

KAISER PERMANENTE SOUTHERN CALIFORNIA



GME RESIDENT POLICY & PROCEDURE MANUAL 2021-2022

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Kaiser Permanente Southern California GME Resident Policy and Procedure Manual

Kaiser Permanente Mission:

Kaiser Permanente exists to provide high-quality, affordable health care services and to improve the health of our members and the communities we serve

Kaiser Permanente Vision:

We are trusted partners in total health, collaborating with people to help them thrive, and creating communities that are among the healthiest in the nation.

Kaiser Permanente Southern California GME Mission:

To provide world-class education, built on the principles of Permanente Medicine, to prepare new physicians to care, to learn, to lead, and to improve the health of their patients and the communities they will serve.

RESIDENT/FELLOW ELIGIBILITY AND SELECTION

Resident Selection

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:
 - Satisfactory Dean's Evaluation;
 - USMLE Part I and Part II scores;
 - Passing grades in medical school; Recommendation from medical school faculty;
 - Assessment of KPSC residency program compatibility from personal statement (suitable applicants are scheduled for interview with program director, faculty, and current residents).

RESIDENT/FELLOW ELIGIBILITY AND SELECTION

Resident Selection

- 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.

RESIDENT/FELLOW ELIGIBILITY AND SELECTION

Resident Recruitment and Eligibility

STATEMENT

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
- IMGs (International Medical Graduates) must submit an ECFMG (Educational Commission for Foreign Medical Graduates) status report at the time of application.

RESIDENT/FELLOW ELIGIBILITY AND SELECTION

Resident Appointment and Promotion

POLICY

- 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.

RESIDENT/FELLOW ELIGIBILITY AND SELECTION

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.

RESIDENT/FELLOW BENEFITS AND REIMBURSEMENT

Resident Salary and Benefits Overview

STATEMENT

Kaiser Permanente Southern California (KPSC) residents and fellows within Kaiser Permanente-sponsored, ACGME-accredited programs are eligible for the following:

Coats

Provided at no expense.

Counseling and Support Services

Residents and fellows will have access to the same confidential counseling and employee assistance program that it provides for the SCPMG physicians. Residents and fellows may seek services from providers within the Medical Group or they may alternatively seek service from external providers using their health plan benefits. Residents and fellows suspected of substance abuse problems are referred to the appropriate counseling program(s) for physician impairment.

Educational and Professional Expense Reimbursement Program

Residents and fellows are eligible to receive a reimbursement for various educational and professional expenses. Please refer to the “Educational and Professional Expense Reimbursement Program” policy for details. In addition, tuition reimbursement may also be available through the KP Tuition Reimbursement Program.

Holidays

Six paid holidays per year: New Year’s Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, and Christmas Day.

Housing Stipend

Based on the locality-specific cost-of-rental data, annualized amounts are per medical center:

Medical Center	2021-2022 Full Academic Year Amount (received in biweekly pay)
Los Angeles	\$10,000
Orange County	\$8,000
Riverside	\$6,000
San Bernardino County	\$6,000
San Diego	\$8,000
Woodland Hills	\$8,000

Meals

A meal allowance is provided depending on program and required rotations at KPSC medical centers.

Medical and Dental

For detailed information regarding medical, dental, life insurance, and other applicable benefits please refer to MyHR.

RESIDENT/FELLOW BENEFITS AND REIMBURSEMENT

Resident Salary and Benefits Overview

Mileage

Mileage to and from core rotations and required community rotations will be paid (for mileage above regular commute to and from personal residence and work).

Moonlighting

Moonlighting within KPSC requires prior written approval from Program Director. Moonlighting outside of KPSC requires prior written approval of the Program Director, required medical licensure, and professional malpractice liability coverage (which will not be provided by KPSC).

Parking

Provided at no expense for self-parking, unless self-parking is not available, within residency and fellowship training curriculum.

Professional Malpractice Liability Coverage

Professional malpractice liability coverage is provided by KPSC for all authorized activities performed within the course and scope of the Program at KPSC and assigned rotations within the state of California.

Salary

The salary structure for the 2021-2022 academic year is as follows:

PGY-1	\$61,605
PGY-2	\$63,647
PGY-3	\$67,367
PGY-4	\$70,282
PGY-5	\$74,129
PGY-6	\$77,614
PGY-7	\$81,430
PGY-8	\$81,430

Sleeping Rooms

Private rooms are provided when on call.

Vacation

Three weeks of paid vacation per year. One additional week of educational time may be available, per program approval.

RESIDENT/FELLOW BENEFITS AND REIMBURSEMENT

Resident & Fellow Leave Benefits

POLICY

- Resident/fellows 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. Resident/fellows 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, as per the ACGME requirement and the specialty specific board requirement.
- When desired leave exceeds a specified amount of time, the resident/fellow will need to notify the residency program director for an extension of residency training to meet the criteria for successful completion of the residency program.

DEFINED LEAVES

Family Leave (FMLA): After 12 months of employment with KP and at least 1,250 hours worked, residents/fellows are eligible for up to 12 weeks per year either to:

- Birth or care of resident/fellow's child within the first year of birth
- Care of an adoptive or foster child within the first year of placement with resident/fellow
- Care of a child, parent, or spouse who has a serious health condition; and/or
- Resident/fellow's own serious health condition

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.

Holidays: KP observes the following holidays: New Years Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day & Christmas Day.

Vacation: Three weeks of paid vacation per year. One additional week of educational time may be available, per program approval.

Jury Duty: Kaiser Permanente provides paid leave.

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

RESIDENT/FELLOW BENEFITS AND REIMBURSEMENT

Educational and Professional Expense Reimbursement Program

STATEMENT

The following is the policy supporting the 2020-2021 enhanced Educational and Professional Expense Reimbursement Program. This policy replaces all prior educational stipend programs.

All PGY Levels:

- BLS, ACLS, PALS, NRP as required by program
- ATLS, FLS, FES, FUSE, Fluoro or other required certification expense incurred during training
- Annual In-Training Exam as required by specialty
- One time: specialty-required equipment as determined by PD and DIO not to exceed \$1500 during the trainee's entire tenure with KPSC GME (see Exhibit 2)
- One time: specialty-required travel to meet ACGME requirements as determined by PD and DIO
- Resident membership in up to two professional specialty societies as determined by PD and DIO
- Study materials, not to exceed \$500 per academic year (see Exhibit 1)
- Up to twice per academic year: pre-approved conference registration and travel expenses within the USA to present for Scholarly Activity (must conform with KP expense guidelines and travel policy)
- Kaiser Permanente branded, personalized jacket (one time – provided by KPSC GME)

Final Year of Training (PGY-3 or higher):

- Actual, single ABMS Board Examination fee incurred during final year of training, not to exceed \$2000

PGY-1:

- Actual USMLE Step 3 or COMLEX-USA Level 3 exam fee
- Postgraduate Training License application fee; and ancillary costs of applying including transcript fee. LiveScan and notary fee will be reimbursed if not provided by KPSC GME

PGY-2:

- DEA Certificate fee

PGY-3:

- As per "All PGY Levels" and/or "Final Year of Training", as appropriate
- For graduating residents who hold a current PTL: California Physician and Surgeon License Fee (Price is discounted from Medical Board while in residency program)

PGY-4 (Including Community Medicine Fellows and PGY-4 Chief Residents):

- California Physician and Surgeon License fee

PGY-5:

- DEA Certificate Renewal fee

RESIDENT/FELLOW BENEFITS AND REIMBURSEMENT

Educational and Professional Expense Reimbursement Program

PGY-6 & 8:

- California Physician and Surgeon License Renewal fee

Exhibit 1: Study materials not to exceed \$500 per academic year:

- Textbooks specific to specialty
- Educational software specific to specialty, or to support scholarly activity (e.g., Statistics)
- Exam prep materials for USMLE Step 3 or COMLEX Level 3
- Exam prep materials for required certifications specific to the specialty
- Exam prep materials for Board certification (may include legitimate question banks or pre-tests)
- Does not include hardware of any kind such as tablets, computers or smartphones
- Does not include general-purpose books, software or other generic materials
- Does not include other attire such as masks, personal scrubs, personal lab coats, shoes or hats

Exhibit 2: Necessary Professional Equipment and Specialty-Required Equipment (as approved in advance not to exceed \$1500 total per trainee during KP Tenure):

- Protective goggles or face shield (one time, non-prescription, not to exceed \$100)
- Stethoscope (one time, not to exceed \$200)
- Dermatoscope (one time, limited to Dermatology)
- Ophthalmoscope (one time, limited to Neurology)
- Surgical telescopes or loupes (one time, limited to General Surgery and Urology)
- Lead apron and lead goggles (one time, limited to IR, Cardiology/IC/CCEP)

RESIDENT/FELLOW LEARNING AND WORK ENVIRONMENT

Resident Education and Work Environment

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:

- Ensuring overall resident/fellow wellness that include mental, physical and emotional well-being
- 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.

- 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 time

RESIDENT/FELLOW LEARNING AND WORK ENVIRONMENT

Disciplinary Process

STATEMENT

KPSC residency programs support an environment for faculty to provide residents with the opportunity to improve performance within an established, stepwise 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.

Step 1: Formal verbal warning with documentation

- A number of reports (usually emails) have been received by the PD regarding poor behavior 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 with 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
- Resident and PD sign plan
- Progress reviewed on specified dates
- Satisfactory remediation is documented, and plan removed from residents 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 representation, and DIO review and approve plan
- Plan specifies behavioral targets, completion dates, and faculty member
- Resident, PD, HR representative and GME Director meet with resident
- Resident is informed that lack of successful completion will result in te

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- Progress reviewed on specified dates
- Satisfactory remediation documented and resident removed from probation



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- 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/FELLOW LEARNING AND WORK ENVIRONMENT

Resident Professional and Academic Grievance Process

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.

RESIDENT/FELLOW LEARNING AND WORK ENVIRONMENT

Resident Professional and Academic Grievance Process

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:**
 - 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.
 - 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.

RESIDENT/FELLOW LEARNING AND WORK ENVIRONMENT

Resident Professional and Academic Grievance Process

- 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.
 - 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.
 - 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.
 - 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.

RESIDENT/FELLOW LEARNING AND WORK ENVIRONMENT

Resident Professional and Academic Grievance Process

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

RESIDENT/FELLOW LEARNING AND WORK ENVIRONMENT

Resident Professional and Academic Grievance Process

- **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.

RESIDENT/FELLOW LEARNING AND WORK ENVIRONMENT

Resident Grievance and Problem Solving

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.

RESIDENT/FELLOW LEARNING AND WORK ENVIRONMENT

Resident Professional and Academic Grievance Process

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.

RESIDENT/FELLOW LEARNING AND WORK ENVIRONMENT

Work Hours and On-Call Activities

STATEMENT

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

Work Hours- All clinical and academic activities related to the program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities, such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.

POLICY

- Each program develops and adopts the work hour policies for its specialty in accordance to ACGME requirements.
- Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting.
- Residents/fellows will have eight hours off between scheduled clinical work and education periods.
 - Residents/fellows who choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education must be within the context of the 80-hour and the one-day-off-in-seven requirements.
- Residents will have at least 14 hours free of clinical work and education after 24 hours of in-house call.
- Residents scheduled for in-house call will not be schedule more frequently than every third night (when averaged over a four-week period)
- Residents will be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-home call will not be assigned on these free days.
- Clinical and educational work periods for residents will not exceed 24 hours of continuous scheduled clinical assignments.
 - Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education. Additional patient care responsibilities will not be assigned to a resident during this time.

