July 2023

CommonSpirit Health© Standards of Conduct:

Our Values in Action

Policy and Reference Guide

July 2023

CommonSpirit®

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Welcome

The CommonSpirit Health name was inspired by scripture:

"Now to each one the manifestation of the Spirit is given for the common good." (1 Corinthians 12:7 NIV)

These words embody why we formed CommonSpirit in 2019 and continue to motivate and guide us every day. Our pledge of corporate responsibility is tied to our values and commitment to the common good.

Personal responsibility and integrity on the part of everyone who works for and with CommonSpirit is fundamental to our corporate responsibility and the advancement of our mission. This means:

- Our daily conduct mirrors our values.
- We behave ethically and appropriately.
- We meet our obligations and are good stewards of our resources.
- We hold ourselves accountable for the decisions we make and the actions we take.
- When in doubt, we seek guidance.

Health care settings are governed by a complex set of rules and laws that are often difficult to understand and apply. This guide is a resource designed to help you make decisions at work. Please become familiar with the standards of conduct defined in this guide.

The examples provided in this guide help illustrate the importance of honesty, directness and respect in your interactions with everyone we serve: patients, residents, family members, colleagues, and business and community partners.

If at any time you believe our standards of conduct are being or have been compromised, please use the CommonSpirit Reporting Process to report your concerns. If the situation is related to human resources, you may also contact your local Human Resources department.

All of us at CommonSpirit share a proud heritage and strive to uphold the legacy of our participating congregations. We carry on their tradition of living our values and maintaining a strong ethical culture, with this guide as an important tool.

Thank you for your continued dedication to our healing ministry.

Sincerely,

Wright Lassiter III
Chief Executive Officer

Nima Davis
Chief Compliance Officer

Our Standards of Conduct Reference Guide and Corporate Responsibility Program

This is a guide to our Corporate Responsibility Program (CRP), which all CommonSpirit employees are obligated to follow. Our Corporate Responsibility Program provides resources for making ethical decisions based on our values and standards of conduct and helps us to understand and comply with legal, ethical and professional standards for the provision of health care and prevent or resolve activity that could lead to fraud, waste or abuse.

This guide is designed to help you work in a responsible, professional and ethical way that demonstrates our values. At a minimum, this means obeying the law and avoiding improper activities.

The Table of Contents helps locate specific topics within the guide.

Additional tools and resources for corporate responsibility include:

- Local and national policies and procedures, including those specific to corporate responsibility.
- Corporate responsibility reference and guidance documents.
- Educational offerings, including training in complex or high-risk areas.
- Consultation with local and national Corporate Responsibility Officers.
- Federal and state laws and regulations.
- Consultation with the CommonSpirit Legal Team.

The CRP collaborates with multiple functional areas to provide guidance to support compliance. By understanding and using this guide, we demonstrate our commitment to our mission and values.

This guide is designed to help you work in a responsible, professional and ethical way that demonstrates our values.

Organizational Beliefs

Mission

As CommonSpirit Health, we make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all.

Vision

A healthier future for all — inspired by faith, driven by innovation, and powered by our humanity.

Values

Compassion

- Care with listening, empathy and love
- Accompany and comfort those in need of healing

Inclusion

- Celebrate each person's gifts and voice
- Respect the dignity of all

Integrity

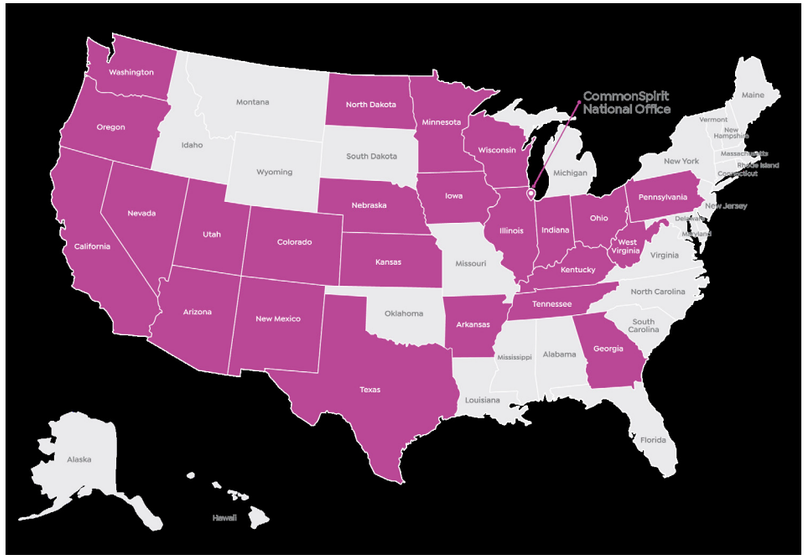
- Inspire trust through honesty
- Demonstrate courage in the face of inequity

Excellence

- Serve with fullest passion, creativity and stewardship
- Exceed expectations of others and ourselves

Collaboration

- Commit to the power of working together
- Build and nurture meaningful relationships



CommonSpirit Health brings health and humankindness to people in 24 states (as of July 2023).

Ethical Standards, Conduct and Guidance

Each employee is accountable to abide by CommonSpirit's mission, vision and values. As part of this commitment, you are expected to follow our ethical standards and conduct while working on behalf of CommonSpirit.

Ethical Standards

CommonSpirit abides by all rules, regulations and laws that govern the health care industry. Our heritage calls us to a higher standard: we follow regulations, but we also engage in ethical decision-making by applying our values to business decisions.

Ethical Conduct

We are expected to be responsible stewards of our ministry by behaving in an ethical manner. Building ethical relationships with employees, patients and families, and business and community partners is important to our ministry.

Guidance for Employees

When you're in a situation that raises questions about ethical conduct, follow these steps:

- Be accountable: Take ownership of your actions and assume responsibility for addressing the situation.
- Apply our values: Your decisions or actions must demonstrate our values of Compassion, Inclusion, Integrity, Excellence and Collaboration.
- Follow the rules that govern us: Identify and adhere to applicable policies, procedures, laws and regulations.
- Report concerns: Contact your manager, Human Resources representative, or Corporate Responsibility Officer.

Deciding to NOT take action may result in serious consequences for the organization and our employees.

Reporting Concerns

Each employee is responsible for promptly reporting potential violations of law, regulation, policy or procedure using the following reporting process.

CommonSpirit Reporting Process:

1. Speak with your manager or another manager.
2. If your manager is not available, you are not comfortable speaking with them, or you believe the matter has not been adequately resolved, contact your Human Resources representative or your local Corporate Responsibility Officer.
3. If you want to anonymously report a concern to a neutral third party 24 hours a day, seven days a week, you have two options.
    a. Call this reporting hotline number: **1 (800) 845-4310**
    b. File a report online: **https://compliancehotline.commonspirit.org.**

All calls to the hotline are received by external, trained staff who document and forward information to your local Corporate Responsibility Officer for appropriate action. You may remain and communicate anonymously if you wish. If you choose to identify yourself, there is no guarantee your identity will remain confidential, however, it is easier for Corporate Responsibility staff to respond. Retaliation against any employee who in good faith reports potential or suspected violations is unlawful and will not be tolerated.

Relevant CommonSpirit Policies

- No-Retaliation Policy

Whistleblower Protection

The federal False Claims Act protects anyone who files a false claim lawsuit – which alleges that improper or false claims have been submitted to the government for payment – from retaliation by their employer.

Failure to Act

CommonSpirit, like other health providers, is regulated by many governing entities and must demonstrate compliance in all aspects of its business. Therefore, all CommonSpirit employees must conduct all business activities in a way that complies with and is consistent with our mission, values, policies and this guide. Failure to do this may result in consequences including but not limited to risks to the safety of those we serve, refund of payments received from government programs, civil or criminal liability, exclusion from federal payment programs, and loss of tax-exempt status. Individuals may also be subject to criminal liability and substantial fines from governing entities.

CommonSpirit reserves the right to implement appropriate disciplinary action, including but not limited to suspension or termination of employment, termination of a non-employed service provider relationship or removal from office or board membership.

