward 80-hour maximum. The frequency of at-home call is not subject to every-third-night limitation but must satisfy requirement for one-day-in seven free of duty.
- All residents will report duty hours on a regular basis depending on program-specific Requirements, but no less frequently than every 9 days.
- Duty hours will be reviewed by the program director or designee for occurrences of noncompliance. Such occurrences will be addressed and resolved in a timely manner.
  - **First Infraction:** Program Director will issue a verbal warning and review the GME Duty Hour Policy with the resident.
  - **Second Infraction:** Program Director will issue a written warning to resident. It is to be documented that the Program Director has discussed the GME Duty Hour Policy with the resident and communicated that another infraction of noncompliance with regard to duty hours will be in violation of the ACGME’s Professionalism competency and will lead to formal remediation.

- Duty hours issues are addressed by the Program Director and/or the DIO, and if necessary the Director of the Center of Medical Education for programs at the Los Angeles Medical Center.
- Duty hours are further monitored through the annual ACGME resident survey, the annual Institutional Resident Survey, the Internal Review Process, and/or local GMECs.

PROCEDURE

All residents are required to report their duty hours using the MedHub system.

Residents must log their duty hours a minimum of once every 9 days.

An email reminder will be sent to a resident who has not logged duty hours by the 5th day from the last date they logged on. A second email reminder will be sent to the resident 4 days after the initial reminder if the resident has still not logged on. If 9 days have passed and the resident has not logged duty hours, a MedHub-generated email will be sent to the Program Director, coordinator, affected resident(s) and the GME Office.
A follow up email will be sent from the GME Office notifying the Program Director and coordinator of the resident(s) who have violated the policy stating the amount of days they are past due and informing them that they have 24 hours to log past due duty hours. The appropriate Program Director and coordinator will be notified if any of their residents remain on the past due list.

Residents are expected to log their duty hours before they leave for vacation/leave of absence. Note: Residents are prohibited from logging future work hours. However, it is permissible to log future vacation/leave of absence (as described above), “day off”, or annual leave hours.

Residents who encounter problems or difficulty complying with the ACGME duty hours requirements should resolve this matter with his/her Program Director. If the matter cannot be resolved with the Program Director or if the resident encounters violations, s/he should contact the Designated Institutional Official.
The KPSC GME Program is committed to promoting patient safety and resident well-being.

DEFINITIONS
- Moonlighting – Professional and patient care activities that are external to the educational program.
- Internal moonlighting – Occurs at any Kaiser Permanente facility.
- External moonlighting – Occurs at any non-Kaiser Permanente facility.

POLICY
- Moonlighting activities, whether internal or external, must be consistent with sufficient time for rest and restoration to promote the residents’ education experience and safe patient care.
- Moonlighting must not interfere with the ability of the resident to achieve the goals and objective of the educational program.
- PGY-1 residents are not permitted to moonlight.
- Moonlighting both internal and external is counted toward the 80-hour weekly duty hours limit.
- Program directors will closely monitor all moonlighting activities and ensure residents are aware of the following:
  - Residents are not required to engage in moonlighting.
  - Residents are required to obtain a written statement of permission from the program director that is placed in the resident’s file. Permission to moonlight will be granted at the sole discretion of the program director.
  - Residents’ performance will be monitored for the effect of these activities upon performance and adverse effects may lead to withdrawal of permission.
- Moonlighting issues are addressed by the residency program director and/or the DIO, and/or the Director of the Center for Medical Education.
- Moonlighting is monitored through the Internal Review Process, the ACGME resident survey, and/or local GMEC.
All KPSC residents and faculty are subject to the policies and stipulations of the “Regulations and Standards for Pharmaceutical Representatives.” They will conduct relationships with pharmaceutical company employees in accordance with the attached KPSC Regional policy.

In addition, all physicians and staff will abide by Kaiser Permanente’s Code of Conduct as described in the “Principles of Responsibilities.”

**Policy**

Kaiser Permanente (KP) makes supplier and vendor selection decisions fairly, objectively, in the interest of patient well-being, and in the best interest of KP. To that end, employee interactions with suppliers/vendors are conducted to avoid or minimize conflicts of interest and the appearance of conflicts of interest.

**Purpose**

The purpose of this policy is to establish requirements for employee interactions with representatives of KP suppliers/vendors and prospective suppliers/vendors to safeguard KP’s corporate integrity including its operations related to patient care, research, and education against conflicts of interest. KP recognizes that ethical interactions are the responsibility of both KP employees and our suppliers/vendors and, therefore, applies a Kaiser Permanente Vendor Code of Conduct.

**Scope/coverage**

- This policy applies to all employees who are employed by the following entities (collectively referred to as “Kaiser Permanente”):
  - Kaiser Foundation Hospitals and Kaiser Foundation Health Plan, Inc. (together, KFH/HP); KFH/HP subsidiaries;
  - Southern California Permanente Medical Group (SCPMG) [NOTE: This policy does not apply to physicians of SCPMG].
DEFINITIONS
- **Conflicts of Interest** arise when personal or financial interests influence professional judgment or decision-making.
- **Potential Conflict of Interest** - A potential conflict of interest exists when personal or financial interests may, at some time in the future, influence professional judgment or decision-making.
- **Products and Services** include, but are not limited to, drugs, devices, equipment, biotech products, computer hardware, software, supplies for purchase or inclusion in a formulary, and legal services.
- **Suppliers or Vendors** include any individual or organization that offers to supply or sell products or services to KP, including consultants.
- **Supplier/Vendor Gifts** are defined as services or things received from a supplier or vendor with a value greater than $25.00.
- **Professional Associations** are organizations formed to unite and inform people who work in the same occupation.

PROVISIONS
General
- It is expected that employees follow the provisions in this policy regarding interactions with suppliers/vendors. There is an exception process available to employees when the situation calls for special consideration. The exception process is described in Appendix 3: Vendor Relations Exception Process.
- Employees working in KP entities or departments with more stringent policies must abide by the more stringent policy. This includes, but is not limited to Pharmacy, Procurement and Supply, the National Products Council, and Sourcing and Standards Teams.
## Vendor Interactions and Relationship

**Effective Date:** 7/1/99  
**Revision Date:** 5/1/14  
**Page:** 3 of 10

### Purchasing and Contracting

#### General
- Selection of products and services must be based on sound clinical (e.g., quality, safety, and effectiveness) and/or business (e.g., availability, cost, innovation, regulatory, dependability, value, and service) criteria and made in the best interest of patient well being and in the best interest of KP.
- Employees with the authority to direct or influence the selection or purchase of products and services by KP must have a current, attested Conflicts of Interest Questionnaire.
- Should a conflict or a potential conflict develop, employees must disclose the conflict to their supervisor to ensure the conflict is appropriately resolved. Appropriate resolution may include: recusal from participating in decisions related to the selection, purchase or utilization of the products or services of the supplier/vendor, or a competitor of the vendor; exclusion from approval or invoices from the supplier/vendor; or prohibition from supervising the vendor’s/contractor’s work for KP.