In rare circumstances, after handing off all other responsibilities, a resident/fellow, on their own initiative, may elect to remain or return to the clinical site in the following circumstances (listed below). These additional hours of care or education will be counted toward the 80-hour weekly limit.

- to continue to provide care to a single severely ill or unstable patient;
- humanistic attention to the needs of a patient or family; or,
- to attend unique educational events

RESIDENT/FELLOW LEARNING AND WORK ENVIRONMENT

Work Hours and On-Call Activities

Under such circumstances, the resident/fellow will:

- Document reasons for remaining and submit to program director
- Program director will review such submissions and track individual and program episodes.

At-Home Call

- Time spent on patient care activities by residents on at-home call must count toward the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every-third night limitation but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks.
- Residents are permitted to return to the hospital while on at home call to provide direct care for new or established patients. These hours of inpatient patient care must be included in the 80-hour maximum weekly limit.

Reporting Work Hours and Violation

- All residents will report duty hours on a regular basis depending on program-specific Requirements, but no less frequently than every 10 business days.
- Work 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 Work 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 Work Hour Policy with the resident and communicated that another infraction of noncompliance with regard to work hours will be in violation of the ACGME's Professionalism competency and will lead to formal remediation.
- Work hours issues are addressed by the Program Director and/or the DIO.
- Work hours are further monitored through the annual ACGME resident survey, the annual Institutional Resident Survey, the Internal Review Process, and/or local Graduate Medical Education Committee's (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 10 business 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.

RESIDENT/FELLOW LEARNING AND WORK ENVIRONMENT

Work Hours and On-Call Activities

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.

Exception to Duty Hours: The Institutional Graduate Medical Education Committee (IGMEC) does not support, nor approve of requests for exceptions to Work Hours.

RESIDENT/FELLOW LEARNING AND WORK ENVIRONMENT

Moonlighting

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

- Internal moonlighting (PGY-3 and higher) require will a Post Training License (PTL), an active DEA certificate and Program Director (PD) approval.
- External moonlighting will require a full California medical license, a DEA certificate and PD approval.
- 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 objectives of the educational program and must not interfere with the resident's fitness for work nor compromise patient safety.
- Moonlighting both internal and external is counted toward the 80- hour weekly work hours limit.
- Moonlighting must not overlap between time when GME duty is expected (between the hours of 8-5 on weekdays) with simultaneous pay for moonlighting.
- PDs 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 PD that is placed in the resident's file. Permission to moonlight will be granted at the sole discretion of the PD.
 - 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 PD, the DIO, and/or the Director of Graduate Medical Education.
- Moonlighting is monitored through the Internal Review Process, the ACGME resident survey, and/or local GMEC.



RESIDENT/FELLOW LEARNING AND WORK ENVIRONMENT
Residency Restrictive Covenants

POLICY

SCPMG and KFH will not require residents enrolled in its ACGME accredited GME programs to sign a non-competition guarantee.

RESIDENT/FELLOW LEARNING AND WORK ENVIRONMENT

Residency Closures and Reductions

POLICY

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.

RESIDENT/FELLOW LEARNING AND WORK ENVIRONMENT

Supervision of Resident

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 resident documentation based on PGY level according to the Accreditation Council for Graduate Medical Education (ACGME).
- 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:
 - Direct Supervision
 - Physical presence of the faculty member.
 - Presence of a fellow or senior resident.
 - Indirect Supervision
 - Immediate availability of supervising faculty or senior resident, either within the institution or via telephone.

COMMON PROGRAM REQUIREMENTS

Resident Transfer

POLICY

In the event 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.

COMMON PROGRAM REQUIREMENTS

Transition of Care

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 cover 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.

COMMON PROGRAM REQUIREMENTS

Transition of Care

- 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 issue
- 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

COMMON PROGRAM REQUIREMENTS

Resident Evaluation

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:
 - Program faculty will evaluate resident performance in a timely manner during and at the conclusion of each rotation or similar educational assignment.
 - Evaluations of resident performance will be accessible for review by the residents.
- Complete a summative evaluation, for which:
 - The program director will evaluate each resident upon completion of the program.
 - 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:
 - Annual KPSC Resident Survey
 - Annual ACGME resident survey
 - Mid-cycle internal review

COMMON PROGRAM REQUIREMENTS

Faculty Evaluation

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).

COMMON PROGRAM REQUIREMENTS

Program Evaluation and Improvement

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
 - 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:
 - Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually
 - 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.

INSTITUTIONAL POLICIES

GME Disaster Policy

APPLICABILITY

This policy applies to all Kaiser Permanente Southern California (KPSC) Accreditation Council for Graduate Medical Education (ACGME)-accredited residency and fellowship programs, associated faculty, residents and fellows (collectively, trainees) and staff.

STATEMENT

KPSC will continue to provide administrative and educational support for Graduate Medical Education (GME) programs and trainees following an event or series of events that cause significant interruption to the provision of patient care and disruption of the clinical learning environment. Safety of patients, members, trainees, faculty and staff shall be the first priority. Other key priorities will include continuity of education, compliance with ACGME and other regulatory requirements, continuity of clinical operations, and timely completion of training.

DEFINITIONS

Disaster: A natural or human-caused event that significantly disrupts the clinical learning environment in which KPSC provides care and education.

Isolated Internal Disasters: Disasters that stress hospital infrastructure (such as local fire, flood, sustained power or water outage) without affecting outside community resources.

External Disasters: Disasters (commercial building fires, plane crashes) that generally leave hospital infrastructure intact and operational. May disrupt transportation or communications.

Regional Disasters: Disasters (earthquakes) that impact both the community and medical center; hospital may or may not be operational. Possible declaration of disaster by government.

National Disasters: Disasters (pandemic, warfare) that cause widespread impact and disruption; medical center may or may not be operational. Possible declaration of disaster by government.

POLICY

- The Designated Institutional Official (DIO) is responsible for maintaining effective communications among program directors and faculty physicians, the Regional Director of GME, GME staff, affiliate institutions, Southern California Permanente Group
- Immediately following the disaster or interruption in patient care, each affected GME program will undertake all reasonable measures to ascertain the whereabouts of all residents and fellows and ensure their safety. Additional steps will be undertaken when residents and fellows have been injured or quarantined, rendered unable to travel, or cannot be located. Programs will report their status to the DIO and Regional Director of GME as soon as possible and will provide periodic updates.
- As soon as possible, the DIO and Regional Director of GME 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.

INSTITUTIONAL POLICIES

GME Disaster Policy

If feasible, the Institutional Graduate Medical Education Committee (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 and make decisions. In some instances, circumstances surrounding these events may dictate a need for immediate decisions and preliminary planning by the DIO and Regional Director of GME. If necessary, the Rapid Response Subcommittee of IGMEC may be convened to carry out assessments of the situation and make or ratify decisions regarding KPSC residency programs.

- Factors that may be reviewed, assessed or acted upon may include:
 - Safety of patients, trainees, faculty and staff
 - Trainees and faculty available 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, computers, inter/intranet)
 - Changes in volumes of patient activity in the short-and-long-term

- If the Rapid Response Subcommittee or full IGMEC determine that a program, medical center or the institution cannot provide an adequate educational experience for trainees because of the disaster, both the individual program(s) and the institution will take steps to:
 - Temporarily facilitate clinical and educational activity by trainees from remote sites using electronic and telephonic means of communication. Residents and fellows will be subject to recall to a clinical site at the discretion of the Program Director and DIO.
 - Temporarily relocate residents or fellows to an alternate site of training within KPSC or to a current local affiliate training site.
 - Arrange temporary transfer for residents or fellows to another KP-sponsored program or an external program until the institution can provide an adequate educational experience. Insofar as is possible at the time of the transfer, the Program Director will inform any trainee being transferred regarding the minimum duration of the transfer and anticipated total duration. This information will be updated and communicated to any affected trainee by the Program Director.
 - Assist residents or fellows in a permanent transfer to another program if necessary.
 - Continue financial support in the event of the disaster depending upon short-and-long-term impact to each program and the institution. For the duration of temporary transfer or as directed by ACGME requirements, KPSC will continue to provide salary and benefits.

- The DIO will contact the ACGME Institutional Review Committee as soon as possible to provide information about the disaster and the response by the institution and IGMEC.

INSTITUTIONAL POLICIES

GME Disaster Policy

- The DIO will serve as the primary institutional contact between KPSC and the ACGME Institutional Review Committee regarding disaster plan implementation and reporting requirements for the Sponsoring Institution; and for liaison with DIOs, program leaders and deans at external sponsoring institutions and medical schools.
- In the event of a disaster affecting other Sponsoring Institutions of GME programs, the Program Directors, GME staff and Regional Director of GME will work collaboratively with the KPSC DIO, who will coordinate on behalf of KPSC the possible acceptance of temporary or permanent transfers of trainees from other institutions. Such coordination will include requesting complement increases with the ACGME as required to accept additional trainees.
- Workforce stoppages or shortages during a strike may interfere with the clinical learning environment for medical students, affiliate resident rotators, residents, and fellows. Residents, fellows, affiliate resident rotators or medical students should not be expected to fulfill functions that normally would be performed by workers who are on strike.
- KPSC Program Directors and Site Directors will approve and initiate all learner rotation changes and ensure such changes are updated by GME staff in KPSC's electronic residency management system. Such changes, if major, will be approved by the DIO and ratified by IGMEC.
- KPSC Program Directors and Site Directors will clarify any changes to resident rotation goals and objectives, supervision, and other areas required in a clinical learning environment.
- KPSC trainees will continue to receive salary and benefits during a work stoppage or disaster. ACGME Program Requirements, including limits on clinical and educational hours, will be observed.

Programs will be responsible for establishing procedures to protect the academic and personnel files of all residents and fellows from loss or destruction by disaster. This will include a plan for storage of backup computerized data in a separate geographic location away from the program site.

INSTITUTIONAL POLICIES

Regional Certification Policy

PURPOSE:

To identify resident and fellow physicians, including employees of Kaiser Foundation Hospitals, Inc. (“trainees”) as well as those rotating from affiliated institutions (collectively, “affiliate trainees”) who are required to maintain American Heart Association (AHA) Advanced Cardiac Life Support (ACLS), Basic Life Support (BLS), Pediatric Advanced Life Support (PALS) and/or AHA/American Academy of Pediatrics (AAP) Neonatal Resuscitation Provider (NRP) certification.

Abbreviations:

(ACLS) - Advanced Cardiac Life Support
(BLS) - Basic Life Support
(PALS) - Pediatric Advanced Life Support
(NRP) - Neonatal Resuscitation Program

POLICY:

1. Kaiser Permanente (KP) accepts AHA approved, ACLS, BLS, PALS and AHA/AAP NRP cards of completion (AHA or AHA/AAP logo is displayed for approved cards). AHA courses are standard for all KP-sponsored trainees in Southern California.

NOTE: Substantially equivalent certifications may be accepted from affiliates, if approved by KFH leadership at the affected Medical Center. These may include American Red Cross BLS for Healthcare, American Red Cross ACLS, and ART/BART for affiliate trainees who hold these alternate certifications

2. The following trainees are required to have BLS certification: All trainees (PGY - ALL) – All Programs
3. The following trainees are required to have ACLS certification: Trainees in all Adult Programs assigned within a Kaiser Foundation Hospital for the duration of the academic year(s) in which those rotations occur (i.e., except those whose assignments are ambulatory for the entire academic year).