Standards of Conduct

The following standards of conduct describe and demonstrate CommonSpirit's commitment to honest and ethical conduct and provide guidance to employees facing uncertain situations. All board and committee members, officers, employees, volunteers, medical staff and others working with CommonSpirit must act in accordance with the following standards of conduct:

Demonstrate fairness, honesty and integrity in all interactions in support of our mission.

Uphold a high standard of skill and knowledge to deliver exceptional quality care, service and outcomes.

Abide by the laws, regulations and policies that govern what we do.

Maintain the integrity and protect the confidentiality of our patient, resident, client, employee and organizational information.

Use our resources wisely to protect our assets, reduce our environmental impact and increase our public health footprint.

Create an environment that promotes community, respects dignity and supports safety and well-being.

Properly disclose and manage situations that pose potential or actual conflicts of interest.

Foster a diverse and inclusive work environment in reverence to our employees, partners and those we serve.

Standard 1

Demonstrate Fairness, Honesty and Integrity in all Interactions in Support of Our Mission

Employee Expectations

In performing your job duties as an employee of CommonSpirit, you are expected to:

- Take responsibility for your actions.
- Know and comply with all policies, guidelines, procedures and practices, including federal health care program requirements. Please refer to this guide and all policies and procedures as they apply to your job responsibilities.
- When in doubt about your job responsibilities or obligations, seek guidance as provided in this guide; as outlined in our policies, guidelines, procedures and practices; or from your manager.
- Refrain from involvement in any illegal, unethical or other improper acts.
- Promptly report any known, potential or suspected violation of our policies or applicable laws and regulations.
- Assist authorized personnel in investigating alleged violations of our policies or applicable laws and regulations.

CommonSpirit provides employees with policies, training and other aids to help fulfill work responsibilities under our standards of conduct.

Management Expectations

Management is responsible for the implementation and enforcement of all compliance efforts. In carrying out these responsibilities, managers are expected to:

- Adhere to applicable policies when screening candidates and supervising employees.
- Inform employees of our Corporate Responsibility Program and their obligation to adhere to all of its requirements.
- Train employees on the requirements in this guide in accordance with applicable laws, regulations, policies, guidelines and procedures.
- Create and maintain a trusting work environment that allows for a free exchange of information about compliance without fear of retaliation.
- Conduct periodic reviews to provide reasonable assurances of employees' adherence to the Corporate Responsibility Program.
- Promptly report any known, potential or suspected violation of law, regulation, policy or procedure.
- Set a proper example of ethical conduct for employees to follow.

Standard 2

Uphold a High Standard of Skill and Knowledge to Deliver Exceptional Quality Care, Service and Outcomes

Documentation Standards

Financial and Business Records

CommonSpirit's financial books and records must not contain false, misleading or deceptive information. Financial reports must fairly and consistently reflect CommonSpirit's performance and accurately disclose the results of operations in accordance with generally accepted accounting principles and other applicable rules and guidelines. Financial reports must also provide a sufficient platform to complete cost reports and requests for payment for services provided to beneficiaries of federal and state health care programs such as Medicare, Medicaid and TRICARE (formerly known as CHAMPUS).

Ethical Use of Technology

The evolution of Artificial Intelligence (AI) and Machine Learning (ML) technology in health care is transforming patient care and operational insights. CommonSpirit is committed to the trustworthy, responsible and ethical use of these technologies in service of the ministry's mission and values. Consequently, CommonSpirit and its employees must ensure that all AI/ML technology is acquired and utilized in objective, compliant and nondiscriminatory ways to minimize undue bias and promote transparency with the communities we serve.

Internal Controls

An internal control is any process or procedure designed to help perform activities safely, accurately and in a way that is consistent with applicable laws, policies and best practices to meet operational objectives. These processes are designed and intended to protect CommonSpirit, its employees and other members of our workforce from errors, fraud or other issues that could lead to non-compliance with applicable laws, regulations or operational goals.

All CommonSpirit employees share responsibility for maintaining and complying with required internal controls. In carrying out their documentation, review, evaluation, financial reporting and recordkeeping responsibilities, employees must provide complete and accurate documentation consistent with CommonSpirit standards and requirements.

In fulfilling their financial reporting obligations, employees must also disclose all material facts related to financial matters to avoid any false or misleading financial reporting.

Employees must cooperate in all audits and investigations, and must not influence, coerce, manipulate or mislead any person or entity involved in the audit or investigation.

Medical Records

CommonSpirit complies with health care program requirements, including federal rules governing documentation and billing of medical necessity determinations and procedures performed in all care settings.

Medical records must be a timely, meaningful, authentic, accurate and legible description of the patient's clinical condition and treatment course. Medical record documentation must meet documentation standards and be consistent with applicable medical staff rules and regulations, policies and health information best practices.

Relevant CommonSpirit Policies

- Medical Record Documentation Standard

Q Clinicians on our unit sometimes perform a service or provide treatment to a patient but do not document it in the chart until later. Is this okay?

A Documentation is to be accurate and completed on a timely basis. A delay in documentation may jeopardize patient care and could impact our ability to receive payment from a federal or state health care program. We are obligated to follow our organization's policies and procedures, bylaws and all applicable federal and state laws regulating documentation.

Coding and Billing

Federal and state laws control third-party billing for patients, residents and others in our care. CommonSpirit submits accurate, complete and timely claims for payment. CommonSpirit could be required to refund payments for filing inaccurate or fraudulent claims, and CommonSpirit and its employees could be subject to criminal prosecution.

Our policy is to provide, document and bill for medically necessary services for the diagnosis or treatment of an illness or injury, in the appropriate location, ordered by a physician or other health care provider.

Clinical, health information management, billing and coding employees and others responsible for creating charges must:

- Provide accurate and timely work that complies with our policies as well as federal and state laws and regulations.
- Bill only for services provided and appropriately documented, using accurate billing and diagnosis codes.
- Immediately notify a manager or a local Corporate Responsibility Officer of inaccuracies so they can be corrected.
- Retain billing and medical record data as required by law and our record retention policies.

Q If documentation is not available when we are ready to submit a bill, is it okay to submit the bill?

A No. Do not submit the bill until appropriate documentation is on file. This verifies the services were provided to the patient.

Q Can we perform services for patients who are not registered in our patient registration system?

A No. All services must be documented and appropriately billed, so all patients must be registered.

Maintaining Licensure Requirements and Qualifications

All individuals whose positions with CommonSpirit have license requirements must:

- Perform job duties within the scope of the license.
- Maintain an active and current license and provide verification on request in compliance with CommonSpirit policies.
- Comply with all licensing and credentialing requirements to remain in good standing and active with the requisite local, state or other licensing authority.
- Immediately inform Human Resources if their license becomes inactive.

Relevant CommonSpirit Policies

- License and Certification Policy

Training and Education

CommonSpirit is committed to providing the training and education necessary to carry out your job duties and conduct yourself in an ethical and responsible way. Training in regulatory compliance, privacy and security is provided at the time of hire and annually thereafter. Failure to complete required training will be noted in your annual evaluation.

Relevant CommonSpirit Policies

- Required Training Policy
- Privacy Education and Training Policy

Standard 3

Abide By the Laws, Regulations and Policies That Govern What We Do

If a government agent contacts you, ask for a government identification card and obtain proof of identification to verify the agent's name, department and agency.

Responding to Government and Regulatory Agencies

CommonSpirit responds to requests from all government and regulatory entities in a timely and cooperative manner. If a government agent contacts you, or you receive a subpoena or search warrant, follow the guidance below:

- Be calm and respectful.
- Ask for a government identification card and obtain proof of identification to verify the agent's name, department and agency.
- Advise the agent that you will contact a manager to assist with their request; ask them to wait.
- Refer any request for information to a manager. Immediately call the following persons, in the order given, until you reach one of them:
    a. Manager or administrator on call
    b. Local Corporate Responsibility Officer or designee
    c. CommonSpirit Corporate Responsibility Officer
    d. Local Legal Team attorney
    e. Reporting hotline number: 1 (800) 845-4310

If a government agent asks to speak with you, you may agree to speak with the agent, but you are not legally required to do so. You have the right to legal representation during an interview. You may tell the agent that you, or someone on your behalf, will contact the agent to discuss their concerns.