#### Acceptance of Gifts from Suppliers/Vendors
- Employees who sign contracts with suppliers/vendors or influence the selection of suppliers’/vendors’ products or services may not accept anything of value provided by suppliers/vendors.
- Employees may not participate in vendor-sponsored raffles by using their business cards or providing KP business contact information at product demonstrations, vendor conferences, or other programs such as conference exhibit halls. A gift received from a supplier/vendor under any circumstance (e.g., door prize, raffle, and special event tickets), must be refused.

#### Supplier/Vendor-Provided Meals
- Meals offered by suppliers/vendors valued at more than $25.00 must be disclosed by the employee to their supervisor in writing prior to acceptance and the employee must provide a business justification.
- Employees may attend celebratory meals sponsored by a KP supplier/vendor (e.g., at the end of an audit or settlement in which KP employees were actively and closely engaged with the supplier/vendor), but the employee’s meals must be paid for by KP.

#### Supplier/Vendor-Provided Entertainment
- Employees may not accept free tickets from a supplier/vendor to attend a sporting or other type of entertainment event. This requirement applies whether the supplier/vendor or the supplier/vendor representative is present or not.
Supplier/Vendor Support for Educational and Other Professional Activities

- KFHP accepts grants for general support of education and research (i.e., without deliverable products or services tailored to benefit/specific to KP) from suppliers/vendors provided the unrestricted grants are made with the approval of the KFH/HP Boards of Directors and not designated for use by specific individuals. See Permanente Medical Group (PMG) policies and procedures for acceptance of PMG grants.

- Educational and research grants may not be made, conditioned upon, or related in any way to any pre-existing or future business relationship with the supplier/vendor or any business or other decision KFHP has made, or may make relating to the supplier/vendor or its products, including coverage or formulary status decisions.

- It is acceptable for employees to attend supplier/vendor-sponsored educational seminars (e.g., webinars, lectures, industry updates) when the educational seminars are open to the public and disclosure regarding the employee’s attendance has been made to the employee’s supervisor prior to attendance.

- A KFH/HP employee’s participation on a supplier/vendor-sponsored advisory board is prohibited unless approved by a member of the National Leadership Team or Regional President. A decision regarding an employee’s attendance at such meetings is based on the senior leader’s determination that the attendance at such meeting is in the best interest of KP. Please refer to Appendix 1 regarding the authorization process for advisory board participation.

- Employees may not represent KP at supplier/vendor or other types of focus groups organized by suppliers/vendors or their representatives unless authorized. Participation in focus groups which discuss products or services used by KP is appropriate when the group is organized or authorized by KP.

- Employees may not accept free products from suppliers/vendors for distribution at community events.

- KP may enter into a formal relationship with a supplier/vendor to distribute discounted services to members and employees pursuant to an authorized, written agreement. Discounts from suppliers/vendors that are not subject to a formal KP agreement are prohibited.
Supplier/Vendor-Sponsored Travel

- Employees may not solicit or accept reimbursement from suppliers/vendors for admission, airfare, lodging, transportation costs to and from the airport, free or special discounted travel, or related expenses to attend product demonstrations, conferences or educational programs. However, the following exceptions may apply:
  - Travel and related expenses associated with training for a newly purchased or enhanced product is allowed. Product training travel arrangements must be made utilizing KP travel policies and submitted for reimbursement from the supplier/vendor.
  - Travel and related expenses paid by professional associations is acceptable when the employee is a presenter at a meeting or a voluntary member of the association’s governance (e.g. board or committee). The travel and related expenses must be disclosed to the employee’s supervisor prior to travel.
  - Travel and expenses paid by KP’s Group Purchasing Organization (GPO) to fund KP’s product sourcing and standards processes.

Supplier/Vendor-Provided Speakers’ Fees and Honoraria

- Employees may not accept and retain speakers’ fees or honoraria or anything else of value from a supplier/vendor for teaching or giving presentations, including payment for time, travel expenses, meals, entertainment, recreational activities, or social activities.
- Honoraria from educational institutions, training programs, professional associations, non-profit organizations, or government agencies may be accepted and retained, with prior written disclosure to the employee’s supervisor, if the presentation/lecture is not prepared or delivered on work time. If the presentation/lecture is prepared or delivered on work time, the employee may be required to remit such honoraria to KP.
- Written disclosure to the employee’s supervisor is required before accepting honoraria or speakers’ fees from outside groups when the presentation or subject matter is related to KP work or could be perceived as relating to KP work. When making presentations that could be perceived as relating to KP work, employees must explicitly state during the presentation that they are not speaking for, or acting on behalf of, KP.
Suppliers/Vendor-Sponsored Product and Services Provided Training

- Occasionally, employees require training about new products, drugs or procedures. These usually represent legitimate industry interactions and employees must ensure suppliers/vendors comply with the following:
  - The supplier/vendor representative works with Procurement and Supply and the appropriate department representative to notify them when education is required for a new product and provides an outline that includes the intent, scope, and timeline of the educational program.
  - Supplier/vendor representatives are not allowed direct contact with patients or their medical records nor are they allowed in any patient care area unless the vendor has completed the appropriate training, signed the necessary confidentiality forms, and the patient has authorized access, or unless the vendor has appropriately executed a Business Associate Agreement (BAA).

Employees’ Relationships with KP Suppliers/Vendors

- Prior to making any decision for the purchase of products or services, employees who have a direct role making such decisions must disclose to their supervisor or Compliance Officer, and in any Request For Exception Bid Process form submitted, any financial interest they or their immediate family have in suppliers/vendors of such products or services during the previous 24-month period. Such financial interests could include equity interest, employment, a paid consultancy, or other forms of compensated relationship. The employee’s supervisor or appropriate Compliance Officer will decide whether the individual must recuse him/herself from the purchasing decision. This provision excludes indirect ownership, such as stock held through mutual funds.
  - Employees may not serve as a member of a board of directors of a KP supplier/vendor.
  - Employees may not be a supplier/vendor to KP while employed by KP.
  - Employees may not also be employed by suppliers/vendors to conduct work for KP or at a KP facility.
  - Employees may not also be contractors to suppliers/vendors for contracts or assignments where the customer or the client is KP.
  - Employees who enter into a dating/sexual relationship, marriage engagement, domestic partnership, or business relationship, such as joint-ownership in an off-duty business venture with a supplier/vendor representative must notify their supervisor as soon as they become aware of the change in status of their relationship.
Compliance Communications to Supplier/Vendor Representatives

- Employees are required to communicate to supplier/vendor representatives that the supplier/vendor is required to comply with all applicable rules, regulations, policies, and procedures of KP as they exist now and as they may be amended from time to time, including, but not limited to, the KP Vendor Code of Conduct and all policies and procedures relating to ingress and egress to and from the premises, parking, confidentiality of patient information, safety, smoking, waste disposal, and infection control.