NOTE: If resident/fellow performs Procedural Sedation, they must have an active ACLS certification. At the time of the Affiliate Trainees rotation, if it is 2 months or less, we will accept the higher certification without active BLS. Active BLS is preferred, but not required.

4. The following trainees are required to have PALS certification: Trainees in all Programs that rotate in inpatient Pediatrics for the duration of the academic year(s) in which those rotations occur.
5. The following trainees are required to have AHA/AAP NRP completion: Trainees in all Programs that rotate in Nursery/NICU, for the duration of the academic year(s) in which those rotations occur.

INSTITUTIONAL POLICIES

Regional Certification Policy

MAINTENANCE OF ACLS/BLS/PALS/NRP CERTIFICATION:

1. It is the trainee's responsibility to maintain ACLS/BLS/PALS and/or AHA/AAP NRP certification. Kaiser Permanente may provide notification to remind them of their responsibility. However, trainees should not rely solely on this notification before taking appropriate steps to ensure that their certification remains valid and does not expire.
2. Copies of evidence of completion must be maintained for trainees that require ACLS/BLS/PALS and/or NRP certification.
3. Trainees must present original documentation as evidence of completion of the renewal.
 - a. Should a trainee who is an employee of Kaiser Foundation Hospitals, Inc. permit his/her required certification(s) to expire, the trainee will be placed on an unpaid administrative leave. He/she shall not be scheduled for duty until certification is obtained and verified.
 - i. If appropriate current documentation of the ACLS/BLS/PALS and/or NRP is not obtained and verified within 30 business days, the trainee is subject to termination after consultation with HR.
 - ii. Should an affiliate trainee rotating at Kaiser Permanente permit his/her required certification(s) to expire, he/she shall be suspended from duty and the Sponsoring Institution notified. He/she shall not be scheduled for duty until certification is obtained and verified.
4. Any manager who knowingly permits a trainee to work for any reason after the date of expiration of required certification(s) shall be subject to disciplinary action

REFERENCES:

The Joint Commission Hospital Accreditation Standards Manual

Kaiser Permanente License, Certification, and Registration Verification [NATL.HR.010](#)

APPROVAL:

Approved by the Institutional Graduate Medical Education Committee (IGMEC) held on April 18, 2019, chaired by Dr. J. Craig Collins, Designated Institutional Official and Karianne Holguin, Regional Director Southern California Graduate Medical Education.

INSTITUTIONAL POLICIES

Licensing

PURPOSE

The purpose of this policy is to comply with the Medical Board of California (MBC) and Accreditation Council for Graduate Medical Education (ACGME) licensing requirements, as applicable.

POLICY

This policy applies to all Kaiser Permanente Southern California (KPSC) residents and fellows.

Resident:

Effective January 1, 2020, Senate Bill 798 (SB798) requires a resident trainee to obtain a Postgraduate Training License (PTL) within 180 days after enrollment in an MBC-approved postgraduate program. All incoming PGY-1 residents will apply in timely fashion for a PTL, which may require some months for issuance, and must be active within 180 days of the residency start date.

Minimum requirements for unrestricted medical licensure in California include an M.D. or D.O. degree from a recognized institution, followed by successful completion of thirty-six (36) months in an MBC-approved postgraduate program. This applies to all applicants, regardless of whether the medical school attended was domestic or international. Of the 36 months, twenty-four (24) months must be completed consecutively in the same postgraduate program to be eligible for a California Physician's and Surgeon's Certificate.

Upon successful completion of 36 months of training, the eligible resident trainee will apply for a Physician's and Surgeon's Certificate with the MBC within 90 days to continue practicing medicine as a trainee in California.

If a physician has successfully completed a three-year residency under a PTL and is not currently enrolled in an ACGME accredited program, the physician must cease all clinical services in California until a Physician's and Surgeon's Certificate is issued. This applies to new graduates of three-year programs, non-ACGME PGY-4 chief residents, non-ACGME PGY-4 fellows, and PGY-4 Community Medicine fellows.

Fellow:

A fellow holding an out-of-state medical license must possess a Physician's and Surgeon's Certificate with the MBC prior to starting fellowship training.

Failure to obtain or maintain required licensure by stated deadlines will result in a 30-day unpaid suspension. Failure to obtain an active license within the 30-day unpaid suspension will result in termination. Resident/Fellow may be eligible for rehire when a license is obtained, should the position still be available, and at the sole discretion of the Program Director.

The licensing requirements stated above are automatically revised, if necessary, to comply with applicable laws or regulations.

INSTITUTIONAL POLICIES

Professionalism

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 Permanente 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 Permanente 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 Permanente 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

INSTITUTIONAL POLICIES

Professionalism

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, fairly, and 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

INSTITUTIONAL POLICIES

Professionalism

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

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

Policy Title: Drug-Free Workplace	Policy Number: NATL.HR.030
Owner Department: Human Resources	Effective Date: 10/12/20
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1.0 Policy Statement

Kaiser Permanente (KP) is committed to protecting the safety, health and well-being of employees and other individuals in KP’s workplace and provides an environment that is free from the abuse of alcohol and drugs. KP recognizes that alcohol abuse and drug use pose a significant threat to KP’s goals. KP also acknowledges that alcohol abuse and chemical dependency may be chronic diseases that require rehabilitative treatment, counseling, and/or access to employee assistance programs.

2.0 Purpose

This policy is consistent with requirements of the federal Drug-Free Workplace Act of 1988, applicable state drug-free workplace requirements, and with KP’s obligation to provide a safe work environment.

3.0 Scope/Coverage

- 3.1** This policy applies to all employees working in any of the following entities (collectively referred to as “Kaiser Permanente”):
- 3.1.1** Kaiser Foundation Hospitals and Kaiser Foundation Health Plan, Inc. (together, KFHP/H);
 - 3.1.2** KFHP/H’s subsidiaries;
 - 3.1.3** The Permanente Medical Group, Inc. (TPMG) [NOTE: This policy does not apply to physicians, podiatrists vice presidents, or members of TPMG Executive Staff, who are covered by separate TPMG policies]; and
 - 3.1.4** Southern California Permanente Medical Group (SCPMG) [NOTE: This policy does not apply to physicians of SCPMG].
- 3.2** All organizations who supply temporary or registry personnel, students or trainees to KP will be held accountable for providing personnel who meet the same drug-free standard imposed by KP on its own employees. Volunteers are also required to meet this drug-free standard. Violation of applicable provisions or refusal to cooperate in the implementation of this Policy can result in contract personnel or volunteers being barred from company premises or from working in its operations.
- 3.3** Employees whose jobs require them to drive KP fleet vehicles are subject to the drug and alcohol testing requirements in the applicable Fleet Management policies. In addition, employees whose jobs require commercial driver’s licenses are subject to a drug and alcohol testing program that fulfills the requirements of the U.S. Department of Transportation (DOT) Regulations. (See the Addendum to *Drug and Alcohol Testing REGL.HR.02a and REGL.HR.02b*.)

4.0 Definitions

- 4.1 Alcohol** – means ethanol alcohol in any consumable form (e.g., beer, wine, liquor).

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4.2 Being under the influence – means an individual is impaired by alcohol or a drug, or the combination of alcohol and drugs, regardless of the level detected. A determination of “under the influence” can be established by a professional opinion, a medically accepted drug or alcohol screening test, and/or based on lay observations by supervisors, co-workers, or others.

4.3 Company premises -- includes parking lots, vehicles and other facilities and property owned, leased or operated by KP, as well as off-site premises used for company-sponsored events.

4.4 Drug -- means:

4.4.1 any drug which is not legally obtainable: any “illicit” drug or “controlled substance” the possession or use of which could result in arrest or other legal sanction according to state or federal statute. Examples include but are not limited to, marijuana, cocaine, crystal methamphetamines (ice), and hallucinogens. [NOTE: Although “medical marijuana” or marijuana use laws may exist in some states, because marijuana is a Schedule I drug and possession or use of it is unlawful under federal law, marijuana is an illicit drug for all purposes under this policy.];

4.4.2 any drug which is legally obtainable but has not been legally obtained;

4.4.3 prescribed drugs not being used for prescribed purposes or at prescribed dosages or by the person for whom the drug is prescribed; and/or

4.4.4 any non-prescription substances that are used contrary to manufacturer’s recommendations.

4.5 Work Time -- time during which an employee is representing, performing work, or conducting business for KP, or is required or scheduled to be on duty.

5.0 Provisions

5.1 Pre-Employment Drug Testing

In accordance with *Pre-Employment Drug Testing NATL.HR.029*, KP requires that all individuals external to KP who have been offered employment complete pre-employment drug testing demonstrating the absence of illegal drugs or prohibited use of legal drugs.

5.2 Employees with Drug and Alcohol Problems

5.2.1 KP supports the use of treatment and programs to address alcohol or drug abuse and will provide them when warranted by conditions and circumstances. However, KP must balance respect and concern for individuals experiencing these problems with KP’s commitment to maintain an alcohol and drug-free environment. KP encourages employees to voluntarily seek help with drug and alcohol problems. (See Addendum for California employees.)

5.2.2 KP encourages any employee covered by this policy who is experiencing alcohol or drug dependency to seek professional assistance, including the

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use of KP’s confidential Employee Assistance Program. Whenever practical, KP will assist employees in overcoming drug, alcohol, and other problems which may affect employee job performance, provided that such assistance is requested prior to violation of this policy.

5.2.3 Employees' voluntary participation in chemical dependency recovery programs or other rehabilitation services will be kept confidential and will not affect their employment as long as they are meeting the terms and conditions of the program. Both KP policy and existing laws protect the confidentiality of persons who seek treatment for chemical dependency.

5.2.4 Depending on the circumstances, an employee’s return to work, reinstatement, and/or continued employment may be conditioned on the employee's successful participation in and/or completion of any and all evaluations, counseling, treatment, rehabilitation programs, or other appropriate conditions as determined by KP.

5.3 Employees Taking Prescribed Medication

The use of prescribed medication at prescribed dosages and for prescribed purposes under the direction of a physician or other appropriate licensed person on either a long-term or short-term basis may affect the safety of the employee, co-workers or members, the employee's job performance, or the safe or efficient delivery of services. Therefore, any employee who experiences an impairment of performance that could impact his/her work duties due to the use of such medication (e.g., vision impairment, lack of balance, loss of reflexes, impaired judgment) must report this to his or her supervisor. If the use of such medication affects the safety of the employee, co-workers or members, the employee's job performance, or the safe or efficient delivery of services, the employee may be required to be away from work temporarily using sick leave, PTO, ETO, medical leave, personal leave, or other time off benefits.

5.4 Prohibited Conduct and Penalties

5.4.1 It is a violation of this policy to use, possess, sell, purchase, trade, and/or offer for sale or to purchase drugs (as defined in this policy) during work time or at any time on KP premises. Being under the influence of a drug by any employee on KP premises or during work time is prohibited.

5.4.2 Being under the influence of alcohol by any employee while on KP premises or during work time is prohibited. The consumption, sale, purchase, or offer for sale or to purchase of alcohol on KP premises is prohibited. Possession or transfer of an open container of alcohol on KP premises is a violation of this policy, except in circumstances in which consumption of alcohol is specifically authorized at a KP sponsored or sanctioned function.

5.4.3 Being at work and failing to report to the supervisor that prescribed medication is impairing the employee’s motor functions is a violation of this policy.

5.4.4 Theft, diversion or unauthorized removal of drugs maintained or dispensed on KP premises is a violation of this policy.