If a government agency conducts an interview or investigation, or serves and executes a search warrant, do not:

- Interfere with the agent.
- Alter, remove, or destroy documents or records belonging to CommonSpirit, including but not limited to paper, electronic, phone or computer records.
- Provide false, misleading or incomplete information.
- Suggest to any employee that they not cooperate with government investigators.
- Offer any item of value to a government official, including food or beverage.

Relevant CommonSpirit Policies

- Government Contact Protocol

Physician Self-Referral Law (Stark Law)

Stark Law is a set of federal laws that prohibit a physician from referring Medicare and Medicaid patients to a health care provider if the physician (or an immediate family member of the physician) and provider have any type of financial arrangement. However, referrals are permitted if the arrangement complies with certain exceptions to the Stark Law. If the arrangement does not fully comply with an exception, the provider cannot bill for certain services ordered or referred by the physician.

Stark Law is subject to "strict liability." This means even unintentional violations may have significant financial penalties. If you have any questions about whether an arrangement with a physician is compliant with Stark Law, contact your local Corporate Responsibility Officer or Legal Team attorney for guidance.

Q A physician provides medical director services to our hospital and is paid for these services. Under Stark Law, does this result in a financial relationship?

A Yes. For the purposes of Stark Law, a financial relationship occurs whenever anything of value is exchanged between a hospital and a physician (or a physician's immediate family members). This arrangement may be permissible if it meets the personal services exception under Stark Law.

Q Who qualifies as an "immediate family member" under Stark Law?

A The term "immediate family member" is defined broadly to mean husband or wife; birth or adoptive parent, child or sibling; stepparent, stepchild, stepbrother or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law; grandparent or grandchild; and spouse of a grandparent or grandchild.

Anti-Kickback Statute

The federal Anti-Kickback Statute (AKS) prohibits individuals and entities from knowingly offering, paying, soliciting or receiving "remuneration" (anything of value, or "kickbacks") to induce or reward referrals of items or services paid for by Medicare, Medicaid or other federally funded programs.

No person may directly or indirectly ask for, pay or provide anything of value to physicians or other health care providers to refer patients to our facilities or other health care entities. If you are in doubt about whether a situation may be problematic, before proceeding, contact your Corporate Responsibility Officer or Legal Team attorney for guidance.

The AKS is intended to prevent:

- Compromised medical judgment and treatment decisions due to financial incentives.
- Overuse of items or services covered by federal health programs.
- Increased costs to the Medicare and Medicaid programs because unnecessary or excessive care has been provided.
- Unfair competition (also see Antitrust section).

Q What are "kickbacks?"

A Kickbacks can be gifts or anything of monetary or other value given with the intent, expectation or

understanding that an individual will make referrals to us or be rewarded for past referrals. In addition to cash and cash equivalents (for example, gift certificates or gift cards), other examples of activities or items of value prohibited under the AKS includes:

- Free supplies, space, personnel or equipment.
- Free travel and lodging.
- Discounts, account adjustments or write-offs (other than those defined in charity care or other discount policies).

Q What types of arrangements are inappropriate to offer physicians and may be considered a kickback?

A Examples include:

- Anything of value given with an expectation of future referrals or as a reward for past referrals.
- Providing office space at less than fair market value.
- Providing items or services free of charge or at less than fair market value (for example, hazardous waste disposal service).
- Writing off a physician's bill or recruitment loan.

Q Dr. Jones occasionally sends patients to our hospital. He said he would send us more patients if we provide him with free or discounted office space. Can we do this?

A No. We must charge and the physician must pay fair market value for office space. Free or discounted lease arrangements may appear to be an incentive for referrals from the physician, also known as a "kickback."

Physician Agreements and Transactions

CommonSpirit maintains positive working relationships with physicians in compliance with applicable state and federal laws and may enter into employment or other arrangements with physicians to provide access to care for our patients. Our policies provide an efficient framework to transact business with physicians in compliance with those laws. All agreements involving payments or other compensation between CommonSpirit or CommonSpirit facilities and physicians or physician-owned entities will comply with policies and applicable law.

For information regarding physician agreements and transactions, contact your Legal Team attorney for guidance before proceeding.

Relevant CommonSpirit Policies

- Physician Transaction Review and Signature Authority Policy
- Physician Non-Monetary Compensation Policy
- Purchases from Physician-Owned Entities Policy
- Gifts and Gratuities To and From Business Sources Policy

Excluded Providers

The federal government prohibits a health care provider from receiving payment for services provided in part or in whole by an individual or entity that the government has excluded from participating in a federally funded health care program. CommonSpirit does not knowingly employ, conduct business with or contract with excluded providers. CommonSpirit conducts pre-employment, pre-contracting, pre-credentialing and ongoing excluded provider status checks on individuals, providers and affiliated entities. Any relationship with an employee, individual or entity found to be an excluded provider may result in termination of that relationship.

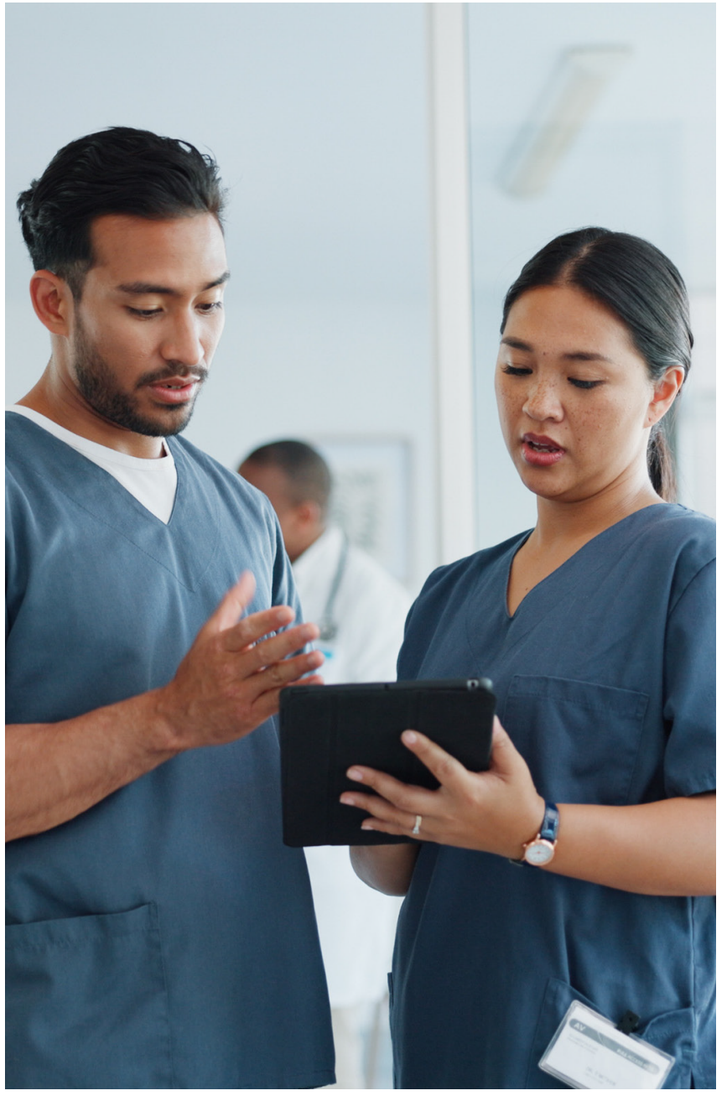
Relevant CommonSpirit Policy

- Screening for Excluded Providers Policy

Antitrust and Trade Regulation Rules

CommonSpirit does not participate in activities that illegally reduce or eliminate competition, control prices and markets or exclude competitors. The purpose of antitrust and trade regulations is to protect the public, CommonSpirit and other companies from unfair trade practices and to support competition.

Because antitrust matters can only be analyzed on a very fact-specific basis, the CommonSpirit Legal Team must be consulted on any arrangement that could affect market competition.