- Employees responsible for supplier/vendor visits who identify a supplier/vendor representative not adhering to the Supplier Representative Visitation policy are required to report this information to their supervisor, local Materials Manager, their Compliance Officer, or the Kaiser Permanente Compliance Hotline. Restriction, up to and including the removal of the representative from KP premises, is possible based upon the type of infraction or the number of re-occurring infractions of the policy.

Employee Training Regarding Potential Conflicts of Interest in Interactions with Suppliers/Vendors

- Employees receive compliance training regarding the need to avoid conflicts of interest in interactions with suppliers/vendors or prospective suppliers/vendors.

Consequences of Non-Compliance

- Failure to comply with the requirements of this policy may subject employees to corrective/disciplinary action, up to and including termination.
Appendix 1

Standards for KFHP/H Employees Regarding Participation on Advisory Boards of Suppliers, Vendors and Prospective Vendors

1.0 Introduction

This document provides standards to Kaiser Foundation Health Plan/Hospitals (KFHP/H) employees who have been invited to participate on Advisory Boards of current and prospective Kaiser Permanente (KP) Suppliers or Vendors.

2.0 Definitions

2.1 Conflicts of Interest arise when personal or financial interests influence professional judgment or decision-making.

2.2 Potential Conflict of Interest exists when personal or financial interests may, at some time in the future influence professional judgment or decision-making.

2.3 Procurement means all activities relating to the sourcing, contracting, leasing or purchasing of goods, services, equipment, property or supplies.

2.4 Prospective Supplier or Vendor includes any individual or organization that is under active consideration for a contract with Kaiser Permanente.

2.5 Supplier or Vendors include any individual or organization that offers to supply or sell products or services to Kaiser Permanente (KP), including consultants. Products and services include, but are not limited to, drugs, devices, equipment, biotech products, computer hardware, software, and supplies for purchase or inclusion in a formulary or Clinical Practice Guidelines.

2.6 Vendor Advisory Board is a formal group established by a supplier or vendor to solicit participant input into product enhancements, usage, best practices, or business strategy, etc.

3.0 Standards

3.1 Key Principles

Participation of KFHP/H employees on a Supplier/Vendor or Prospective Supplier or Vendor Advisory Board is permitted when these standards are followed (e.g. approval from a Senior Vice President and notice to NCO, see sections 3.4 and 3.5) and the benefits to KFHP/H exceed the potential risks to the organization’s reputation and procurement integrity. Benefits can include access to industry trends, gain of information to assist with strategic product decisions,
and the opportunity to influence product development in KP’s favor. Risks can include the appearance of a conflict of interest, an actual conflict of interest, perception of unfair perks, perception of inappropriate use of company time, inability to calculate costs for SOX compliance and perception of lavish gifts and entertainment at the expense of member dues.

3.1.1 Employees must adhere to other applicable policies of KFHP/H.

3.1.2 Procurement decisions must be made free of conflicts of interest. Participants serving on an Advisory Board of a unit and or KP Supplier/Vendor or a Prospective Supplier or Vendor may provide input into the procurement process but must recuse themselves from procurement decisions and disclose the conflict to the decision makers and their immediate manager.

3.2 Travel Expenses

3.2.1 Expenses for an employee’s participation must not be paid or reimbursed by the vendor or supplier. This includes, but is not limited to airfare, hotel accommodation, car rental/transportation between airport and meeting location and meals. The employee’s participation expenses are paid by his or her department or regional budget. Note: modest meals provided during a Vendor Advisory Board meeting to all meeting participants can be paid by the vendor. (National Procurement and Supply staff. Please see National Product Council’s Conflict of Interest policy for additional requirements.)

3.3 Gifts, Entertainment and Compensation

3.3.1 Employee or members of the employee’s family may not accept gifts or entertainment from the vendor which are not permitted by the Principles of Responsibility, Vendor Relationships policy or other policy.

3.3.2 The employee may not accept compensation or an honorarium in any form, including, but not limited to cash, cash equivalents, shares or options, for participation on an Advisory Board.

3.4 Approval by Regional President or National Leadership Team Member

3.4.1 Employee seeking approval to participate on an Advisory Board of a KP Supplier or Vendor or Prospective Supplier or Vendor must complete an exception form and obtain approval from a Regional President or a National Leadership Team member. (See Approval Form)
3.1.1 Approval must be renewed annually.

3.1.2 Certain KP organizations and functions may have additional policies, procedures and approvals required such as the National Product Council and National Procurement and Supply. It is the employee’s responsibility to obtain the additional approvals required to prior to participation on a Vendor Advisory Board.

3.2 Notifications

3.4.2 Employee must notify the National Compliance Ethics and Integrity Office (NCO) of approval to participate, and any changes in conditions under which the employee participates on the Advisory Board of a KP Supplier or Vendor or Prospective Supplier or Vendor.

3.4.3 Employee must disclose participation on an Advisory Board of a KP Supplier or Vendor or Prospective Supplier or Vendor in the Annual Conflicts of Interest Questionnaire.

3.5 Reporting

3.5.1 NCO provides a report to the National Leadership Team KFHP/H employee participation on Advisory Boards of KP Suppliers or Vendors or Prospective Supplier or Vendor annually.
Appendix 2
Approval Form

Employee Request for Participation on
Advisory Boards of Suppliers, Vendors and Prospective Vendors

Instructions: To request approval please complete the Approval Form and send completed Form to either your Regional President or National Leadership Team Member, as appropriate. Once you have received approval, please send notification of Approval to the following e-mail address: VendorAdvisoryBoardCompliance@kp.org

Name: 
Title: 
Email Address: (i.e., john.doe@kp.org)
Manager's Name: 
Manager's Email Address: 
Name of Vendor or Supplier: 

Please describe:

- The business of the supplier or vendor
- Kaiser Permanente’s current business relationship with the supplier or vendor, including KP annual spend
- Your role at KP including interaction with the supplier or vendor or its competitors
- The time and travel commitments required by your participation on the board
- The benefits to KP expected from your participation on the Advisory Board of this supplier or vendor
Check here if this is a request for renewal of previously approved exception.

I am requesting approval to join the Advisory Board of the KP supplier or vendor named above: I declare that the following statements are true.

Based on the description above, the benefit to KP from my participation on the Vendor Advisory Board exceeds the potential risks.