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5.4.5 It is a violation of this policy for employees to unlawfully manufacture, distribute, dispense, possess, sell, purchase, or use an illegal drug while off duty or off premises, where the conduct adversely affects the employment relationship or KP's business interests.

5.4.6 Violation of this policy will subject employees to corrective/disciplinary action, up to and including termination of employment, and may result in a referral to law enforcement agencies for possible criminal prosecution.

5.5 Notification of Convictions

5.5.1 Any employee who is convicted of a criminal offense for a drug violation must, as a condition of employment, notify Human Resources within five days of that conviction. Failure to provide timely notification will result in corrective/disciplinary action, up to and including termination of employment.

5.5.2 Federal contracting agencies will be notified of employee convictions when appropriate.

5.6 Reasonable Suspicion of Prohibited Alcohol or Drug Use

5.6.1 A supervisor may have a "reasonable suspicion" that an employee is under the influence based upon observation of conduct and/or events. Factors which may establish reasonable suspicion include, but are not limited to:

5.6.1.1 Sudden unexplained changes in behavior which adversely impact work performance.

5.6.1.2 Discovery or presence of alcohol or illegal drugs in an employee's possession or near the employee's work space.

5.6.1.3 Odor of alcohol and/or residual odor peculiar to alcohol or controlled substances.

5.6.1.4 Personality changes or disorientation.

5.6.1.5 Violation of safety policies, or involvement in an on the job accident or near accident.

5.6.2 When reasonable suspicion has been established to indicate an employee is under the influence of alcohol or drugs, the employee will be asked to provide breath, blood and/or urine specimens for laboratory testing. Employees are required to follow regional policies/procedures regarding drug and alcohol testing. (See *Drug and Alcohol Testing REGL.HR.02a and REGL.HR.02b.*)

5.6.3 Where there is reasonable suspicion that employees possess or their personal effects (including vehicles, purses, briefcases, clothing, personal containers) contain an illegal drug or an open container of alcohol, KP may, with consent, search such individuals or their personal effects. Refusal to consent to such searches may be considered insubordination. (See *Corrective/Disciplinary Action NATL.HR.014.*) Illegal drugs which are confiscated will be turned over to local law enforcement agencies.

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5.7 Confidentiality

KP recognizes the importance of maintaining confidentiality in any situation where current and former employees covered by this policy are suspected of alcohol or drug related infractions. Every effort will be made to assure the privacy of suspected employees throughout investigatory and corrective/disciplinary action proceedings.

5.8 Policy Attestation

New employees are required to read the policy and sign the Drug Free Workplace Attestation at hire which states that they acknowledge, understand, accept, and agree to comply with this policy, and that failure to comply with this policy may result in corrective/disciplinary action up to and including termination.

5.9 State Requirements

In addition to the federal requirements regarding a drug-free workplace some states have related laws or statutes that KP must comply with in applicable regions (see Addendum).

5.10 Additional Employee Obligations and Responsibilities

Employees who abuse drugs and/or alcohol often affect the performance of other employees. KP cannot provide quality health care without the cooperation and assistance of all employees. As discussed in the KP's Principles of Responsibility, employees who observe activities prohibited by this policy are responsible for alerting their supervisors or whatever management is necessary to resolve the issues. Failure to report violations may result in corrective/disciplinary action.

6.0 References/Appendices

- 6.1** Addendum – Alcohol & Drug Rehabilitation for California employees
- 6.2** Drug-Free Workplace--Employee Acknowledgement
- 6.3** Corrective/Disciplinary Action NATL.HR.014
- 6.4** Drug and Alcohol Testing REGL.HR.02a and REGL.HR.02b
- 6.5** Employment Screening NATL.HR.011
- 6.6** Pre-Employment Drug Testing NATL.HR.029
- 6.7** Employee Assistance Program
- 6.8** Federal Drug-Free Workplace Act of 1988
- 6.9** California Drug-Free Workplace Act of 1990
- 6.10** Cal Govt Code § 8355 et seq.
- 6.11** Virginia Drug-free Workplace Act
- 6.12** Virginia Code § 2.2-4312

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7.0 Approval

Update approval 10/12/20

In accordance with the charter of the National HR Policy Roundtable, this policy update was approved by the National HR Policy Roundtable members, as chaired by Derek Reimer.

Policy Revision History

Original Approvals	Update Approvals	Revision Approvals
Approval Date: 1/28/10	Approval Date: 10/30/12; 11/29/12; 4/30/15; 7/21/17; 10/12/20	Approval Date: 9/9/10
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Communicated Date: n/a		Communicated Date: n/a

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Addendum

Alcohol & Drug Rehabilitation
For employees working in California

Time Off

Employees may take time off work to voluntarily enter and participate in an alcohol or drug rehabilitation program. The amount of time off must be reasonable and not create an undue hardship on KP operations.

Nothing in this policy prohibits KP from refusing to hire or discharging an employee due to current use of drugs or alcohol, inability to perform his or her duties due to drug or alcohol use, or inability to perform his or her duties without endangering the health or safety of the employee or others.

Eligibility

Any employee who voluntarily enters and participates in an alcohol or drug rehabilitation program.

Notice & Documentation Requirements

Time off for this purpose will be granted if an employee provides reasonable notice of the request and a doctor's note to his/her manager. In the alternative, the employee may provide notice to his/her local Human Resources Representative.

Paid or Unpaid Time Off

Employees are required to use available paid time off for this purpose (sick leave, vacation, Paid Time Off or Earned Time Off) before taking leave without pay.

Confidentiality

Any records and information regarding an employee's absence for participation in an alcohol or drug rehabilitation program will be maintained as confidential. Managers and supervisors will take all reasonable steps to safeguard the privacy of an employee regarding participation in an alcohol or drug rehabilitation program.

Law/statute

California Labor Code, Sections 1025-1028

Policy Title: Commitment to a Harassment-Free Work Environment	Policy Number: NATL.HR.005
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1.0 Policy 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 and abusive conduct. In keeping with this commitment, KP strongly disapproves of, and will not tolerate, any kind of harassment or abusive conduct (as defined below) of employees or applicants for employment by anyone, including any manager, supervisor, physician, coworker or non-employee.

2.0 Purpose

N/A

3.0 Scope/Coverage

This policy applies to all employees who are employed by the following entities (collectively referred to as "Kaiser Permanente"):

- 3.1** Kaiser Foundation Health Plan, Inc., and Kaiser Foundation Hospitals (together "KFHP/H");
- 3.2** KFHP/H subsidiaries;
- 3.3** The Permanente Medical Group, Inc. (TPMG) [NOTE: This policy does not apply to physicians, podiatrists, vice presidents, or members of the TPMG Executive Staff, who are covered by separate TPMG policies]; and
- 3.4** Southern California Permanente Medical Group (SCPMG) [NOTE: This policy does not apply to physicians of SCPMG].

4.0 Definitions

N/A

5.0 Provisions

5.1 Harassment Definition

- 5.1.1** This policy prohibits harassment, whether verbal, physical, or visual, that is unwelcome and based upon a person's race, color, religion, sex (including pregnancy, childbirth, or related medical conditions, including childbearing capacity), gender identity, transgender, sex stereotyping, 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.)

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5.1.2 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:

- 5.1.1.1** Submission to the conduct is made either explicitly or implicitly a term or condition of employment;
- 5.1.1.2** Submission to or rejection of the conduct is used as the basis for an employment decision; and/or
- 5.1.1.3** 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.

5.1.3 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 the intention or motive of the harasser or whether the conduct is sexual in nature.

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

5.2 Harassing Conduct Prohibited by this Policy

5.2.1 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.

5.2.2 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

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is related to any of the participant's employment or adversely affects KP's operations.

5.2.3 Some examples of sexual or sex/gender based conduct prohibited by this policy include:

5.2.3.1 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;

5.2.3.2 Unwanted physical contact, such as touching, pinching, grabbing, kissing, patting, or brushing against another's body;

5.2.3.3 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;

5.2.3.4 Offensive leering, flirtatious eye contact, staring at parts of a person's body, sexually oriented gestures;

5.2.3.5 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;

5.2.3.6 Inappropriate electronic mail usage and transmissions, including sexually explicit messages, cartoons, jokes, and unwelcome propositions; as well as accessing or viewing pornographic websites.

5.2.4 Some examples of other conduct based on protected status that is forbidden by this policy include:

5.2.4.1 Racial, ethnic, or religious slurs, epithets, or jokes;

5.2.4.2 Derogatory or stereotypical comments based on race, religion, national origin, age, disability, sexual orientation, gender identity, or other protected status;

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5.2.4.3 Abusive or hostile treatment or similar offensive and unwelcome conduct based on an individual's protected status;

5.2.4.4 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.

5.3 Abusive Conduct Prohibited by this Policy

This policy prohibits conduct of an employer or employee in the workplace, with malice, that a reasonable person would find hostile, offensive, and unrelated to an employer's legitimate business interests. Abusive conduct may include repeated infliction of verbal abuse, such as the use of derogatory remarks, insults, and epithets, verbal or physical conduct that a reasonable person would find threatening, intimidating, or humiliating, or the gratuitous sabotage or undermining of a person's work performance.

5.4 Reporting Obligations

5.4.1 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 or conduct 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. [Note: Oregon employees, see additional reporting information in Protected Status State Addenda]

5.4.2 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 or abusive.

5.4.3 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

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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.

5.5 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 *EEO Internal Complaint Procedure NATL.HR.004*). If an investigation confirms that a violation of this policy has occurred, appropriate corrective/disciplinary action will be taken against the offender, 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 and other conduct prohibited by this policy. The level of corrective/disciplinary action will depend on the nature, severity and frequency of the conduct. Further, conduct involving a violation of law may also subject the offender to civil and criminal legal liability.

5.6 No Retaliation

Kaiser Permanente policies, 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 or prohibited conduct. Therefore, employees should object to sexual and other forms of harassment and prohibited conduct 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.

6.0 References/Appendices

- 6.1** Intent of HR Policies
- 6.2** Kaiser Permanente Principles of Responsibility
- 6.3** Equal Employment Opportunity and Affirmative Action NATL.HR.003
- 6.4** Equal Employment Opportunity Internal Complaint Procedure NATL.HR.004
- 6.5** Workplace Guidelines Pertaining to Transgender and Gender Nonconforming Employees and Physicians
- 6.6** Protected Status—California Addendum
- 6.7** Protected Status—Colorado Addendum

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- 6.8** Protected Status—District of Columbia Addendum
- 6.9** Protected Status—Hawaii Addendum
- 6.10** Protected Status—Maryland Addendum
- 6.11** Protected Status—Oregon Addendum
- 6.12** Protected Status—Virginia Addendum
- 6.13** Protected Status—Washington Addendum

7.0 Approval

Update approval 10/1/2020

In accordance with the charter of the National HR Policy Roundtable, this policy update was approved by the National HR Policy Roundtable members, as chaired by Derek Reimer.