- Do not engage in:
  - Price fixing, which is an agreement between organizations about the prices one or both will charge others for goods or services.
  - Bid rigging, which is any agreement between organizations about who will or will not bid.
  - Customer allocation, which is an agreement between organizations or individuals to divide customers, patients or other business among themselves.
- Do not discuss with any competitor:
  - Prices, terms or conditions of sales.
  - Where CommonSpirit intends to sell or bid.
  - To whom CommonSpirit intends to sell or bid.
  - Whether or at what price, CommonSpirit intends to sell or bid.
- If any representative of a competitor attempts to discuss any of these subjects with you, terminate the conversation immediately and report it to your manager.
- Do not improperly use a competitor's confidential information or trade secrets, or engage in conduct that may be perceived as intimidating or threatening.

Emergency Medical Treatment and Labor Act (EMTALA)

CommonSpirit requires our facilities with dedicated emergency departments to comply with the federal Emergency Medical Treatment and Labor Act (EMTALA), sometimes called the "Anti-Dumping Law." Numerous states have also enacted similar laws, and some are more stringent than the federal law.

Consistent with our commitment to people who are poor and underserved, any person, regardless of their ability to pay, who comes to one of our emergency departments is provided an appropriate medical screening examination to determine if an emergency medical condition exists; or, for pregnant women, if active labor exists. Appropriate stabilizing treatment is provided within the capability of the staff and the facility for patients determined to have an emergency medical condition. EMTALA also applies when the need for emergency care is apparent or requested by an individual on the facility's property outside of the dedicated emergency department.

CommonSpirit facilities may not delay medical screening examinations or stabilization to obtain financial or demographic information from the patient. CommonSpirit facilities may only transfer unstable patients with an emergency medical condition to another health care facility if:

1. The patient requests the transfer and has been informed of the facility's obligations and the risks and benefits of transfer; or
2. The facility does not have the capability to provide necessary stabilizing treatment and a physician certifies the medical benefits provided at another facility are reasonably expected to outweigh the increased risks involved with the transfer.

Q Does the EMTALA law permit us to register an individual who comes into our emergency department before we perform a medical screening examination and stabilization procedures?

A You may register an individual first only if the process does not:

1. Delay the medical screening examination and any necessary stabilizing treatment.
2. Include questions about the individual's method of payment or ability to pay.

Registration processes must not discourage the individual from remaining in the emergency department for further evaluation. CommonSpirit facilities shall not request prior authorization from the individual's insurance company or managed care plan before completing a medical screening examination or beginning stabilization treatment.

False Claims Act

The federal False Claims Act makes it a crime for any person or organization to knowingly make a false record or file a false claim with the government for payment. "Knowingly" means the person or organization:

- Knows the record or claim is false.
- Seeks payment while ignoring whether the record or claim is incomplete or false.
- Seeks payment with reckless disregard for whether the record or claim is false.

Under certain circumstances, an inaccurate claim submitted to the government could be alleged to be a false claim. Examples of possible false claims include:

- Knowingly billing Medicare or other government payers for services not provided.
- Billing for services provided, but not medically necessary.
- Submitting inaccurate or misleading claims about the type or level of services provided.
- Making false statements to obtain payments for products or services.
- Failing to repay the federal or state government for an identified overpayment.

A person who has information regarding improper or false claims submitted to the government for payment may file a lawsuit in federal court on behalf of the government (known as a "Qui Tam" or "whistleblower claim").

Fraud, Waste and Abuse

Federal and state governments pay for a large share of health care in the United States. To ensure that it is appropriately paying for Medicare and Medicaid beneficiary health care services, the government actively checks for and investigates potential fraud, waste and abuse (FWA) by health care companies and beneficiaries. According to the government, billions of dollars are improperly spent due to FWA.

CommonSpirit works to actively prevent, detect and correct FWA. Medicare Advantage Plans require that they be notified of FWA. Identification of potential FWA may require that we notify the government or our health plan partners. To remain compliant with federal and state laws, we have policies, procedures and plans in place to detect and prevent FWA.

- Fraud includes intentionally submitting false information to the government to get payment. An example is knowingly billing the government for patient services that did not occur.
- Waste occurs when a health provider's actions result in unnecessary costs to the government without unlawful intent, such as the ordering of too many or unnecessary laboratory tests.
- Abuse takes place when the government pays for services when there is no legal entitlement to that payment, such as when a provider misuses codes on a claim resulting in increased payment.

Marketing Practices

CommonSpirit marketing, communications, fundraising and advertising activities educate our communities about health issues, increase awareness of our services and facilitate employee recruitment. Any advertising or marketing conducted by CommonSpirit must:

- Present truthful and accurate information to the public.
- Distinguish opinion from fact when presenting issues.
- Obtain the consent of any person whose name or likeness will be used before the advertising or marketing material is shared with the public.
- Comply with applicable federal and state laws and system policies for marketing and advertising activities, including any marketing and advertising activities provided for or with non-employed physicians or physician groups.

Q Two oncologists who are not employees of the hospital just joined the medical staff to provide a new service. We would like to send an announcement to the community to highlight this new service. Is this a permitted marketing practice?

A Yes, it is generally acceptable for a hospital to market a new service line. However, this type of announcement and its cost must be in accordance with applicable state and federal fraud and abuse laws and CommonSpirit physician marketing guidelines. Consult your local Corporate Responsibility Officer or Legal Team attorney to determine the applicable requirements and the restrictions for non-employed physician and physician group advertising and marketing activities.

Relevant CommonSpirit Policies

- Uses and Disclosures of Protected Health Information for Marketing
- Uses and Disclosures of Protected Health Information for Fundraising

Patient Care and Rights

We deliver quality care without regard to race, color, national origin, ancestry, sex, pregnancy, childbirth or related medical condition, marital status, religion, creed, physical/mental disability, medical condition, age, gender identity, sexual orientation, citizenship, payer source or ability to pay, or any other protected categories as defined by law. We treat every person in our care with dignity and respect. Our commitment to quality and service is shared by our board and committee members, employees, officers, volunteers, medical staff and other representatives of our organization. Our commitment to our distinctive Catholic culture enables us to obtain desired outcomes.

We provide individuals in our care with information regarding their rights and responsibilities, and we protect those rights. Individuals in our care have the right to

accurate, timely information about their health, payment options (including charity care) and other information to help them make decisions about their treatment. It is our responsibility to provide this information. Please refer to your organization's guidelines for a description of patient rights.

Q To whom do I report quality of care issues?

A Such issues may include many aspects of care and must first be discussed with your manager. More serious issues may need to be evaluated by the Quality and Risk Management Departments or the Patient Grievance Committee. If you believe a quality of care

issue is not being addressed, use the CommonSpirit Reporting Process.

Q If I see that an individual in our care is not being treated with the proper courtesy and respect, what should I do?

A First, make sure the individual is not in harm's way. Then, talk with your manager. If your manager does not provide a satisfactory response, contact your local patient advocate, patient experience or risk manager, or use the CommonSpirit Reporting Process.

Q What am I to do if I know a medical error has occurred? Should I tell the patient or family?

A CommonSpirit supports compassionate disclosure whenever an error has occurred. To assist the family in making any additional and well-informed care decisions, the disclosure must take place in a coordinated manner. Contact your manager and your quality or risk manager for guidance on handling the disclosure appropriately.

Q How can I help a patient or family member get the information they need to make informed decisions?

A Work with your team to make sure all educational documentation is provided in an easy-to-understand format. Use teach-back methods to build understanding. If you think a patient or family is being pressured to make a particular decision, talk with your manager, your local patient advocate, patient experience manager, or quality or risk manager.

Relevant CommonSpirit Policies

- Patient Rights and Responsibilities

Research Integrity

CommonSpirit is committed to high standards of ethics and integrity when engaging in research. Any dishonesty, misconduct, fraud or harm to research subjects may damage the reputation and credibility of researchers, the scientific community at large, and CommonSpirit. Researchers must be knowledgeable about applicable laws and regulations as well as CommonSpirit policies and procedures related to research compliance.

Grant and Contract Management

CommonSpirit may receive money, in the form of grants and contracts, to conduct specific research studies. The grant/contract awarding organization may be a state or federal government agency or a nonprofit or for-profit company. Effective grant/contract management requires CommonSpirit to demonstrate accountability with sponsor's funds and comply with the specific terms and conditions of each contract and grant. Proper processes must be in place to remain compliant with all federal, state and agency rules and regulations as well as CommonSpirit policies and procedures related to research and grant management. Understanding these requirements prior to accepting an award is important because this information, as well as additional approvals, may be necessary for the application and award acceptance processes.