<table>
<thead>
<tr>
<th>Travel related Expenses including airfare and hotel to be paid by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Neither I nor any family member will receive compensation, gifts, entertainment etc. from the vendor.</td>
</tr>
<tr>
<td>□ I may give input into the procurement process but will recuse myself from purchasing decisions related to this company or its competitors.</td>
</tr>
<tr>
<td>□ Upon approval, I will notify the National Compliance, Ethics and Integrity Office (NCO). (see routing instructions below)</td>
</tr>
<tr>
<td>□ I will disclose this affiliation on my Annual Conflicts of Interest Questionnaire</td>
</tr>
</tbody>
</table>

Declaration: I have read the *Principles of Responsibility*, the Conflict of Interest Policy, National Vendor Relationships policy and the Standards for KFHP/H Employees Regarding Participation on Advisory Boards of Suppliers, Vendors and Prospective Vendors

Participation on Advisory Boards Standards. I hereby declare that I will abide by the conditions of approval of participation on the Vendor Advisory Board. I understand that this approval must be renewed annually, and will notify NCO of any changes to my participation on the Vendor Advisory Board.

**Sanctions:** In the event an employee does not receive approval for this request and fails to comply with the provisions of the Conflict of Interest Policy, the employee will be subject to disciplinary action, up to and including termination.

Response needed by: __________________________
Routing for Approval: Names and Dates

Regional President or National Leadership Team Member

Copy provided to VendorAdvisoryBoardComplianc@kp.org on Date
KFHP/H requires that procurement decisions be free of conflicts of interest. Participation on Advisory Boards is permitted on occasion when it may be in the best interest of KFHP/H to have an employee actively work with a supplier or vendor as part of an Advisory Board to ensure our members’ needs are met in the development of systems, products, or services. Further information can be found in Standards for KFHP/H Employees Regarding Participation on Advisory Boards of Suppliers, Vendors and Prospective Vendors.

**Participation on Supplier/Vendor Advisory Board Approval Process**

1. Benefits to KP must outweigh risks.
2. KP pays travel related expenses.
3. Employees and family members do not receive compensation, gifts, entertainment etc.
4. Recusal from purchasing decisions

**Note 1. Requirements**

Employee invited to participate on Advisory Board

Employee agrees to participation requirements? (1)

- Yes
  - Completes Exception Request Form
  - Regional President Or National Leadership Team Member Approval
  - Copy of approval to National Compliance Office (NCO)
  - Employee Participates on Supplier/Vendor Advisory Board
  - NCO Compiles Summary Reports to National Leadership Team (NLT)
  - Participation not appropriate

- No
  - Participation not appropriate

(1) Not applicable to employees in Purchasing and/or Finance roles.
Appendix 3
Vendor Relationships Policy Exception Process

1. While it is expected that employees follow the provisions of this policy, it is recognized that every interaction regarding suppliers/vendors cannot be anticipated. If a situation calls for special consideration, the exception process is contained in this appendix.

2. The exception process has been established to ensure unique situations are appropriately considered and monitored. Requests and responses must be in writing, and the National Compliance Office must be notified of approved exceptions.

3. The exception process should be used ONLY in the case that a situation appears to require an exception to the policy, and the situation is unique in a way that makes the benefits to Kaiser Permanente or its members outweigh the risks of non-adherence to the policy.

4. The process described is for exceptions only. Before applying for an exception, employees should seek assistance in interpretation of the policy is available as follows:
   a. Frequently Asked Questions on the National Policy Website.
   b. Your Local, Regional or National Department Compliance Office

5. When an exception is required, it must be approved by a Vice President. Exceptions requested by a Vice President must be approved by a Senior Vice President or Region President. Request for exception must be in writing and include ALL of the following:
   a. Statement of the situation
   b. Provision of the policy for which exception is requested
   c. Benefit to Kaiser Permanente
   d. Plan for management of potential conflicts of interest arising from the exception.

6. A Vice President, in deciding whether to approve the exception, must consider the best interests of the organization and members. The Vice President should consult the resources above to address questions.

7. Response to a request for an exception must be in writing. It must include whether or not an exception is approved. If an exception is approved, any oversight and management expectations must be in writing.

8. The employee requesting the exception is responsible for notifying the National Compliance Office of the approved exception. Notify the National Compliance Office of the approval by forwarding by e-mail the approval notification to VendorPolicyCompliance@kp.org.

9. NCO provides a report annually to the National Leadership Team of KFHP/H of approved exceptions to the policy.
POLICY
SCPMG and KFH will not require residents enrolled in its ACGME accredited GME programs to sign a non-competition guarantee.
STATEMENT
KPSC strives to provide administrative support for GME programs and residents subsequent to an event or series of events that cause significant interruption to the provision of patient care and thus alteration to the residency experience.

This policy applies to all KPSC ACGME-accredited residency programs, associated faculty, residents and staff.

DEFINITIONS
Disaster: a natural or man-made event that significantly disrupts the environment in which KPSC provides care.

Isolated internal disasters: Disaster that stresses the hospital’s infrastructure (such as via fire, flood, sustained power outage) without affecting outside community resources.

External disasters: Disasters (commercial building fires, plane crashes) generally leave hospital infrastructure intact and operational.

Regional disasters: Disasters (earthquakes) impact both the community and medical center; medical center may or may not be operational.

POLICY
- The DIO is responsible for maintaining communications between various program directors, the director of physician education, Medical Group leadership.
- Immediately following the disaster or interruption in patient care, each GME program affected will undertake all reasonable measures to ascertain the whereabouts of all residents and ensure their safety. Additional steps will be undertaken when residents have been injured or cannot be located.
- As soon as possible, the DIO/GME staff will gather information from facilities and programs regarding the extent of the damage and the impact of the disaster on short-term (days/weeks) and long-term (weeks/months) function of individual programs and/or sites of training.
- If possible, the IGMEC will hold an emergency meeting following the disaster to review the available information regarding the impact of the disaster on clinical operations and training programs. In some instances, extenuating circumstances surrounding these
events may dictate a need for immediate decisions and preliminary planning. If necessary, an Executive Committee of the IGMEC may be established to carry out continued assessments of the situation and make decisions regarding KPSC residency programs.

- Issues that may be reviewed, assessed or acted upon by said Executive Committee may include:
  - Patient safety
  - Safety of housestaff, faculty and staff
  - Supply of available housestaff and faculty for clinical and educational duties
  - Extent/impact of damage of physical plant/facilities
  - Extent/impact of damage to clinical technology and clinical information systems
  - Extent/impact of damage to communication technology (phones, pagers, inter/intranet)
  - Changes in volumes of patient activity in the short-and-long-term

- If the GME Executive Committee or IGMEC determine that a program, medical center or the institution cannot provide an adequate educational experience for a resident because of the disaster, both individual programs and the institution will work to:
  - Temporarily relocate a resident to a site of training within the institution or to a current local affiliate training site.
  - Arrange a temporary transfer for a resident to another program until the institution can provide an adequate educational experience for the resident. In so far as is possible at the time of the transfer, the program will inform the resident being transferred regarding the minimum duration of the transfer and anticipated total duration.
  - Assist the resident in a permanent transfer to another program.
  - Continue financial support in the event of the disaster depending upon short-and-long-term impact of each program and the institution as well. For the duration of time spent in temporary transfer, KPSC will continue to provide salary and benefits.

- The DIO will contact the ACGME as soon as possible to provide an update on the disaster and the initial steps taken by the institution and IGMEC.