Policy Revision History

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Protected Status State Addenda

CALIFORNIA ADDENDUM

Revised 1/1/20

Protected Status

In California, discrimination/harassment is prohibited on the basis of the following protected status:

- Race (inclusive of traits historically associated with race, including, but not limited to, hair texture and protective hairstyles. Protective hairstyles include, but is not limited to, such hairstyles as braids, locks, and twists.)
- Color
- Religion
- Religious creed
- Sex (including pregnancy, childbirth, or related medical conditions including childbearing capacity, and breastfeeding or medical conditions related to breastfeeding)
- Gender
- Gender identity, including the perception of gender identity
- Gender expression
- Transgender, including whether an individual is transitioning, or is perceived to be transitioning
- National origin
- Age
- Physical or mental disability
- Veteran status
- Military status
- Sexual orientation
- Sex stereotype
- Genetic information
- Ancestry
- Marital status
- Medical condition
- Request to accommodate disability or religious beliefs
- Other status protected by applicable federal, state, or local laws, or by corporate policy

Policy Title: Identification Badges	Policy Number: SC.HPHO.96.1
Regional Business Owner Title: Senior Vice President, COO, KFHP/HP-SCAL Region	
Regional Custodian Title: Vice President, Support Services	Original Effective Date: 11/10/1999
Medical Center Business Owner Title: MSAAT/MCAT	
Medical Center Custodian Title: AMCA for Support Services	Revision Effective Date: 01/10/2020
	Page: 1 of 3

1.0 Policy Statement

This policy sets forth the overall process and guidelines for identification badges.

2.0 Purpose

To establish policies for processing and wearing identification badges to comply with applicable laws, provide a means for members and visitors to identify Kaiser Permanente staff, and provide a method for Kaiser Permanente staff to identify individuals not authorized to be in assigned work areas.

3.0 Scope/Coverage

3.1 This policy applies to all employees who are employed by any of the following entities (collectively referred to as "Kaiser Permanente"):

- 3.1.1** Kaiser Foundation Health Plan, Inc. and Kaiser Foundation Hospitals (together, KFHP/H);
- 3.1.2** KFHP/H's subsidiaries;
- 3.1.3** Southern California Permanente Medical Group (SCPMG)

4.0 Definitions

N/A

5.0 Provisions/Procedures

5.1 All Kaiser Permanente staff including physicians, residents, employees, volunteers, contractors, consultants and on-call registry personnel are required to wear a Kaiser Permanente produced photo identification badge while working at a Kaiser Permanente medical facility or divisional office.

5.1.1 Exceptions to this section are permissible if the non-KP employee has a company issued photo ID badge.

5.2 All badges are to be worn on the front upper torso and shall be clearly visible to observers, including patients. Nothing is to be attached to the badge or cover any portion of the badge.

5.3 Managers or supervisors are responsible for initiating progressive discipline for employees who fail to obtain a badge or who do not wear their badge, as required.

5.4 Identification badges are the property of Kaiser Permanente and will be returned to the department manager or supervisor upon termination, resignation or transfer from a facility or divisional office. Managers or supervisors will collect badges and return them to the Security Department or designated department performing photo identification services.

Policy Title: Identification Badges	Policy Number: SC.HPHO.96.1
Regional Business Owner Title: Senior Vice President, COO, KFH/HP-SCAL Region	
Regional Custodian Title: Vice President, Support Services	Original Effective Date: 11/10/1999
Medical Center Business Owner Title: MSAAT/MCAT	
Medical Center Custodian Title: AMCA for Support Services	Revision Effective Date: 01/10/2020
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- 5.5** The Security Department or designated department performing photo identification services will retain all records and copies of photos related to each identification badge.
- 5.6** Each person is responsible for safekeeping of the badge and may be charged a replacement fee for a lost or willfully damaged badge. No fee will be charged for a replacement badge due to a legal name change, job title change or department name change.
- 5.7** A staff member is permitted to have only one badge unless that person is working different jobs in different facilities (e.g., holding a regular job as a Programmer Analyst in Division offices and a part time job as a Nurse in a medical facility).
- 5.8** The Security Department or designated department performing photo identification services will supply and process badge applications as well as prepare and distribute badges in accordance with local policy. Badges will conform to the following requirements:
- 5.8.1** All new photo-identification badges will be produced using the KP approved badge maker. The first name or first initial of the first name, last name, license or certified title of all physicians, licensed health care professionals and other technically certified health care professionals working in medical facilities must be displayed on their badges using 18-point type.
- 5.8.2** Physicians and Staff who are permanently assigned to the Emergency Department are permitted to use their First Name and Last Name initial on their identification badge.
- 5.8.3** All other non-physician, non-licensed or non-technically certified practitioner staff or other employee badges are to be considered for 18-point type as operationally appropriate.
- 5.8.4** In cases where the full name will not fit on the badge, the initial of the person's first name may be used, along with the last name and license or certification title and department name. **NOTE:** Where more than one person working in a facility has the same first and last name, use the middle initial to identify each person.
- 5.8.5** Department name appearing on all badges may not be smaller than 18-point type.

Policy Title: Identification Badges	Policy Number: SC.HPHO.96.1
Regional Business Owner Title: Senior Vice President, COO, KFH/HP-SCAL Region	
Regional Custodian Title: Vice President, Support Services	Original Effective Date: 11/10/1999
Medical Center Business Owner Title: MSAAT/MCAT	
Medical Center Custodian Title: AMCA for Support Services	Revision Effective Date: 01/10/2020
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5.8.6 Color stripes, other than blue, can be used, as locally required, to distinguish contractors, consultants, volunteers, non-Kaiser registry personnel as well as for staff accessing facility-recognized vulnerable areas requiring special control measures (e.g., Labor and Delivery, etc.).

5.8.7 Approved Badge Holders will be distributed by the Security Department.

5.9 Physicians and employees are expected to question any person not wearing an identification badge who is in a work area not commonly accessed by members or visitors and direct the person to the location she/he is seeking. Suspicious individuals are to be immediately reported to local security or local law enforcement.

5.10 Security shall respond to all suspicious person(s) reports and question any person not wearing an identification badge.

6.0 References/Appendices

6.1 Business and Professions Code, Article 7.5, Section 680

6.2 Fraud Investigations, Training and Referral Compliance Program (Pursuant to Section 1348 of the California Health and Safety Code)

7.0 Signature Lines

Appropriate Signature(s) on file of the senior regional leader(s) that approved the policy and procedure in accordance with the SCAL regional policy and procedures guidelines.

Policy Title: Job Accommodation	Policy Number: NATL.HR.027
Owner Department: Human Resources	Effective Date: 1/30/2020
Custodian: Chair, National HR Policy Roundtable	Page: 1 of 6

1.0 Policy Statement

To comply with the requirements of the applicable federal and state laws (i.e. Americans with Disabilities Act (ADA), Office of Federal Contract Compliance (OFCCP), etc.), Kaiser Permanente (KP) provides reasonable accommodation(s) 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.

2.0 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.

3.0 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"):

- 3.1** Kaiser Foundation Health Plan, Inc., and Kaiser Foundation Hospitals (together, KFHP/H);
- 3.2** KFHP/H's subsidiaries;
- 3.3** The Permanente Medical Group, Inc. (TPMG) [NOTE: This policy does not apply to physicians, podiatrists, vice presidents, or members of the TPMG Executive Staff, who are covered by separate TPMG policies]; and
- 3.4** Southern California Permanente Medical Group (SCPMG) [NOTE: This policy does not apply to physicians of SCPMG].

4.0 Definitions

4.1 Eligible applicants and employees – Individuals who:

- 4.1.1** have a known physical or mental disability for which accommodation is both necessary and reasonable to enable satisfactory performance of essential job functions; and
- 4.1.2** 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.

4.2 A job function may be considered an **essential job function** for various reasons, including but not limited to:

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

Policy Title: Job Accommodation	Policy Number: NATL.HR.027
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4.3 Evidence of whether a particular function is an **essential job function** includes, but is not limited to, the following:

- the employer’s judgment as to which functions are essential;
- written job descriptions prepared before advertising or interviewing applicants for the job;
- the amount of time spent on the job performing the function;
- the consequences of not requiring the incumbent to perform the function;
- the terms of a collective bargaining agreement;
- the work experiences of past incumbents in the job; and
- the current work experience of incumbents in similar jobs.

5.0 Provisions

5.1 Job Accommodations

5.1.1 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 5.1.3 below) on KP’s operations.

5.1.2 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:

5.1.2.1 Making facilities accessible.

5.1.2.2 Acquiring or modifying furniture, equipment or assistive devices, or otherwise modifying the work environment (e.g., telephone amplifier, specialized computers, keyboards, assistive software, ergonomic workspace, modifications to lighting or sound equipment, adjustable desks).

5.1.2.3 Job restructuring (i.e., reallocating non-essential 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, and accommodations generally, must be in accordance with applicable collective bargaining agreements.

5.1.2.4 Modification of work schedule and/or nonessential job duties.

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5.1.2.5 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).

5.1.2.6 Reassignment to a vacant position for which the employee is qualified and able to perform all essential job functions, either with or without a reasonable accommodation. (Reassignment is only available to current employees, not job applicants. Reassignment is considered 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.)

5.1.2.7 Any other reasonable accommodation that may be needed to enable a qualified individual with a disability to perform the essential functions of a job.

5.1.3 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. Because this is a high standard that requires a complex and fact-specific analysis, the question of whether a proposed accommodation would create an undue hardship must be carefully evaluated on a case-by-case basis by Human Resources (HR)/Disability Management (DM) and may require review by Legal Counsel.

5.2 Interactive Process

5.2.1 When an employee/applicant requests an accommodation for a disability, or when KP otherwise knows and/or KP recognizes that a disabled employee/applicant needs a reasonable accommodation, KP will engage in an interactive process to determine if the disability can be reasonably accommodated. The purpose of the interactive process is (1) to identify and discuss (a) the essential functions of the position(s) in question; (b) 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 (c) potential reasonable accommodations, including (for applicants) assistance/accommodations regarding completing the online application, pre-hire assessments and the interview process; and (2) to implement effective accommodations as needed. The interactive process is an ongoing, timely dialogue between the individual and the manager/supervisor/recruiter/appropriate HR representative and, if requested, a union representative to clarify the individual's needs in performing essential job functions and identify the appropriate

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

- 5.2.2** 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.
- 5.2.3** If the disability and need for accommodation are obvious, and an accommodation that will assist the employee/applicant to perform the essential job duties is not difficult or costly to implement, the manager should promptly notify HR/DM before providing the accommodation to ensure that the accommodation is appropriate, effective, and well-documented. [NOTE: Examples of accommodations that managers may be able to implement without much difficulty include relocation/movement of office furnishings, and acquisition of assistive devices, such as telephone headset, document holder, glare shield for monitor.] HR/DM should be consulted before software purchases are made. A manager should not alter or eliminate the essential functions of a position as an accommodation.
- 5.2.4** When an accommodation is requested and the manager has not already provided an effective accommodation as indicated in section 5.2.3, the manager/supervisor/recruiter should promptly contact HR/DM. HR/DM will meet with the employee/applicant and engage in and document the interactive process with the employee and manager/supervisor/recruiter. While the steps taken to engage with employees may vary depending on the circumstances, they will generally include the following actions:
 - 5.2.4.1** Analyze the job and determine the essential job functions and skills and attributes required to perform those functions.
 - 5.2.4.2** In consultation with the employee, determine the individual's job-related functional limitations and their impact on the performance of essential job functions.
 - 5.2.4.3** Ask the employee/applicant what specific accommodations the individual believes are needed and consider any requested accommodations.
 - 5.2.4.4** Determine if a requested accommodation is related to the online application process and/or performance of essential job functions and is reasonable and effective (will enable the individual to perform the essential job functions).
 - 5.2.4.5** Consider the accommodation preferred by the individual, but if there is more than one reasonable accommodation that is effective for both the individual and KP, select and implement one of those effective reasonable accommodations.

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5.2.4.6 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.

5.2.4.7 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.