Human Subjects Research

All human subjects research at CommonSpirit shall have designated Institutional Review Board (IRB) approval or determination of exemption from IRB oversight. The IRBs also perform Privacy Board responsibilities as required under HIPAA. It is important to determine if a project is classified as research or another activity, such as performance improvement, quality assurance or program evaluation.

Human subjects research includes obtaining information or biospecimens through intervention or interaction with an individual and using, studying or analyzing the information or biospecimens; or obtaining, using, studying, analyzing or generating identifiable private information or identifiable biospecimens. IRB approval is required for creation of a biorepository or database if one purpose of the biorepository/database is for research, even if it is not the primary purpose. Individuals shall obtain IRB approval or a determination of exemption from IRB oversight before accessing any tissue, other biospecimens or data including patient information for systematic analysis.

Clinical Research Billing Compliance

Clinical research tests and procedures may be paid for by the sponsor of the study or may be reimbursable by a federal, state or private payer, subject to coverage criteria. Determining how each research test and procedure will be paid and accurately communicating the coverage to the research subject and billing departments is essential for accurate billing.

Animal Subjects Research

CommonSpirit-designated Institutional Animal Care and Use Committees (IACUC) shall approve all vertebrate animal research. Researchers are responsible for proper animal care and handling of animals used in their studies, in accordance with applicable federal and state regulations and CommonSpirit policies and procedures.

Conflict of Interest Management

Potential conflicts of interest shall be identified and managed to promote objectivity and eliminate bias or the appearance of bias in research. A research conflict of interest may exist when a researcher's personal financial, intellectual or equity interest could directly and significantly affect the design, conduct or reporting of the research. Researchers shall report personal interests related to their institutional responsibilities as required by federal and state regulations and CommonSpirit policies and procedures.

Relevant CommonSpirit Policies

- Research Conflicts of Interest ADDENDUM F

Research Misconduct

Federal regulations prohibit misconduct in research, which includes intentional fabrication, falsification or plagiarism in proposing, conducting, reviewing or reporting research results. Honest errors or differences of opinion do not constitute research misconduct. The CommonSpirit Research Integrity Officer follows formal research misconduct inquiry and investigation procedures to determine if research misconduct occurred and protect the rights of all individuals involved. Anyone who suspects research misconduct must immediately contact the Research Corporate Responsibility Officer to discuss their concerns.

Relevant CommonSpirit Policy

- Reporting and Investigating Allegations of Research Misconduct Policy

Contact your Research Institute/Center or the Research Corporate Responsibility Officer if you have any questions related to these requirements.

CommonSpirit is committed to high standards of ethics, integrity and compliance with law when engaging in research.

Tax-Exempt Status

CommonSpirit and most of its related organizations are nonprofit, tax-exempt entities operated solely for religious and charitable purposes. This status gives CommonSpirit certain benefits. To maintain our tax-exempt status, we must use our resources to further the religious and charitable purposes of our mission. Tax laws prohibit our tax-exempt organizations from:

- Providing goods, services, leases, compensation or other benefits to organizational insiders (such as an officer, director, key employee or physician) without receiving equivalent value in return. Some examples include:
  - Paying more than fair market value for services, products or leases.
  - Providing courtesy discounts and other uncompensated benefits to physicians, officers, directors and trustees, other than those provided for by organizational policy.
  - Accepting research grants from third parties when the researcher keeps the funds for personal use or the CommonSpirit organization is not paid for the use of its time, equipment or facilities in connection with the research.
  - Allowing a physician to market their private business inside our clinic/hospital (such as a botox clinic or skin care line, or any product that may be used in the clinic/hospital).
- Providing goods, services, leases, compensation or other benefits to a third party (who is not an insider) without receiving equivalent benefit in return, subject to certain exceptions. Some examples include:
  - Taking part in a joint venture, partnership or similar transaction that results in an improper private benefit (gain) to a third party.
  - Recruiting physicians or other key employees with incentives or compensation plans in excess of fair market value or that do not serve an identified community need.
  - Leasing a facility to a third party at less than fair market value.
  - Providing services to a third party at less than fair market value, such as billing services to private physicians or providing health care services at less than fair market value, except where permitted by CommonSpirit's charity, prompt pay or other discount policies.
  - Permitting any person to buy, sell, lease or use organizational property at less than fair market value.
  - Use of tax-exempt space for private practice or for-profit purposes.

Political Activities

The tax-exempt status of CommonSpirit carries certain restrictions on political activities. The law delineates between political campaign activity (such as involvement with the nomination, appointment or election of candidates for public office) and policy activities (such as advocacy and lobbying to influence public policy). Participation by tax-exempt organizations in political campaign activity is not permitted. As a result, CommonSpirit does not use corporate resources for political purposes and complies with all applicable state and federal laws.

As allowed by law, CommonSpirit actively participates in public policy advocacy, particularly on behalf of people who are underserved. Our advocacy and lobbying activities focus on attempts to influence the development of legislation and regulations (including ballot questions, including referenda, initiatives, constitutional amendments, and bond measures, which are considered to be legislation). The CommonSpirit Advocacy Team and our employees participate in these activities to influence public policy at the local, state and federal level.

"Substantial" lobbying activity at the local, state or federal level is not permitted for tax exempt organizations. There is no precise definition of "substantial," but a general rule is committing more than 5% of an organization's total expenditures to lobbying. The Internal Revenue Service

watches and investigates the political activities of tax-exempt organizations. Because violation of this rule could jeopardize our tax-exempt status, CommonSpirit closely monitors and tracks spending on political activities.

The following guidelines provide an overview of what is and is not allowed.

Permissible Political Activities for a Tax-Exempt Organization

- Encouraging individuals to call or write a letter to elected officials to express the organization's view on public policy issues or legislation.
- Arranging personal visits with elected officials, legislators and government agencies to provide the organization's perspective on public policy issues or legislation.
- Holding public forums, lectures and debates to raise awareness of public policy issues and to inform voters of their impact on the organization.
- Providing financial and in-kind support to groups sponsoring ballot initiatives, referenda and similar measures.
- Hosting candidate forums, debates and visits as long as all candidates for office are given an opportunity to appear and speak to employees.
- Allowing a candidate to appear at an organization if the appearance is based on the candidate's status as an expert, public figure or celebrity, as long as no mention is made of the candidacy and there is no campaign or election-related activity.
- Using the organization's resources, facilities and personnel to sponsor non-partisan voter registration drives.

Permissible Political Activities for Employees of a Tax-Exempt Organization

- Personally endorsing, supporting or opposing a candidate as long as the employees do not imply that they are representing CommonSpirit, use their CommonSpirit titles, or use organizational resources (such as phones, office supplies and email).
- Contributing personal funds to support or oppose a candidate or to a political action committee (PAC).

Impermissible Political Activities for a Tax-Exempt Organization

- Endorsing, supporting or opposing a candidate for public office.
- Contributing organizational funds or resources to a candidate, election campaign committee or PAC.
- Sponsoring a fundraiser or another event that endorses a candidate on or off the property of the organization.
- Inviting a candidate or a select group of candidates to appear at a tax-exempt organization for the purpose of conducting election-related activity or promoting a candidacy.
- Permitting candidate, political party or PAC literature to be placed or distributed on the organization's premises.

Impermissible Political Activities for Employees of a Tax-Exempt Organization

- Engaging in activities or making statements that imply CommonSpirit endorses, supports or opposes a candidate.
- Asking or pressuring a fellow employee to endorse, support or oppose a candidate.
- Using the organization's resources (such as phones, office supplies and email), facilities or personnel to solicit support, opposition or contributions for a candidate or PAC.

Use of Copyrighted, Trademarked or Licensed Material

Employees must not copy documents or computer programs that are protected by copyright laws or licensing agreements. Employees must not use confidential business information improperly obtained from competitors or that may violate any employee or organizational contractual obligation.