- The DIO will continue to communicate with the ACGME regularly as needed to provide updates on any additional program or institutional issues and with regard to final plans to reconfigure any programs.
KPSC agrees to notify all residents of any adverse actions cited by the ACGME.

If the Institution decides to reduce the size or close a residency program, KPSC will notify the residents as early as possible and attempt to phase out the program over a period of time to allow residents currently in the program to finish training.

If this is not possible, KPSC and the program director will assist the residents in obtaining another accredited residency program position.
In the event that a resident transfers to a KPSC sponsored residency program from another residency program, the program director must receive written verification of previous educational experiences regarding the performance evaluation of the transferring resident prior to acceptance into a KPSC program. The written verification must be completed, signed and dated by the previous residency program director.

If a KPSC sponsored resident leaves the program prior to completion, the program director is responsible for providing a written summative performance evaluation of the resident’s educational experiences in a timely manner.
STATEMENT
KPSC residency program faculty members evaluate resident performance in a timely manner during and at the conclusion of each rotation, or similar educational assignment, and document this evaluation at the completion of the assignment.

DEFINITIONS
Formative Evaluation – Reviews resident performance for a specific rotation or educational assignment.
Summative Evaluation – Performed and provided upon completion of the residency program.

POLICY
Each program will:
- Provide objective assessments of competencies in patient care, medical knowledge, proactive-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.
- Use multiple evaluators (e.g., faculty, peers, patients, staff).
- Document progressive resident performance improvement appropriate to educational level.
- Provide each resident with a documented semiannual evaluation of performance with feedback.
- Complete formative evaluations, for which:
  o Program faculty will evaluate resident performance in a timely manner during and at the conclusion of each rotation or similar educational assignment.
  o Evaluations of resident performance will be accessible for review by the residents.
- Complete a summative evaluation, for which:
  o The program director will evaluate each resident upon completion of the program.
  o Evaluations will document the resident’s performance during the final period of education and verify that the resident has demonstrated sufficient competence to enter practice competently and without direct supervision.
- Residents are provided copies of the formative and/or summative evaluations upon request.
- Compliance with this policy will be assessed through the:
  o Annual KPSC Resident Survey
  o Annual ACGME resident survey
  o Mid-cycle internal review
POLICY

• At least annually, the program must evaluate faculty performance as it relates to the residency program.

• Evaluations include review of the faculty’s clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.

• Evaluations include at least annual confidential evaluations by the residents.

• Annual faculty evaluations are forwarded to the chief of service for incorporation into physician evaluation.

• Compliance with this policy will be assessed during the review of the Annual Program Evaluation (APE).
STATEMENT
The KPSC GME Program seeks to develop and maintain high caliber residency programs that provide an excellent educational experience and learning environment. Each program must document formal systematic evaluation of the curriculum at least annually.

POLICY
The program director must appoint the Program Evaluation Committee (PEC).

- The Program Evaluation Committee:
  - must be composed of at least two program faculty members and should include at least one resident;
  - must have a written description of its responsibilities; and,
  - should participate actively in:
    - planning, developing, implementing, and evaluating educational activities of the program;
    - reviewing and making recommendations for revision of competency-based curriculum goals and objectives;
    - addressing areas of non-compliance with ACGME standards; and,
    - reviewing the program annually using evaluations of faculty, residents, and others, as specified below.

The program, through the PEC, must document formal, systematic evaluation of the curriculum at least annually, and is responsible for rendering a written and Annual Program Evaluation (APE).

The program must monitor and track each of the following areas:
- resident performance;
- faculty development;
- graduate performance, including performance of program graduates on the certification examination;
- program quality; and,
  - Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and
  - The program must use the results of residents’ and faculty members’ assessments of the program together with other program evaluation results to improve the program.
• progress on the previous year’s action plan(s).

The PEC must prepare a written plan of action to document initiatives to improve performance in one or more of the areas listed above, as well as delineate how they will be measured and monitored.

• The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.
### COMMON PROGRAM REQUIREMENTS

**TITLE:**

Exception to Duty Hours

**POLICY**

The Institutional Graduate Medical Education Committee does not support, nor approve of requests for exceptions to Duty Hours.
INSTITUTIONAL POLICIES

TITLE: Institutional Residency Training & Program Letters of Agreements

EFFECTIVE DATE: 7/1/99
REVISION DATE: 7/1/11

STATEMENT
KPSC retains responsibility for ensuring appropriate execution of institutional and program agreements.

DEFINITIONS

Sponsoring Institution: The organization (or entity) that assumes the ultimate financial and academic responsibility for a program of GME. The sponsoring institution has the primary purpose of providing educational programs and/or health care services (e.g., a university, a medical school, a hospital, a school of public health, a health department, a public health agency, an organized health care delivery system, a medical examiners office, a consortium, an educational foundation).

Major Participating Institution: A Review Committee-approved site to which all residents in at least one program rotate for a required educational experience, and for which a master affiliation agreement must be in place. To be designated as a major participating site in a two-year program, all residents must spend at least four months in a single required rotation or a combination of required rotations across both years of the program. In programs of three years or longer, all residents must spend at least six months in a single required rotation or a combination of required rotations across all years of the program. The term “major participating site” does not apply to sites providing required rotations in one year programs.

Participating Institution: An organization providing educational experiences or educational assignments/rotations for residents/fellows. Examples of sites include: a university, a medical school, a teaching hospital which includes its ambulatory clinics and related facilities, a private medical practice or group practice, a nursing home, a school of public health, a health department, a federally qualified health center, a public health agency, an organized health care delivery system, a health maintenance organization (HMO), a medical examiners office, a consortium or an educational foundation.

Institutional Agreement (Master Affiliation Agreement): A written document that addresses GME responsibilities between a sponsoring institution and a major participating site.

Program Letter of Agreement (PLA): A written document that addresses GME responsibilities between an individual accredited program and a site other than the sponsoring institution at which residents receive a required part of their education.
Program Letters of Agreement:

- The program director will identify a learning opportunity or educational experience at a new participating institution and request that a proposal for a new participating site be placed on the IGMEC agenda for approval.
- Following IGMEC approval, the residency staff will generate a PLA.
- The PLA will:
  - Identify faculty who will assume both educational and supervisory responsibilities for residents.
  - Specify responsibilities for teaching, supervision, and formal evaluation of residents.
  - Specify the duration and content of the educational experience.
  - State the policies and procedures that will govern resident education during the assignment.
  - Assign responsibility for resident salary, benefits, and malpractice coverage.
  - Be forwarded to the supervising physician at the participating site for review, signature, and date.
  - Be signed and dated by the KPSC program director.
  - Be filed in the residency program’s administrative office upon completion.