5.3 Medical Documentation

5.3.1 The employee/applicant is responsible for providing KP with medical documentation that assists KP in assessing the employee/applicant's functional limitations and determining possible reasonable accommodations. If an employee/applicant fails to provide necessary medical documentation during the interactive process, KP may no longer have an obligation to continue the interactive process.

5.3.2 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. [NOTE: The request for documentation is directed to the employee and not the health care provider. The employer may draft a letter addressed to the health care provider that sets forth the information needed and describes the employee's essential job duties, but it must be clear that it is the employee's responsibility to deliver the letter to the health care provider, obtain a response, and deliver that response to the employer.]

5.3.3 Medical information provided by the employee/applicant's health care provider must be sufficient to enable KP to evaluate the functional limitations to determine possible accommodations. If the medical documentation is insufficient, KP should explain to the individual why and allow the individual a reasonable period of time to provide the missing information. If the individual fails to provide the necessary information, or if the information provided is contrary to KP's observation of the employee's work performance, KP may request that the employee/applicant consent to a medical examination conducted by a physician selected by KP.

5.3.4 Information obtained under this section regarding the medical condition or history of any applicant or employee shall be collected and maintained on separate forms and in separate medical files and treated as a confidential medical record, except that:

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5.3.4.1 Supervisors and managers may be informed regarding necessary restrictions on the work or duties of the applicant or employee and necessary accommodations.

5.3.4.2 First aid and safety personnel may be informed, when appropriate, if the disability might require emergency treatment; and

5.3.4.3 Government officials engaged in enforcing federal and state laws shall be provided relevant information upon requests.

5.4 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.

6.0 References/Appendices

7.0 Approval

Update approval 1/30/2020

In accordance with the charter of the National HR Policy Roundtable, this policy update was approved by the National HR Policy Roundtable members, as chaired by Shalesha Richardson.

Policy Revision History

Original Approvals	Update Approvals	Revision Approvals
Approval Date: 8/31/09	Approval Date: 6/9/11; 8/23/13; 5/2/16; 12/15/16; 1/30/2020	Approval Date: n/a
Effective Date: 8/31/09	Effective Date: 6/9/11; 8/23/13; 5/2/16; 1/23/17; 1/30/2020	Effective Date: n/a
Communicated Date: n/a		Communicated Date: n/a

Policy Title: Religious Accommodation	Policy Number: NATL.HR.040
Owner Department: Human Resources	Effective Date: 3/12/2020
Custodian: Chair, National HR Policy Roundtable	Page: 1 of 5

1.0 Policy 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.

2.0 Purpose

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

3.0 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"):

- 3.1 Kaiser Foundation Health Plan, Inc., and Kaiser Foundation Hospitals (together, KFHP/H);
- 3.2 KFHP/H's subsidiaries;
- 3.3 The Permanente Medical Group, Inc. (TPMG) [NOTE: This policy does not apply to physicians, podiatrists, vice presidents, or members of the TPMG Executive Staff, who are covered by separate TPMG policies]; and
- 3.4 Southern California Permanente Medical Group (SCPMG) [NOTE: This policy does not apply to physicians of SCPMG].

4.0 Definitions

- 4.1 **Religious Belief, Observance or Practice** is 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.
- 4.2 **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, interference with workplace safety, burdens on other employees, depriving another employee of a job preference or other benefit guaranteed by a bona fide seniority system or collective bargaining agreement, or other violation of a collective bargaining agreement. (Refer to the Addendum for varying specific state requirements.)

5.0 Provisions

- 5.1 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

Policy Title: Religious Accommodation	Policy Number: NATL.HR.040
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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.

- 5.2** Both KP and the employee/applicant have a duty to cooperate in good faith in the interactive process.
- 5.3** KP is not required to implement the accommodation preferred by the employee if it offers an alternative, reasonable accommodation that effectively eliminates the religious conflict.
- 5.4** KP will reasonably accommodate a religious belief, observance or practice which does not pose an undue hardship. Examples of reasonable accommodation may include, but are not limited to:
 - 5.4.1 allowing religious dress and/or grooming practices
 - 5.4.2 obtaining volunteers to substitute for a shift on a religious holiday or Sabbath
 - 5.4.3 flexible scheduling
 - 5.4.4 change of non-essential job duties
 - 5.4.5 transfers to vacant positions
- 5.5** Regional policies may address additional requirements for religious accommodation in accordance with applicable regulations and state laws.
- 5.6** Whether a requested accommodation is reasonable or poses an undue hardship should be reviewed by Human Resources.

6.0 References/Appendices

- 6.1** NATL.HR.003, Equal Employment Opportunity and Affirmative Action
- 6.2** NATL.HR.004 Internal Complaint Policy Addendum (California & Oregon)

7.0 Approval

Update approval 3/12/2020

In accordance with the charter of the National HR Policy Roundtable, this policy update was approved by the National HR Policy Roundtable members, as chaired by Shalesha Richardson.

Policy Revision History

Original Approvals	Update Approvals	Revision Approvals
Approval Date: 1/7/14	Approval Date: 2/23/17; 3/12/20	Approval Date: n/a
Effective Date: 1/7/14	Effective Date: 2/23/17; 3/12/20	Effective Date: n/a
Communicated Date: n/a		Communicated Date: n/a

Policy Title: Religious Accommodation	Policy Number: NATL.HR.040
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ADDENDUM

In addition to coverage under NATL.HR.040, Religious Accommodation, KP employees may be covered by regulations and/or state laws governing the locality where the employee works.

For employees working in the state of California

[NOTE: The following provisions apply to all employees working in the state of California, including Program Offices and IT employees.]

Accommodation of Religious Beliefs

In accordance with the California Fair Employment and Housing Act (FEHA), Kaiser Permanente will reasonably accommodate the religious beliefs, observances, and practices of applicants, interns, and employees in California unless it would cause undue hardship, as defined below.

Religion, religious beliefs, religious observance, and religious creed, include religious dress and grooming practices, observance of a Sabbath or other religious holy day or days, and reasonable time necessary for travel prior and subsequent to a religious observance.

Definitions

- **Religious dress practice** - The wearing or carrying of religious clothing, head or face coverings, jewelry, artifacts, and any other item that is part of the observance by an individual of his or her religious creed.
- **Religious grooming practices** - All forms of head, facial, and body hair that are part of the observance by an individual of his or her religious creed.
- **Reasonable accommodation** - An accommodation that eliminates the conflict between the religious practice and the job requirement. It may include, but is not limited to, job restructuring, job reassignment, modification of work practices, or allowing time off in an amount equal to the amount of non-regularly scheduled time the employee has worked in order to avoid a conflict with his or her religious observances.
- **Undue Hardship** – An action requiring significant difficulty or expense, when considered in light of the following factors: (1) the nature and cost of the accommodation needed; (2) the overall financial resources of the facilities involved, the number of persons employed at the facility, and the effect on expenses and resources or the impact otherwise of these accommodations upon the operation of the facility; (3) the overall financial resources of the employer, the overall size of the employer with respect to number of employees, and the number, type, and location of its facilities; (4) the type of operations, including the composition, structure, and functions of the employer’s workforce; and (5) the geographic separateness, administrative, or fiscal relationship of the facility or facilities.

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Additional Provisions

- As part of the reasonable accommodation process, KP will explore any available reasonable alternative means of accommodating the religious belief or observance, including the possibilities of excusing the person from those duties that conflict with his or her religious belief or observance or permitting those duties to be performed at another time or by another person, unless it would cause undue hardship.
- Segregating an individual from other employees or the public is not a reasonable accommodation of a person's religious dress or grooming practices.
- Any determinations of undue hardship for a religious accommodation must be reviewed by Human Resources.

Statute and Regulation

Cal. Govt. Code 12940(l) and CCR 11059, 11060

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For employees working in the state of Oregon

[NOTE: The following provisions apply to all employees working in the state of Oregon, including Program Offices and IT employees.]

Accommodation of Religious Beliefs, Observances, and Practices

In accordance with the Oregon Workplace Religious Freedom Act:

KP will not impose an occupational requirement that restricts the ability of an employee to wear religious clothing in accordance with the employee's sincerely held religious beliefs or to take time off for a holy day or to participate in a religious observance or practice, unless reasonably accommodating these activities would impose an undue hardship on the employer, or unless these activities would have more than a temporary or tangential impact on the employee's ability to perform the essential functions of the employee's job.

KP will not prohibit an employee from using vacation leave, or other available time off leave for the purpose of engaging in religious observances or practices of the employee, unless reasonably accommodating the employee's use of leave would impose an undue hardship on operation of the business. However, this provision does not apply to leave as to which a KP policy or applicable collective bargaining agreement restricts the manner in which the leave may be used.

Definition

- **Undue Hardship** – Under the Oregon Workplace Religious Freedom Act, a reasonable accommodation imposes an undue hardship on the operation of the employer's business if it requires significant difficulty or expense based on consideration of the following factors: (1) the nature and cost of the accommodation needed; (2) the overall financial resources of the facilities involved, the number of persons employed at the facility, and the effect on expenses and resources or other impacts on the operation of the facility caused by the accommodation; (3) the overall financial resources of the employer, the overall size of the employer's business with respect to the number of employees, and the number, type and location of the employer's facilities; (4) the type of business operations conducted by the employer, including the composition, structure and functions of the employer's workforce and the geographic separateness and administrative or fiscal relationship of the employer's facility or facilities; and (5) the safety and health requirements in a facility, including the requirements for the safety of other employees and any other person whose safety may be adversely impacted by the requested accommodation.

Statute and Regulation

ORS 659A.033 and OAR 839-005-0140; ORS 659A.350 and OAR 839-005-0003(10)

Policy Title: Social Media	Policy Number: NATL.COMM.001
Owner Department: Communications	Effective Date: 06/01/2020
Custodian: National Director of Social Media	Page: 1 of 6

1.0 Policy Statement

Kaiser Permanente (KP) employees who identify themselves as working at KP or who 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.

2.0 Purpose

The purpose of this policy is to provide KP employees with clear information about KP's expectations of their behavior when they are using Social Media, including both KP-hosted Social Media, and non KP-hosted social media to the extent specifically stated in this policy. When employees, members, or the public raise concerns about social media content, KP reviews and responds to those concerns in accordance with the provisions of this and other KP policies.

3.0 Scope/Coverage

This policy applies to all employees who are employed by the following entities (collectively referred to as "Kaiser Permanente"):

- 3.1** Kaiser Foundation Health Plan, Inc., and Kaiser Foundation Hospitals (together, KFHP/KFH);
- 3.2** KFHP/KFH's subsidiaries;
- 3.3** The Permanente Medical Group, Inc. (TPMG) [NOTE: This policy does not apply to physicians, podiatrists, vice presidents, or members of the TPMG Executive Staff, who are covered by separate TPMG policies]; and
- 3.4** Southern California Permanente Medical Group (SCPMG) [NOTE: This policy does not apply to physicians of SCPMG.]

4.0 Definitions

See Appendix A – Glossary of Terms for additional definitions.

5.0 Provisions

5.1 Using Social Media.

5.1.1 KP employees are required to comply with this policy when using social media:

- 5.1.1.1** On KP electronic systems or using KP hosted social media tools;

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5.1.1.2 During working time; and/or

5.1.1.3 Any time a KP employee identifies him or herself as a KP employee (or is publicly identified as a KP employee) and:
 (a) uses personal social media tools to share content related to KP; or (b) makes statements that can create significant operational or reputational harm to KP.

5.1.2 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 always disclose their KP affiliation when endorsing or promoting KP products or services. Employees should not make knowingly untruthful statements about competitors (or their products). Laws may be different depending on where the employee works and lives.