Standard 4

Maintain the Integrity and Protect the Confidentiality of Our Patient, Resident, Client, Employee and Organizational Information

HIPAA Privacy and Security

HIPAA is a federal law that safeguards the privacy and security of protected health information. Privacy and security are separate rules within HIPAA, but go hand-in-hand.

- The Privacy Rule focuses on health care entities' uses and disclosures of patients' protected health information (PHI). It covers the confidentiality of PHI in all formats, including electronic, paper and oral. The rule safeguards PHI from unauthorized use and disclosure.
- The Security Rule focuses on administrative, technical and physical safeguards as they relate to electronic PHI (ePHI). Protecting ePHI from unauthorized access, whether external or internal, stored or in transit, is covered by the security rule. Typically, ePHI is stored in:
  - Electronic services and applications such as email, Google Drive, electronic medical records (EMRs), department file shares and personal drives.
  - Internet-based services such as cloud storage, third-party services, vendor-hosted applications, etc.
  - Computer hard drives, magnetic tapes, disks, memory cards and removable/portable storage devices.

Confidentiality

Confidential information includes information about patients, residents, employees and other members of our workforce, as well as proprietary information used while conducting business. It is vital that we protect this information in any form – such as paper and electronic records, email, digital media and oral discussions – and do not share it with anyone unless there is a job-related need to know. Improper use or sharing of confidential information can harm our mission, our reputation, individuals in our care and our business partners. Texting is one example of sharing information improperly. Texting patient information can pose a significant risk to patient privacy and confidentiality as it can be easily intercepted or misdirected. Only approved secure methods can be utilized for texting communications for the protection of this sensitive protected health information (PHI).

Refer to CommonSpirit's policies and standards for privacy, security and confidentiality for more information. Violating these policies, standards, laws or regulations may result in disciplinary action and civil or criminal penalties against the individuals involved or CommonSpirit. If you have any questions, please contact your local Privacy Officer or your local Security Officer.

Relevant CommonSpirit Policies

- Privacy Policies and Standards

Q We just hired a new employee in our department. She has not yet received her computer login information, and she cannot begin her work assignments. She asked me to share my username and password with her so she could begin her new assignment. What should I do?

A Passwords are confidential information and must not be shared with others, including managers and IT employees. Sharing your username and password violates CommonSpirit's information security policies. If you share passwords you will be held accountable for any actions taken under that password, as well as for violation of our policies. Ask your new colleague to speak to their manager and to contact the Information Technology Services (ITS) Help Desk to gain appropriate access.

Relevant CommonSpirit Policies

- Data Asset Usage Policy

Q In order not to fall behind on my assignments, I sometimes take work home. May I email confidential information or work documents to my personal email address, copy them to a portable storage device or save them to my personal laptop computer for this purpose?

A No. You must not email, copy or save work-related documents to an external personal email address, portable storage device or personal computer if the reason is to work from home. All work done for our organization must be done on equipment the organization provides and/or authorizes for work purposes. Use of your personal email address is not permitted for work purposes and use of any portable storage device must be authorized by Information Technology. If you are authorized by your manager to work during times when you are not at our facility, and you are paid hourly as a non-exempt employee, you must also track all time worked for timely and proper payment of wages. Beyond this, you must only use organization equipment provisioned to you or equipment authorized for work purposes. Consult with your manager and your Human Resources Business Partner before engaging in work outside your scheduled work hours and location.

Q Why am I not allowed to use my own USB drive to back up my work files or work from home?

A Many USB drives are not encrypted, and they are easy to lose. Some of the largest breaches of confidential information in health care have been due to lost, unencrypted USB drives.

In addition, USB drives are not a good backup solution and are less reliable than saving information on a Google/network drive. If you have critical files and are concerned about backing them up you are to contact IT and request a network share to be allocated.

Once CommonSpirit information is copied to any removable media device, the organization may not be able to maintain custody or an adequate level of security over the information. Personal computers/laptops do not maintain the same level of protection against computer viruses and hacking as the CommonSpirit network.

Q Can I reuse passwords from other workplace or personal accounts? Can I use a password vault, so I do not have to remember so many passwords?

A CommonSpirit requires that you use strong and unique passwords for business accounts. Reuse of passwords, even strong passwords, may compromise our business accounts as well as any other accounts you have with that same password. Password vault services are not permitted for our business accounts because of the risk of data breaches. Several publicly available password vault applications have experienced breaches that put all stored credentials at risk. Also, password vaults are often tied to your mobile device, which could be lost, stolen or compromised by malware.

CommonSpirit allows users with certain privileges to use an enterprise-grade password management system. However, this is only intended for sensitive system accounts and is not available to store user account information.

Q I am excited about the work I do at CommonSpirit and would like to post information about my work on social media to share with friends. Is it okay to do this?

Individual employees are not authorized to speak, comment or make representations on behalf of CommonSpirit in social media posts.

A Please limit the work-related information you post on social media to general comments. Your personal social media posting must be done during non-working time. Remember that individual employees are not authorized to speak, comment or make representations on behalf of CommonSpirit, nor use our logo, workplace photos, coworker photos or other company insignia in social media posts. If you have questions, contact your Human Resources representative.

You are not permitted to comment on or reference patients or patient events, including but not limited to confidential information. Posting confidential information – such as patient names or other PHI, photographs, videos or business information – violates HIPAA and CommonSpirit privacy and security policies and may result in disciplinary action.

Relevant CommonSpirit Policies

- Corrective Action for Privacy and Security Violations Policy

Employee Information

Employees trust us to keep their personally identifiable information confidential by following applicable laws, regulations and human resources policies. This information includes wages and salaries; employment contracts, history and status; Social Security numbers; and financial and banking information.

Q I work in payroll. A friend who also works at the hospital is being promoted to a management position. He asked me to access our systems to look up how much other managers are making. Can I do so and share the information I accessed from our systems if I do not give specific names?

A No. You may not use our systems to access information that you have no legitimate business purpose for in performing your job duties. This constitutes unauthorized access. Questions about compensation must be referred to your Human Resources representative.

Business Information

We maintain and protect the confidentiality of our proprietary information. This includes but is not limited to information about our intellectual property, competitive position, business strategies, contract terms or negotiations, payments, reimbursements and negotiations with employees or outside organizations. Proprietary information can be used only for legitimate business purposes and protections are in place to prevent unauthorized use or disclosure. If your employment or association with CommonSpirit or our associated businesses ends, you have an ongoing obligation to maintain the confidentiality of this information. Competitive information obtained in violation of a covenant not to compete, a prior employment agreement, or other contract relationship may not be used to conduct business on behalf of CommonSpirit.

Q Before coming to work at CommonSpirit, I had a consulting relationship with a competitor and obtained confidential information about the competitor that would help CommonSpirit negotiate contracts. Should I share the information?

A No. It is inappropriate to use a competitor's confidential information in any business dealings. It would also be unethical for you to share CommonSpirit's confidential information with another employer.

Patient and Resident Information

We follow federal and state privacy and confidentiality laws such as HIPAA. Violating these laws may result in civil or criminal penalties for CommonSpirit or the responsible individuals. Our standards of conduct speak to the importance of confidentiality for our patients, residents and clients.

Employees, affiliated physicians and health care partners may only use and disclose PHI to care for our patients and residents; as allowed for treatment, operations and payment functions; or as allowed or required by other applicable laws and regulations. Any other use or disclosure of PHI requires a specific authorization from the patient, resident or client.

If you think PHI is being improperly used, accessed or disclosed, report your concern to your local Privacy Officer or by using the CommonSpirit Reporting Process.

Q In the break room, I heard my coworker discussing the condition of a physician's spouse who is receiving treatments at our hospital. What should I do?

A Physicians and their families are entitled to have their health information kept confidential in the same manner as other patients. This situation may violate HIPAA and our policies. Report the issue to your manager or local Privacy Officer or use the CommonSpirit Reporting Process.

Q One of my family members is in the intensive care unit. May I look at her medical information to let other family members know how she is doing?

A No. You may not access medical information without proper authorization from the patient. Being an employee of a health care organization does not give you greater access rights to the medical information of your family members. You may only access the information if it is part of your assigned job duties, or if the patient signs an authorization allowing you to access their records.

Q As a CommonSpirit employee, can I look at my own medical information?