Master Affiliation Agreement:

- An institutional residency training agreement needs to be executed for any regular, ongoing rotations to a participating institution.
- If it is determined that a Master Affiliation Agreement is required, the program director or his/her designee will contact the Director of Physician Education to pursue creation of the document.
- The Director will manage the development of the agreement, conferring with the designated attorney from Health Plan Legal Department as necessary.
- The Director will initiate the contract and, in collaboration with the DIO and the program director, negotiate the contract compensation terms.
- The Director will forward the contract to the participating institution for signature(s).
- The Director will obtain the signature(s) from the appropriate SCPMG and Kaiser Foundation Hospital/Health Plan (KFH/HP) leadership and distribute a copy to the participating site and to the appropriate medical center.
- The Director or his/her designee will track contract expiration dates, consult with the program director prior to renewing the contract, and renew if appropriate.
- Compliance with this policy will be monitored through the Internal Review process.
The following SCPMG guideline, “Permanente Professionalism” is applicable to KPSC residents and fellows.

STATEMENT

Permanente Professionalism
A physician commits to on-going professional development, commitment to ethical principles, and demonstration of sensitivity to patient’s culture and diversity. A physician exhibits the following behaviors: altruism, accountability, excellence, humanitarianism, respect for others, honor and integrity.

DEFINITIONS

Altruism – putting the best interests of the patient over self.

Accountability – to patients, society, and the profession.

Excellence – commits to life-long learning.

Humanitarianism – commitment to service.

Respect for Others – collaborates with patients, colleagues, and staff.

Honor and Integrity – exhibits the highest standards of behavior.

SCPMG physicians strive to exemplify Permanente Professionalism, Partnership and Values.
A Permanent physician demonstrates Professionalism by working in a manner that exhibits the highest level of ethics and accountability, humanitarianism, and the best interests of the patient, a constant yearning to maintain clinical excellence, and collaboration with colleagues and others on the health care team.

A Permanent physician demonstrates the principles of Partnership by adopting best practices, keeping current with SCPMG business initiatives, voting in partnership elections when eligible to vote, and actively advocating for the success of SCPMG.

A Permanent physician demonstrates the Southern California Kaiser Permanente values by exhibiting partnership, accountability and flexibility, embracing innovation, demonstrating integrity, contributing to our diverse workplace, and achieving the highest results in quality and service.
Physician Professional Responsibilities

Accountability expectations:
- Schedules patient according to departmental and Area expectations
- Takes ownership of all duties assigned to the physician, both clinical and administrative
- Meets commitments in a timely fashion
- Uses referrals and consults appropriately
- Maintains clinical competencies appropriate for work responsibilities
- Maintains licensure, certifications, and required education
- Uses benefits appropriately as indicated in the Partnership Agreement/Rules and Regulations (PAR&R) with proper documentation as required

Flexibility expectations:
- Adapts quickly to address the changing needs of patients, colleagues, department, and co-workers
- Adjusts goals and priorities based upon changing conditions
- Does everything he/she can to fulfill the unique needs of patients and colleagues
- Willing and able to change course of action when needed
- Successfully manages multiple priorities

Innovation expectations:
- Contributes to efficiency in the workplace
- Willing to participate in implementation of new approaches to care, such as pilot programs and other new programs
- Adopts new treatments and technologies once approved by SCPMG, if necessary
- Supports and advocates for organizational change whenever supported by substantial evidence
- Participates fully in the physician’s department quality improvement process
- Thinks creatively and develops new programs or supports colleagues who develop new programs
Integrity expectations:
• Acts truthfully, honestly and ethically, even in the most difficult situations, and has a reputation for always doing what is right
• Values and promotes open, candid, and courageous communications to constructively address issues and challenges
• Demonstrates professionalism through civic virtue and citizenship by behaving in a manner that is consistent with the Principles of Responsibility and compliant with the law and all internal policies and procedures
• Treats everyone equitably and fairly—able to be impartial when assessing a situation
• Accounts for and takes responsibility for errors
• Uses electronic assets and social media responsibly and in accord with internal policies

Partnership expectations:
• Contributes equitably to departmental duties (panel size, call, difficult cases)
• Extends self willingly, extra call, difficult cases
• Establishes rapport with colleagues and staff (cordially engages)
• Collaborates and “partners” with patients and is empowering
• Participates in departmental meetings and hospital committee meetings
• Meets productivity standards for department
• Participates in the business of SCPMG and Kaiser Permanente

Diversity expectations:
• Avoids judgmental or prejudiced behaviors
• Is culturally sensitive to the needs of the community
• Actively supports Culturally Responsive Care (CRC) for members

Quality expectations:
• Demonstrates technical ability
• Uses time and resources wisely
• Expresses self clearly
INSTITUTIONAL POLICIES

TITLE: Professionalism

EFFECTIVE DATE: 5/1/14

SERVICE EXPECTATIONS:

• Puts members’ needs first
• Treats patients and their families with respect and courtesy
• Treats staff and colleagues with respect and courtesy
• Facilitates hand-offs between providers
• Goes out of the way to help a member or colleague
• Understands the unique needs of the patient

RESULTS EXPECTATIONS:

• Meets and exceeds targets Region has set related to different performance metrics
• Participates in programs that help us to achieve the targets we have set
• Strives to meet access and utilization metrics by working with employees and staff to track and fill schedule
Please refer to the following Kaiser Permanente National H.R. Policy, “Religious Accommodation”

**STATEMENT**
Kaiser Permanente (KP) provides reasonable accommodation for an employee's or applicant's religious belief, observance or practice unless it would cause undue hardship for KP.

**PURPOSE**
The purpose of this policy is to provide religious accommodation in compliance with Title VII of the Civil Rights Act.

**SCOPE/Coverage**
This policy applies to all applicants and employees who are employed by any of the following entities (collectively referred to as “Kaiser Permanente”):
- Kaiser Foundation Hospitals and Kaiser Foundation Health Plan, Inc. (together, KFH/HP);
- KFH/HP’s subsidiaries;
- The Permanente Medical Group, Inc. (TPMG) [NOTE: This policy does not apply to physicians, podiatrists or Vice Presidents of TPMG, who are covered by separate TPMG policies]; and
- Southern California Permanente Medical Group (SCPMG) [NOTE: This policy does not apply to physicians of SCPMG].

**Definitions**
- **Religious Belief, Observance or Practice** is broadly defined to include moral or ethical beliefs as to what is right and wrong which are sincerely held by an individual with the strength of traditional religious views, and are more than merely secular beliefs or preferences.
- **Undue Hardship** under this policy is anything that would be more than a minimal cost or disruption to the employer or its operations, including loss of efficiency in business operations, burdens on other employees, and interference with workplace safety or bona fide seniority rights under a collective bargaining agreement. (Refer to the Addendum for specific state laws with more stringent or varying requirements.)
PROVISIONS

- When a request for religious accommodation is made, KP will engage in the interactive process with the individual to determine if the individual can be reasonably accommodated. The interactive process is a dialogue between the individual and the KP representative (e.g., manager, recruiter) to clarify the individual’s needs and identify the appropriate reasonable accommodation.