5.1.3 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. See *Electronic Asset Usage NATL.HR.025* and *Nonretaliation NATL.NCO.003*.

5.1.4 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.

5.2 Prohibited Social Media Use.

5.2.1 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 a written HIPAA-compliant authorization 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. See *Obligations Regarding Confidentiality REGL.HR.001a* and *Obligations Regarding Confidentiality REGL.HR.001b*.

5.2.2 Confidential and Proprietary Information. Employees may not use or disclose any confidential and proprietary information on an external, non-KP hosted site. Employees must follow KP terms of use if using KP hosted sites. See section 5.3.3.

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5.2.3 Personal Opinions. Employees are personally responsible for the content that they publish online. Employees should be mindful that content published on a social media site can be copied or stored indefinitely by the site itself or by a third party. Employees should also be mindful that an employee’s affiliation with KP on one site can be linked to statements made on another social media site and accordingly take care to understand the impact that even non-work-related communications can have on their own reputation as well as that of KP. This policy in no way impinges on any employee’s right under the law to express either protected political opinions or to engage in protected concerted activity under the National Labor Relations Act.

5.2.3.1 KP employees may not represent themselves as a spokesperson for KP without express authorization from Communications 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.

5.3 Accessing Social Media on KP-Hosted Sites or through KP Assets.

5.3.1 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. See *Acceptable Use of KP Information Systems and Assets NATL.IS.002*.

5.3.2 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.

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

5.4 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.

6.0 References and Appendices

6.1 Kaiser Permanente’s Principles of Responsibility

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- 6.2** Corrective / Disciplinary Action NATL.HR.014
- 6.3** Electronic Asset Usage NATL.HR.025
- 6.4** Acceptable Use of KP Information Systems and Assets NATL.IS.002
- 6.5** Nonretaliation NATL.NCO.003
- 6.6** Obligations Regarding Confidentiality REGL.HR.001a
- 6.7** Obligations Regarding Confidentiality REGL.HR.001b

7.0 Approval

This policy was approved by the following representatives of Kaiser Foundation Health Plan, Inc., Kaiser Foundation Hospitals, and their subsidiaries.

Approver: Catherine Hernandez, VP, Interim National Communications Leader

Approval Date: May 23, 2020

Approver: Arlene Peasall, SVP, HR Consulting

Approval Date: May 26, 2020

REVISION HISTORY

ORIGINAL APPROVAL	UPDATE APPROVAL	REVISION APPROVAL
APPROVAL DATE(S): 05/06/2009	APPROVAL DATE(S): 01/06/2017	APPROVAL DATE(S): 09/15/11; 10/11/13
EFFECTIVE DATE(S): 04/30/2009	EFFECTIVE DATE(S): 01/06/2017	EFFECTIVE DATE(S): 09/15/11; 11/01/13
COMMUNICATION DATE(S): 05/13/2009	COMMUNICATION DATE(S):	COMMUNICATION DATE(S): 09/15/11; 10/28/13

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Appendix A – Glossary of Terms

Blog – A site that allows an individual or group of individuals to share a running log of events and personal insights with online audiences.

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:

- a. Information KP is required by law to keep confidential, such as social security numbers and medical records;
- b. Privileged and/or protected quality and peer review records;
- c. Attorney-client privileged or attorney-work product materials;
- d. Legally protectable financial information such as performance data and forecasts;
- e. 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;
- f. Product and technical information about software programs, discoveries and inventions, and product and service development, and trade secret information;
- g. 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
- h. Any of the information described in a. through g. 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 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.

KP-Hosted Sites - A Social Media website, application, 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.

Microblog - A microblog differs from a traditional blog in that its content is typically smaller in both actual and aggregate file size. Microblogs allow users to exchange small elements of content such as short sentences, individual images, or video links.

Podcast – A collection of digital media files distributed over the Internet, often using syndication feeds, for playback on portable media players and personal computers.

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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 individually identifiable health information:

- (i) In education records covered by the Family Educational Rights and Privacy Act, as amended;
- (ii) In records of students attending postsecondary institutions which are made or maintained for the purpose of the students’ treatment;
- (iii) In employment records held by a covered entity in its role as employer; and
- (iv) Regarding a person who has been deceased for more than 50 years.

Not PHI. Identifiers will not be protected health information if they cannot be associated with an individual’s health information (i.e., the individual’s past, present or future status as a patient or member, health condition, receipt of health care services, eligibility for or receipt of health care benefits) as a result of:

- (i) The identifiers’ combination with other data;
- (ii) The circumstances surrounding the disclosure of such identifiers; and/or
- (iii) Other public or private information accessible to the recipient of the identifiers. The disclosure of other identifiers or identifiable information in the possession of covered entities may be prohibited or limited without authorization under laws unrelated to protections for protected health information. For example, Social Security numbers have California and federal privacy protection even when not associated with health information. Individually identifiable health information in KP employment records is not PHI; however, it may be subject to other state and federal privacy protections.

Syndication feeds – A family of different formats used to publish updated content such as blog entries, news headlines or podcasts and “feed” this information to subscribers via e-mail or by an RSS reader. This enables users to keep up with their favorite Web sites in an automated manner that’s easier than checking them manually (known colloquially as “really simple syndication”).

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 social networks such as Facebook, LinkedIn, and Instagram; microblogs such as Twitter; video and audio sharing; blogs, podcasts, discussion forums, online collaborative information and publishing systems accessible either internally or externally; consumer ranking sites such as Yelp; and collaborative information sources such as Wikipedia.

Social Network Site – Any website, online property or mobile application that allows users to interact, share content, add others to their visible lists of contacts, form or join sub-groups around shared interests, or publish content for consumption by a specified group of subscribers or the public.

Wiki -- Allows users to create, edit, and link Web pages easily; often used to create collaborative Web sites and to power community Web sites.



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1.0 Policy Statement

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.

2.0 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.

3.0 Scope/Coverage

This policy applies to all employees who are employed by the following entities (collectively referred to as "Kaiser Permanente"):

- 3.1** Kaiser Foundation Hospitals and Kaiser Foundation Health Plan, Inc. (together, KFH/HP);
- 3.2** KFH/HP subsidiaries;
- 3.3** Southern California Permanente Medical Group (SCPMG) [NOTE: This policy does not apply to physicians of SCPMG].

4.0 Definitions

- 4.1 Conflicts of Interest** arise when personal or financial interests influence professional judgment or decision-making.
- 4.2 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.
- 4.3 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.
- 4.4 Suppliers or Vendors** include any individual or organization that offers to supply or sell products or services to KP, including consultants.
- 4.5 Supplier/Vendor Gifts** are defined as services or things received from a supplier or vendor with a value greater than \$25.00.
- 4.6 Professional Associations** are organizations formed to unite and inform people who work in the same occupation.



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5.0 Provisions

5.1 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.

5.2 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.

5.3 Purchasing and Contracting

5.3.1 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.

5.3.2 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.

5.3.3 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.

5.4 Acceptance of Gifts from Suppliers/Vendors

5.4.1 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.

5.4.2 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.

5.5 Supplier/Vendor-Provided Meals

5.5.1 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.

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5.5.2 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.

5.6 Supplier/Vendor-Provided Entertainment

5.6.1 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.

5.7 Supplier/Vendor Support for Educational and Other Professional Activities

5.7.1 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 KFHP/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.

5.7.2 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.

5.7.3 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.

5.7.4 A KFHP/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.

5.7.5 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.

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

5.7.7 KP may enter into a formal relationship with a supplier/vendor to distribute discounted services to members and employees pursuant to an

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authorized, written agreement. Discounts from suppliers/vendors that are not subject to a formal KP agreement are prohibited.

5.8 Supplier/Vendor-Sponsored Travel

5.8.1 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:

5.8.1.1 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.

5.8.1.2 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.

5.8.1.3 Travel and expenses paid by KP's Group Purchasing Organization (GPO) to fund KP's product sourcing and standards processes.

5.9 Supplier/Vendor-Provided Speakers' Fees and Honoraria

5.9.1 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.

5.9.2 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.

5.9.3 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.

5.10 Supplier/Vendor-Sponsored Product and Services Provided Training

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5.10.1 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:

5.10.1.1 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.

5.10.1.2 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).

5.11 Employees' Relationships with KP Suppliers/Vendors

5.11.1 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.

5.11.2 Employees may not serve as a member of a board of directors of a KP supplier/vendor.

5.11.3 Employees may not be a supplier/vendor to KP while employed by KP.

5.11.4 Employees may not also be employed by suppliers/vendors to conduct work for KP or at a KP facility.

5.11.5 Employees may not also be contractors to suppliers/vendors for contracts or assignments where the customer or the client is KP.

5.11.6 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.

5.12 Compliance Communications to Supplier/Vendor Representatives

5.12.1 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

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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.

5.12.2 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.

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

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

5.14 Consequences of Non-Compliance

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

6.0 References/Appendices

6.1 References

- 6.1.1** NATL.NCO.02 Code of Conduct
- 6.1.2** NATL.NCO.07 Conflicts of Interest
- 6.1.3** NATL.NCO.11 Fraud, Waste and Abuse Control
- 6.1.4** NATL.FIN.ACCT.3.J Incoming Non-Federal Research Grants and Contracts
- 6.1.5** NATL.FIN.ACCT.3.M Incoming Federal Research Grants
- 6.1.6** PSA 306.1 Procurement and Supply Giving and Receiving Gifts
- 6.1.7** Kaiser Permanente Vendor Code of Conduct
- 6.1.8** "Doing Business with Kaiser Permanente" brochure
- 6.1.9** Regional Independent Contractors policies
- 6.1.10** Supplier Representative Visitation Policy

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6.2 Appendix

- 6.2.1** Appendix 1: Standards for KFHP/H Employees Regarding Participation on Advisory Boards of Suppliers, Vendors and Prospective Vendors
- 6.2.2** Appendix 2: Employee Request for Participation on Advisory Boards of Suppliers, Vendors and Prospective Vendors
- 6.2.3** Appendix 3: Vendor Relations Exception Process

7.0 Approval

This policy was approved by the following representative of Kaiser Foundation Health Plan, Inc, Kaiser Foundation Hospitals and their subsidiaries.

Daniel P. Garcia, Senior Vice President and Chief Compliance Office

Signature: _____ s/"Signature on File" _____ Date: 11/01/2014 _____

POLICY LIFE HISTORY

ORIGINAL APPROVALS	REVISION APPROVALS	UPDATE APPROVALS
APPROVAL DATE(S): NOVEMBER 19, 2009	APPROVAL DATE(S):	APPROVAL DATE(S): 11/20/11; 11/20/13
EFFECTIVE DATE(S): JANUARY 1, 2010	EFFECTIVE DATE(S):	EFFECTIVE DATE(S): 12/01/11; 12/01/13;
COMMUNICATION DATE(S): NOVEMBER 19, 2009	COMMUNICATION DATES(S):	

Policy Title: Environmental, Health and Safety	Policy Number: NATL.EHS.001
Owner Department: National Environmental, Health and Safety	Effective Date: November 15, 2019
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1.0 Policy Statement

Kaiser Permanente (KP) maintains an Environmental, Health and Safety Program to provide a safe and healthy work environment for the staff of the organization.

2.0 Purpose

The purpose of this policy is to promote consistent practices in compliance with federal, state and local laws and regulations, to support a culture of health and safety and to protect the environment of the communities in which KP provides services, operates, or is the building owner.