A You must follow the same procedures required of any individual in our care by requesting access to your information from local Health Information Management (HIM), your designated release of information representative, or the patient portal. Being an employee of a health care organization does not give you greater access rights, even to your own medical information.

Relevant CommonSpirit Policies

- Permissible Uses and Disclosures of Protected Health Information
- Uses and Disclosures of PHI Requiring Authorization
- Privacy Complaint and Breach Investigation Management
- Right of Access to the Designated Record Set
- Minimum Necessary Standard for Use and Disclosure of PHI

Job Shadowing

HIPAA allows:

- Health care systems to use and disclose PHI when conducting training programs for students, trainees or practitioners learning under supervision to improve their skills as practitioners.
- Students engaged in a program formally affiliated with CommonSpirit.

To remain compliant with HIPAA, shadowing activities must meet the following requirements:

- Education and orientation about privacy and security practices.
- Compliance with Data Asset Usage Policy.

- Adequate supervision to prevent actual or potential access to PHI.
- Written patient authorization from any patient whose PHI would be viewed, accessed or disclosed.

No video/audio recording or photography of any kind can occur during any type of job shadowing, and additional consents and authorizations are required.

Relevant CommonSpirit Policies

- Data Asset Usage Policy
- Shadowing, Tours and HIPAA Implications

Social Media Guidance

We do not want patients to worry about their privacy before, during or after their visit to one of our facilities. We must protect – both during and after the work day – any information about a patient that employees access, use or otherwise learn about while performing their jobs. Do not:

- Post or share any patient-related information on any social media platforms, including private pages or private groups.
- Take photographs or videos of patients on a personal cell phone or post any patient-related images to the internet, even if you believe the patient cannot be identified.
- Discuss patients or hospital/clinic events, including patient information or employee information, in internet chat rooms or on any internet site, including social media forums, even if the information is publicly known outside our health system.
- Use personal cell phones to send or receive patient information.
- Use personal cell phones or data devices except on breaks from regular work assignments and in non-patient care areas.

Relevant CommonSpirit Policies

- Social Media: Guidelines and Best Practices For Your Personal Social Media Use

Standard 5

Use Our Resources Wisely to Protect Our Assets, Reduce Our Environmental Impact and Increase Our Public Health Footprint

Protecting our Assets

CommonSpirit is committed to protecting our assets, including our financial resources, supplies, equipment and reputation. Employees are accountable for making wise and ethical decisions so that our assets are used to support our healing ministry. As responsible stewards of our resources, you are responsible for:

- Following this guide, as well as all policies and procedures.
- Keeping accurate and reliable financial records and reports.
- Using organizational equipment, supplies, materials and services for authorized purposes only, and protecting assets from loss, theft and misuse.
- Using the CommonSpirit Reporting Process to report any improper use of organizational assets.

Environmental Responsibility

Advancing the care and stewardship of the planet is part of our commitment to the common good. Local, national and global communities must nurture a sustainable and healthy environment. As a responsible corporate citizen, CommonSpirit is committed to:

- Expanding and strengthening environmental actions to meaningfully improve the outcomes of our health care ministry.
- Seeking proactive solutions to enhance the health and well-being of all, while avoiding adverse impacts to people and the environment.
- Minimizing and managing adverse impacts where avoidance is not possible, while seeking meaningful alternatives to promote the greater good.
- Enhancing and expanding partnerships and stakeholder engagement at all levels of society to build resilience and reinforce common goals that are life-affirming and mitigate environmental risk.

The ecological crisis we now face, with climate change being one of the most evident manifestations, is serious and urgent. CommonSpirit's efforts to see everything as connected – called integral ecology – underlies our commitment to addressing poverty and inequality among all people and to protecting and conserving our common home for present and future generations.

We promote a balanced approach to all social efforts to maximize patient, employee and community health and safety.

Social Responsibility

CommonSpirit is dedicated to advancing the care and stewardship of all people. This is a commitment to the common good, recognizing that local, national and global communities must promote social and economic justice. As a responsible corporate citizen, CommonSpirit will:

- Expand and strengthen social actions to meaningfully improve the outcomes of our health care ministry.
- Seek proactive solutions to enhancing the health and well-being of all, while avoiding adverse impacts to people.
- Minimize and manage adverse impacts where avoidance is not possible, while seeking meaningful alternatives to promote the greater good.
- Enhance and expand partnerships and stakeholder engagement at all levels of society to build resilience and reinforce common goals that are life-affirming and mitigate social risk.
- Seek to promote safety and security for colleagues, communities and society by addressing and preventing violence in all its forms. This includes directly prohibiting human trafficking within the organization and among all who interact with the organization.

Social responsibility is based on the concept that sustainable development must be founded on a "universal respect for, and observance of, human rights and fundamental freedoms for all" . CommonSpirit does not promote or contribute to violations of international human rights obligations and treaties. CommonSpirit will support the protection and fulfillment of human rights, including addressing, reducing and preventing the negative impacts of social determinants of health.

CommonSpirit promotes a balanced approach to all social efforts to maximize patient, employee and community health and safety.

Standard 6

Create an Environment that Promotes Community, Respects Dignity and Supports Safety and Well-being

Health and Safety

CommonSpirit facilities maintain a safe and healthy working environment. Employees:

- Must be adequately trained on and adhere to all safety policies and procedures.
- Must conduct themselves in a manner that minimizes health and safety hazards and promptly notify their manager of any actual or potential unsafe working conditions or practices.
- Must properly generate, store and dispose of biological, medical, chemical and other hazardous waste according to applicable laws and policies designed to protect human, environmental and community health.
- Who are authorized to operate incinerators, sterilizers, decontaminators and underground storage tanks (containing fuel for emergency generators) and other equipment containing chemicals must be adequately trained to operate devices according to all permits, regulations and applicable procedures.

Prohibitions on Discrimination, Harassment and Retaliation

CommonSpirit is committed to ensuring a safe, inclusive and collaborative work environment where employee talents, ideas and expertise are respected and encouraged. Consistent with our policies prohibiting discrimination, harassment or retaliation, the work environment must be free of discrimination, harassment, intimidation/bullying or retaliatory conduct. As an employee in any role, you are expected to comply with our policies and prohibitions on discrimination, harassment and retaliation in all aspects of your work with our organization.

Relevant CommonSpirit Policies

- No-Retaliation Policy
- Anti-Discrimination and Harassment-Free Workplace

Human Trafficking

CommonSpirit's Human Trafficking Response Program equips physicians, advanced practice providers and staff to identify patients who may be victims of human trafficking or other types of abuse, neglect and violence, and to provide trauma-informed, healing-centered care to affected patients and families. This includes victim-centered intervention assistance, such as warm referrals (i.e., personal introductions) to community agencies and continued care that promotes healing and recovery. If you have concerns that a patient may be affected by abuse, neglect or violence, including labor trafficking or sex trafficking, refer to the Abuse, Neglect, and Violence CommonSpirit policy (located in the Human Trafficking Response Program link below). To learn more about human trafficking, see the CommonSpirit educational course, *Human Trafficking 101: Dispelling the Myths,* in the CommonSpirit learning management system.

Relevant CommonSpirit Policies

- Human Trafficking (HT) Response Program

CommonSpirit facilities maintain a safe and healthy working environment. Employees must adhere to all safety policies and procedures.

Standard 7

Properly Disclose and Manage Situations that Pose Potential or Actual Conflicts of Interest

Conflicts of Interest

Conflicts of interest occur when personal interests or activities influence or appear to influence our ability to act in the best interests of CommonSpirit. Actions or relationships that could create a conflict of interest must be disclosed in writing, in advance, and managed appropriately according to policy. CommonSpirit employees must properly disclose and cooperate in the management of situations that pose potential or actual conflicts of interest.

Gifts and Gratuities

CommonSpirit defines a gift as an item of value, including cash; cash equivalents, such as a gift certificate or a voucher; grants; scholarships; educational funding; meals, lodging and transportation; and tickets to a sporting, cultural or community event, including any fees associated with that event. Accepting gifts from vendors can create the perception that decisions are made based on personal benefit rather than what is in the best interests of CommonSpirit. This perceived conflict of interest can undermine the trust of patients and community members.