- Both KP and the employee/applicant have a duty to cooperate in good faith in the interactive process.

- KP is not required to implement the accommodation preferred by the employee if it offers an alternative accommodation that effectively eliminates the religious conflict.

- KP will reasonably accommodate a religious belief, observance or practice which does not pose an undue hardship. Examples of reasonable accommodation include, but are not limited to:
  - allowing religious dress and/or grooming practices
  - obtaining volunteers to substitute for a shift on a religious holiday or Sabbath
  - flexible scheduling
  - change of non-essential job duties
  - transfers to vacant positions

- Regional policies may address additional requirements for religious accommodation in accordance with applicable regulations (e.g., The Joint Commission) and state laws.

- If there is a question as to whether an accommodation is reasonable, it should be reviewed by Legal.
INSTITUTIONAL POLICIES

TITLE: Social Media

EFFECTIVE DATE: 11/1/13

PAGE: 1 of 5

Please refer to the following Kaiser Permanente National H.R. Policy, “Social Media Policy”

STATEMENT
Kaiser Permanente (KP) employees who choose to identify themselves as working at KP or access social media through KP-owned devices will use social media in a manner that is consistent with KP policy and the Principles of Responsibility, KP's Code of Conduct. Nothing contained in this policy or in the policies referenced herein is intended to prohibit communications concerning wages, benefits, or other terms and conditions of employment, or that otherwise are legally protected under the National Labor Relations Act or any other applicable law.

PURPOSE
Kaiser Permanente (KP) employees who choose to identify themselves as working at KP or access social media through KP-owned devices will use social media in a manner that is consistent with KP policy and the Principles of Responsibility, KP's Code of Conduct. Nothing contained in this policy or in the policies referenced herein is intended to prohibit communications concerning wages, benefits, or other terms and conditions of employment, or that otherwise are legally protected under the National Labor Relations Act or any other applicable law.

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- KFH/HP’s subsidiaries;
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- Southern California Permanente Medical Group (SCPMG) [NOTE: This policy does not apply to physicians of SCPMG].
DEFINITIONS

Confidential and Proprietary Information
Confidential and proprietary information includes any information that is not accessible to the public; gives KP a competitive advantage in doing business; or, if disclosed to a third party or the public could reasonably be expected to be harmful to KP members and patients. Examples of confidential and/or proprietary information for purposes of this policy include:

- Information KP is required by law to keep confidential, such as social security numbers and medical records;
- Privileged and/or protected quality and peer review records;
- Attorney-client privileged or attorney-work product materials;
- Legally protectable financial information such as performance data and forecasts;
- Legally protectable information concerning non-public business plans, strategies and techniques, research and development plans, data, objectives, and unreleased, draft or preliminary findings and conclusions;
- Product and technical information about software programs, discoveries and inventions, and product and service development, and trade secret information;
- Non-public information that employees are able to access solely due to the performance of their duties (such as information an HR professional might know because of access to confidential employee information); and
- Any of the information described in 4.1.1 through 4.1.7 as it relates to any KP vendors, contractors or consultants.

Note: Confidential information does not include information about wages, hours, benefits, and other terms and conditions of employment.

KP-Hosted Sites - A Social Media website or software that is owned and/or operated by Kaiser Permanente, e.g., @kpshare or the Center for Total Health blog. KP-hosted sites may reside on servers located at a KP data center or a third party data center or service provider.
### INSTITUTIONAL POLICIES

**TITLE:** Social Media

**EFFECTIVE DATE:** 1/7/14

**PAGE:** 3 of 5

**KP Assets** Can be both tangible (physical) and intangible (intellectual). Assets include equipment, (for example, cameras, ergonomic equipment), furniture, supplies, organization funds (including purchasing cards), electronic devices, voicemail and instant messages, e-mail, knowledge, information, buildings, identification cards, time, and media sites (including Kaiser Permanente’s Facebook pages and YouTube channels). See Electronic Asset Usage policy for more information.

**Protected Health Information (PHI)** - Individually identifiable health information that is transmitted by or maintained in electronic media, or is transmitted or maintained in any other form or medium. PHI excludes some specific individually identifiable health information. See Appendix: Glossary of Social Media Policy Terms for full definition of PHI.

**Social Media** – Any KP or publicly available website or software that enables users to post, send, receive or otherwise share information of any type with other users. This includes but is not limited to blogs, podcasts, discussion forums, online collaborative information and publishing systems that are accessible to internal and external audiences (i.e., Wikis), microblogs such as Twitter and Yammer, RSS feeds, video and audio sharing, consumer ranking sites such as Yelp, and social networks such as Facebook and LinkedIn. See Appendix: Glossary of Social Media Policy Terms.

### PROVISIONS

#### Using Social Media.
- KP employees are required to comply with this policy when:
  - Using social media on KP electronic systems or using KP hosted social media tools;
  - When using social media during working time; and/or
  - Anytime a KP employee identifies him or herself as a KP employee and uses personal social media tools to share content related to KP.
• **Comply with Legal Obligations.** To protect employees and KP, it is critical that employees respect the laws governing copyright and fair use of copyrighted material owned by others, including KP’s own copyrights, as well as any other laws governing online activities. Employees should not make knowingly untruthful statements about competitors (or their products). Laws may be different depending on where the employee works and lives.

• **Adhere to KP Policies and Compliance Requirements.** All the rules and KP policies that apply to other KP communications apply to Social Media communications. Employees are expected to comply with all other KP policies, and the Principles of Responsibility. Employees may not post any material about KP or KP members and patients, contractors or suppliers, or other KP employees in a manner that reasonably could be viewed as obscene, threatening, or intimidating, or that violates KP’s workplace policies against discrimination, harassment, retaliation, illegal activity, and/or threats of violence. Employees should make sure that participation in Social Media does not interfere with their job performance.

• **Maintain Honesty and Accuracy.** Employees should be complete, honest and accurate when posting information on Social Media, and must not post anything they know to be false about KP, KP members, patients, contractors, suppliers, or other KP employees.

**Prohibited Social Media Use.**

• **Member and Patient Confidentiality.** Employees may not use or disclose PHI of any kind, including photographs and any other unique identifiers of any KP member or patient, on any Social Media without the express written permission of the affected member or patient. Even if an individual is not identified by name, if there is a reasonable basis to believe that the member or patient could still be identified from that information, then its use or disclosure could violate the Health Insurance Portability and Accountability Act (HIPAA) and KP policy.

• **Confidential and Proprietary Information.** Employees may not use or disclose any Confidential and Proprietary Information, as defined in Section 4.1, in any Social Media.

• **Personal Opinions.** KP employees may not represent themselves as a spokesperson for KP without express authorization from Brand Communication to do so. Employees may not represent that they are communicating the views of KP, or do anything that might reasonably create the impression that they are communicating on behalf of or as a representative of KP. To prevent creating the wrong impression, it is best to include a disclaimer that the statements made are not the opinions of KP.
Accessing Social Media on KP-Hosted Sites or through KP Assets.