3.0 Scope/Coverage

This policy applies to all employees who are employed by the following entities (collectively referred to as "Kaiser Permanente"):

- 3.1** Kaiser Foundation Health Plan, Inc and Kaiser Foundation Hospitals. (together KFHP/H);
- 3.2** KFHP/H subsidiaries;
- 3.3** 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
- 3.4** Southern California Permanente Medical Group (SCPMG) [NOTE: This policy does not apply to physicians of SCPMG].

4.0 Definitions

- 4.1 Hazard:** the potential for an activity, condition, circumstance, or changing condition or circumstances to produce harmful effects to human health or the environment.
- 4.2 EH&S Significant Events (Significant Events):** significant hazardous material/waste spills and releases to the environment; any EH&S-related regulatory agency letter, visit, notification of violation, citation, fine or penalty (excluding planned annual regulatory visits, such as the annual Fire Department visit UNLESS it results in violation(s), citation(s), fine or penalty); EH&S-related legal action against KP; EH&S-related adverse media attention.
- 4.3 Incident:** An unintended or unplanned event that resulted or could be predicted to result in impacts to human health or safety, property damage, or environmental impact.
- 4.4 Staff:** includes employees, physicians, affiliate providers, consultants, students, vendors, volunteers, interns, etc., who are working on KP premises.

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- 4.5 Workplace Safety Serious Reportable Adverse Events (SRAEs):** include events that result in fatality, hospitalization, amputation or avulsion, or loss of consciousness; more than one person requiring medical treatment is injured in the same incident. Also included are burns, second degree or worse; chemical exposure that requires medical treatment; compound fracture or multiple fractures; trauma from significant electric shock; significant laceration requiring sutures or similar treatment, or other SRAEs as defined by the national KP Workplace Safety Leadership Team.

5.0 Provisions

- 5.1** KP's EH&S Program identifies environmental, health and safety hazards; assess environmental, health and safety risks and control hazards; monitors the work environment; evaluates the effectiveness of related programs; and reports EH&S incidents, violations, injuries, and illnesses.
- 5.1.1** The EH&S program elements include: implementing policies and procedures and standards; conducting effective training and education; developing effective lines of communication; conducting internal monitoring and auditing/assessing; responding with appropriate priority to emerging risks and hazards; and tracking EH&S legislation and regulatory requirements.
- 5.2 General Responsibilities**
- 5.2.1 Senior Leaders are responsible for:**
- 5.2.1.1** Supporting their supervisors and managers with the equipment, training and resources needed to maintain compliance and provide a safe and healthy work environment, where KP provides services, operates, or is the building owner.
- 5.2.1.2** Modeling behavior consistent with a safe and healthy work environment.
- 5.2.1.3** Establishing EH&S committees and ensuring their efforts are coordinated with Compliance committees and other stakeholder groups nationally, regionally and locally.
- 5.2.1.4** Creating a culture of safety that reduces injuries and illnesses by reducing hazards; including focusing on employee recognition, respect, resources, and taking the necessary steps to ensure employee safety.
- 5.2.1.5** Establishing processes and assigning responsibilities for regulatory reporting detailed in Sections 5.3.6 and 5.3.6.1.
- 5.2.2 Supervisors and Managers are responsible for:**
- 5.2.2.1** Providing systems, equipment, training and support to allow employees to work safely.

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- 5.2.2.2** Confirming safety procedures are accurate, available and comprehensive.
- 5.2.2.3** Reporting occupational incidents, including exposure to infectious diseases, and environmental releases that occur in their work areas in accordance with section 5.2.
- 5.2.2.4** Addressing identified safety issues in a timely manner.
- 5.2.2.5** Informing employees of the presence of hazards in their workplace, ensuring employees receive information on the location and operation of emergency equipment and first aid measures; posting a current OSHA "It's The Law" worker rights poster; and that employees receive required EH&S training.
- 5.2.2.6** Ensuring the safety performance of their employees.
- 5.2.2.7** Implementing safe and responsible environmental practices.
- 5.2.2.8** Modeling behavior consistent with a safe and healthy work environment.
- 5.2.2.9** Completing the proper forms within the required timeframes to report injuries, illnesses, or incidents, and to ensure an investigation takes place.
- 5.2.3 Employees are responsible for:**
 - 5.2.3.1** Working safely following established safety policies and procedures.
 - 5.2.3.2** Actively looking for and reporting to management environmental, health and safety conditions and behaviors that put patients, staff and/or the environment at risk.
 - 5.2.3.3** Developing, contributing to, and participating in patient and worker safety focused activities.
 - 5.2.3.4** Applying environmentally safe and responsible practices.
 - 5.2.3.5** Participating in safety and EH&S compliance training.
 - 5.2.3.6** Immediately notifying their supervisor of a work-related injury, illness or incident, (including exposure to infectious diseases), environmental release, or unsafe working condition in accordance with section 5.2.
- 5.2.4 Environmental, Health and Safety departments are responsible for:**
 - 5.2.4.1** Participating in the design, implementation, management and sustainability of EH&S programs.

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5.2.4.2 Collaborating with stakeholder to enable effective EH&S Program implementation and ongoing management.

5.3 Incident Reporting and Investigation

5.3.1 Occurrences of occupational injuries, illnesses, and incidents must be reported and investigated promptly in accordance with regional policies and procedures, and measures taken to prevent future injuries, illnesses, and incidents.

5.3.2 Employees will not be subject to disciplinary action or retaliation for reporting incidents, work-related injuries or illnesses or unsafe or unhealthy working conditions. See *Non Retaliation NATL.NCO.03* policy.

5.3.3 If an employee is too ill to report an injury, illness, or incident, his or her representative or manager/supervisor should report it. An employee uncomfortable reporting an issue to his or her supervisor may report it to the Safety/EH&S Manager or another manager who must document the issue, or the employee can report anonymously by using the KP Compliance Hotline. See *Reporting Compliance and Ethics Concerns NATL.NCO.04* policy.

5.3.4 A current OSHA "It's The Law" worker rights poster is prominently displayed in each work location. The poster includes information on employee "rights" including reporting injuries and illnesses, and employer legal requirements for reporting to OSHA.

5.3.5 SRAEs must be reported to local and regional leadership within 24 hours and to national leadership within 48 hours.

5.3.5.1 SRAEs involving employees must be reported by the department supervisor using the "Workplace Safety Serious Reportable Adverse Notification & Follow Up" report form. SRAEs that involve workers other than employees are to be reported to the extent those work-related incidents are made known to KP. There is not a requirement to establish a new reporting mechanism for non-employee work-related incidents.

5.3.5.2 All SRAEs are promptly investigated using Cause Mapping Process. Corrective Action Plans based on Cause Mapping Processes are submitted to the Director of Workplace Safety within 60 days of submission of the report of an SRAE.

5.3.6 Injuries, hospitalizations, and fatalities are reported to Federal or State Occupational Safety and Health (OSHA) in accordance with regulatory notification and timeline requirements. Environmental releases are reported to federal, state, and local regulatory

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agencies in accordance with regulatory requirements and timelines.

5.3.6.1 Processes and procedures are established to enable required regulatory reporting to occur during normal operating hours, outside of normal operating hours, and during emergency situations.

5.3.7 Program-wide data systems established by KP must be used as the source of data for reporting to external regulatory agencies (e.g., OSHA 300 reporting).

5.3.8 Significant Events must be promptly reported to local and regional leadership, and local, regional, and national Compliance departments.

5.3.9 All reported workplace injuries, illnesses, incidents, and Significant Events are promptly investigated to determine root causes and to identify appropriate corrective actions.

5.3.9.1 Investigations of Significant Events (that are not SRAEs) are due 21 calendar days after date of event. All Significant Events are closed out within 45 days. Corrective action plans must be established and implemented for substantiated Significant Events.

5.3.9.2 Investigations of injuries, illnesses, and incidents (that are not SRAEs) are completed within 7 days of being reported or within more stringent timelines established by regional policy.

5.4 Identification and Control

5.4.1 Processes to assess, identify, document and control EH&S hazards are established and implemented. A hierarchy of controls is used to control hazards and reduce risk based on feasibility including: eliminate the hazard; reduce the hazard level; provide warnings; provide safety procedures and personal protective equipment.

5.4.2 Employees will have access to information about hazards in their work environment and access to their personal exposure and/or medical records in accordance with record request procedures

5.4.3 EH&S training is provided to employees in accordance with Federal and State OSHA and EPA requirements, and in accordance with other federal, state and local regulatory agency requirements. Training is delivered to employees in accordance with the *Compliance Training NATL.HR.012* policy.

5.5 Prevention Through Design

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KP supports the concepts of prevention through design, whereby occupational safety and health needs are addressed in the design of work processes and facilities to prevent or minimize the work-related hazards and risks associated with the construction, use, maintenance and disposal of facilities, materials and equipment.

5.6 Monitoring

KP monitors the work environment to evaluate and document the effectiveness of controls on an ongoing basis including: conducting site inspections (e.g., EH&S rounding) data and document review; leak detection systems (e.g. underground storage tank leak detection). Corrective actions to address deficiencies identified from monitoring processes are implemented and documented.

5.7 Audit and Assessment Program

KP maintains an environmental, health and safety audit and assessment program to assess and communicate EH&S risks to management and senior leadership. Managers, supervisors and employees are required to participate in EH&S audits. Corrective actions to address deficiencies identified from auditing and assessment processes are implemented and documented.

5.8 Performance and Metrics

5.8.1 Processes to evaluate measure and regularly report on the effectiveness of EH&S programs to leadership are established.

5.8.2 Processes to report on progress towards environmental stewardship goals to leadership are established.

5.9 Environmental Stewardship Practices

KP recognizes that a healthy workplace, healthy communities, and a healthy environment are critical to the health and wellness of every person. As part of KP's commitment to environmental stewardship, environmental programs benefit from participation of EH&S professionals.

5.9.1 EH&S will partner with stakeholders to provide appropriate expertise. EH&S departments will be included in the design and implementation of selected environmental stewardship programs. Examples of these programs include but are not limited to minimizing the quantity and toxicity of waste and reducing and eliminating the use of chemicals of concern.

5.9.2 KP's stewardship practices include striving to conserve natural resources, reduce greenhouse gas emissions that contribute to climate change, reduce the volume and toxicity of waste and reduce and eliminate the use of chemicals of concern at work and in our communities. See policies: *Sustainable Energy NATL.NFS.003*, *Sustainable Water NATL.NFS.005* and *National Waste Reduction NATL.EVS.001*.

5.10 Compliance Requirements

5.10.1 KP complies with federal, state and local requirements.

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5.10.2 Processes to identify new and revised regulatory requirements and communicate requirements to stakeholders are established.

6.0 References/Appendices

- 6.1** Regional safe and healthy work environment policies.
- 6.2** Compliance Training NATL.HR.012
- 6.3** Non Retaliation NATL.NCO.03
- 6.4** Sustainable Resources NATL.NFS.003
- 6.5** National Waste Reduction NATL.EVS.001.
- 6.6** Reporting Compliance and Ethics Concerns NATL.NCO.04
- 6.7** Federal, state, and local environmental, health and safety regulations.

7.0 Approval

This policy was approved by the following representative of Kaiser Foundation Health Plan, Inc., Kaiser Foundation Hospitals, and their subsidiaries. Confirmation of approval is on file in National Policy Services.

The policy was reviewed and updated with minor changes: November 15, 2019

Approver: Arlene Peasall, SVP and Interim Chief Human Resources Officer

Policy Revision History

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