- **No Expectation of Privacy.** Employees should use KP electronic systems, and KP-hosted Social Media tools, with the understanding that all content, including personal messages, is subject to being read or heard by KP, and employees should have no expectation of privacy, whether password protected or not, to the extent permitted by applicable law. Managers should keep in mind that their direct or indirect reports may read anything shared through Social Media.

- **Obtain Pre-approval before Setting up KP-hosted Sites.** Employees must seek approval from the appropriate KP national, regional or Permanente Medical Group communications department before setting up a KP-hosted site or other Social Media content created to communicate information about KP.

- **Follow the Rules of KP-Hosted Sites.** Employees are expected to follow the Terms & Conditions and rules of participation applicable to Social Media sites.

- **Disclosure of Personal Social Media Passwords.** No employee may require that a co-worker or subordinate allow him/her access to, or provide a password for, a personal Social Media account. This does not include KP-Hosted sites.
Southern California Graduate Medical Education Social Media Accounts

- Administrators of social media accounts representing KPSC are required to complete the following KP Learn courses prior to creating accounts.
  
  Social Media 101-Part1
  Social Media 101-Part2
  Social Media Training Quiz*

  *Certification of completion must be submitted with handle/page information.

- Upon creating Twitter and/or Facebook pages, administrators must e-mail a copy of certification of KP Social Media Training Quiz completion to the Residency Administration and Recruitment department at socal.residency@kp.org.

- Public Affairs reviews handles/pages for compliance, recommendations (if needed) and approval.
The purpose of this policy is to comply with the California Medical Board and ACGME licensing requirements.

This policy applies to all KPSC residents and fellows.

A resident who:
- Graduated from a U.S./Canadian medical school must obtain licensure from the Medical Board of California or, if applicable, from the Osteopathic Medical Board of California prior to beginning his/her 25th month of an ACGME accredited training program.
- Graduated from an International medical school must obtain licensure from the Medical Board of California prior to his/her 37th month of ACGME accredited training program.

Fellows and resident transfers who hold out-of-state licenses must possess a California Medical License prior to starting fellowship training.

Failure to obtain or maintain required licensure by said deadlines will result in a 30-day unpaid suspension. Failure to obtain license within the 30-day unpaid suspension will result in termination. Resident/Fellow may be eligible for rehire when license is obtained should the position still be available.

The licensing requirements stated above are automatically revised if necessary to comply with applicable laws or regulations.
In an effort to be compliant with all organizational policies and procedures regarding expense reporting and reimbursement and be good stewards of organizational funds, all residents, faculty members and staff are required to submit reports according to the guidelines and requirements listed below.

For residents, some expenses are covered by the regional or program non-payroll budget. These items include:
- USMLE 3 taken prior to December 1 of the R2 year (must be taken by this date in order to be eligible for reimbursement).
- CML application
- CML
- DEA

These items are not attributed to the resident’s individual education stipend. However they are prepaid by the resident and submitted for reimbursement. They are subject to the guidelines below.

Items appropriate for the educational stipends ($500/year; $1500 in senior/final year of residency or fellowship program):
- Costs for obtaining medical school transcripts/FedEx fees for mailing documents
- Mini/iPad
- Educational Software
- Appropriate books
- Equipment (i.e., stethoscope)
- Travel to approved conferences
- Board review course
- Board examination application fee

How to get reimbursed:

Expense incurred by a credit card charge must be paid by a card issued in the name of the resident or faculty member (do not use a parent’s or spouse’s card).

Expenses must be processed within 30 days.
All air, hotel and car rental reservations must be booked through the KP Travel Service. Exception: If attending a conference and the room is booked at the conference hotel. Note: Reimbursement can be denied for reservations not booked through the KP Travel Service.

All expenses must be accompanied by a receipt regardless of amount. Detailed, itemized receipts are required for all meals, including those from room service. Restaurants and hotels generally will provide receipts after departure if the receipt is lost or forgotten. If a receipt is not attainable, a Lost Receipt form must be submitted that includes a brief explanation of the cost. The form is signed by a manager prior to submission of and accompanies the expense report. Credit care statements alone are not sufficient proof of expense payment. The resident must have a receipt from the vendor/hotel/restaurant.

**Meal Expenses:**
KP employees and Permanente physicians may be reimbursed for travel meal expenses based on the following limits:
- Breakfast: $20
- Lunch: $30
- Dinner: $50

These amounts are inclusive of tax and gratuity.

If alcoholic beverages are consumed, the costs must be assumed by the individual. If a meal is consumed with another KP colleague and paid on one check, the individual submitting the expense must include the name(s) of the other individual(s).

Costs of snacks or drinks not consumed as part of a meal are the responsibility of the individual. Examples of this include coffees, sweets, granola bars purchased in airports.

**Car Rental:**
Rental may be approved when such travel is more cost-effective than air or rail travel. A care may be rented at the destination when it is comparable to other modes of transportation, such as taxi. Rental insurance must be declined as KP is self-insured for auto insurance. Every effort must be made to refuel the rental car before returning to the agency.
Mileage:
If a work-related trip begins and ends at the individual’s residence, mileage should be claimed only in excess of the usual commute mileage. A MapQuest or Google Maps document verifying the driving distance (minus commute) must accompany the expense report. Resident rotations to sites external to the home program are considered to be part of the regular work location, so are not applicable for mileage reimbursement.

Celebrations:
Expenses for program or department celebrations, such as birthdays, going-away, wedding/baby showers are not reimbursable. These costs must be absorbed by the participants.
POLICY
SECTION: Regional Certification Policy

TITLE: Advanced Cardiac Life Support (ACLS)
       Basic Life Support (BLS)

EFFECTIVE DATE: 7/1/13

PAGE: 1 of 1

STATEMENT
In accordance with Kaiser Permanente’s National License, Certification and Registration Verification Policy, Kaiser Permanente Southern California (KPSC) residents are required to provide current verification of Basic Life Support (BLS), Advanced Cardiac Life Support (ACLS) from the American Heart Association (AHA).

POLICY
• KPSC shall only accept current BLS and/or ACLS certification cards issued by the AHA.
• Certification cards issued by private agencies or online will not be accepted.
• This policy is applicable to all KPSC residents, fellows and affiliates.
  o Affiliates are required to provide and maintain AHA-issued BLS certification.
  o KPSC residents/fellows in specialities requiring ACLS certification must provide and maintain AHA-issued ACLS certification.
• Only original AHA certification cards shall be accepted.
• Evidence of current certification must be maintained in residents/fellows/affiliates files.
• Residents, fellows and affiliates are responsible for maintaining current certification.
• Resident/Fellow/Affiliate whom fails to maintain certification will be subject to corrective/disciplinary action, up to and including termination.

REFERENCE
Kaiser Permanente License, Certification, and Registration Verification NATL.HR.010