Improper gift giving and receiving may also violate the federal Anti-Kickback Statute, which prohibits individuals and entities from knowingly offering, paying, soliciting or receiving remuneration (anything of value, or "kickbacks") to induce or reward referrals of items or services paid for by federally funded programs. If a vendor's gift causes concern, talk with your manager and local Corporate Responsibility Officer to review the facts and circumstances of the situation.

Relevant CommonSpirit Policies

- Gifts and Gratuities To and From Business Sources Policy (includes a FAQ)

Outside Activities and Employment

If you own or have any type of employment or consulting arrangement with an outside entity (including vendors), the arrangement must be disclosed to your manager for review and approval. If your manager approves, any consulting or other business activities must be conducted on your personal time (not work time) using non-CommonSpirit resources, and must not conflict with or affect your work performance.

Relevant CommonSpirit Policies

- Payments and Arrangements Between Business Sources and Employees Policy

Vendor Relations

Business relationships with vendors must be conducted fairly and in the best interests of CommonSpirit, without inappropriate personal ties to or bias toward vendors. Employees must disclose to their manager any personal relationships and business activities with contractors, vendors and referral sources or referral recipients. Use the CommonSpirit Reporting Process to:

- Ask questions if you are concerned about a contractor relationship.
- Report attempts by contractors to inappropriately influence business activities.

Participation on Outside Boards of Trustees/ Directors

CommonSpirit encourages employees to be active in their communities. This may include serving on the boards of charitable, community and civic organizations. You must not accept a position on a board if that participation conflicts, or may conflict, with the interests of CommonSpirit. If you choose to accept such a position when there is or may be a conflict of interest and appropriate steps are not taken to mitigate or manage the conflict, such action will be treated as a violation of the Conflicts of Interest Policy. If you have any questions as to whether such a conflict exists, check with your manager or your local Corporate Responsibility Officer.

When serving on outside boards:

- Do not participate in actions on matters that might affect the interests of CommonSpirit.
- Do not identify yourself as speaking on behalf of CommonSpirit unless permitted to do so by the conflict of interest management plan.
- Conduct outside board service on your personal time, not work time, using non-CommonSpirit resources. Outside board service must not conflict with or affect your work performance.

Relevant CommonSpirit Policies

- Conflicts of Interest Policy

Endorsement and Testimonial Guidance

Employees may not provide endorsements, testimonials or other forms of external communications on behalf of CommonSpirit or your local organization unless you have written approval in accordance with applicable CommonSpirit policies. You may not provide statements, testimonials or endorsements for use by a vendor, contractor, the media or other third parties except as allowed by CommonSpirit's Endorsements/ Advertisement Policy (see link below).

Q I have been asked to serve on a speaker panel at a vendor-sponsored event, what do I need to do?

A You must:

- Obtain the written approval of your manager, the CommonSpirit Senior Vice President of Marketing and Communications Officer and the Senior Vice President of Brand, or their respective designees.
- Confirm your participation in the event is not an explicit endorsement, but a collaborative partnership that improves patient care, operational performance, community health or environmental sustainability.
- Verify your presentation slide deck is branded as CommonSpirit and not co-branded.

Relevant CommonSpirit Policies

- Endorsements/Advertisement Policy

Employees may not provide endorsements or testimonials on behalf of CommonSpirit unless you have written approval.

Standard 8

Foster a Diverse and Inclusive Work Environment in Reverence to Our Employees, Partners and Those We Serve

Diversity, Equity, Inclusion and Belonging

CommonSpirit's commitment to Diversity, Equity, Inclusion and Belonging (DEIB) strengthens our ministry's values. We work to embed DEIB best practices in every aspect of our ministry – from the delivery of quality health services to employee and physician engagement, patient experience, clinical quality and safety, leadership development and culture. Our key goals include:

- Valuing and acknowledging the diversity of our employees, patients and the communities we serve.
- Acting with inclusion by creating a welcoming and kind engagement of those who share in the work of our health care ministry, celebrating everyone's gifts and voice.
- Ensuring fair and equitable health care practices for all people.
- Striving to create a sense of belonging by connecting our shared experiences as community, patients and employees for a safe and trusting environment.
- Sharing our collective commitment to health equity by removing barriers to a fair and just opportunity to be as healthy as possible.

Conclusion

CommonSpirit's values and standards of conduct, as found in this guide, serve as guiding principles for ethical behavior. It is our responsibility to understand and follow these standards of conduct. Contact your manager, Corporate Responsibility Officer or call the reporting hotline number: 1 (800) 845-4310 with questions or concerns. No retaliatory action will be taken against anyone who makes a good-faith report of a potential violation of the standards, guidelines and policies outlined in this guide. By promoting our values and ethics, we can strengthen our organization and live out the mission of CommonSpirit.

Appendix A: Acknowledgement and Certification

I acknowledge I have received an electronic or physical copy of the CommonSpirit Standards of Conduct: Our Values in Action Policy and Reference Guide.

- I agree to read it completely.
- I agree to discuss any questions or concerns regarding this guide with my manager or other appropriate CommonSpirit leader.
- As a policy document, I certify that I will comply with the standards and guidelines in this guide and any other standards or applicable policies set by CommonSpirit.
- I understand:
  - It is my responsibility to report any concerns regarding possible violations of these standards, guidelines or policies.
  - I may be asked to cooperate in an investigation of matters that may affect or relate to compliance with applicable standards, guidelines or policies and agree to do so.
  - Neither CommonSpirit nor the local organization I serve will retaliate against me for making a report in good faith.
  - CommonSpirit or the local organization I serve will conduct an excluded provider background check prior to my employment or association and periodically thereafter. CommonSpirit reserves the right to terminate my employment or other association if I am an excluded provider/individual.
  - This guide contains standards of conduct within CommonSpirit and is not a contract for employment or other services.
  - These standards may be amended, modified or clarified at any time, and I will receive periodic updates to these standards.

PLEASE PRINT

Name

Department, Board, Board Committee or Other Affiliation

Organization

Signature

Date

Your acknowledgment and certification above will be collected and retained. Consult with Human Resources or your local Corporate Responsibility Officer if you have any questions about this process.

CHI St. Vincent

POLICY NUMBER	**704**
ORIGINAL DATE:	**07/01/2003**
TITLE:	**STAFF RIGHTS**

POLICY

It is the policy of CHI St. Vincent to provide staff members with a mechanism to request not to participate in an aspect of patient care due to cultural values, ethics or religious beliefs, while ensuring that patient care will not be negatively affected if the request is granted.

PROCEDURES

STEP 1

If an employee requests not to participate in an aspect of patient care due to cultural values, ethics or religious beliefs, the request should be presented in writing to his/her manager on the Staff Rights Request Form. The request should specify the objectionable aspect of patient care and the reason it conflicts with or is impacted by the staff member's cultural values, ethics or religious beliefs. The manager will ensure that sufficient information is received on the form and will discuss with the staff member the basis for the request. The manager will respond to the staff member within five days, utilizing the Staff Rights Request Form.

Unless the staff member is presently engaged in the objectionable aspect of patient care at the time of the request, he/she will be excused from the objectionable aspect of patient care at the time the request is made, pending a decision by the manager. If possible, the staff member will be reassigned to other duties while a decision is being made. However, if the objectionable aspect of patient care constitutes a significant part of the staff member's duties and if there is no other position immediately available, the staff member will be relieved of his/her duties without pay pending a decision. The manager will immediately ensure an available replacement for the objectionable aspect of patient care with the replacement having equivalent competence and skill.

If the request is made while the staff member is engaged in the objectionable aspect of patient care, he/she will not be relieved from any responsibility until a comparable replacement is obtained, and only if the replacement is able to immediately assume the staff member's responsibilities without causing any negative effect whatsoever on the patient in question.

STEP 2

If the staff member does not agree with the manager's decision, he/she may proceed to the second step. Within three days of receiving the manager's decision, the employee will sign the Staff Rights Request Form indicating

his/her desire to have the decision reviewed and return the form to Human Resources. The request will then be forwarded to the appropriate Administrative Executive.

Human Resources will schedule a meeting between the staff member and the appropriate Executive within five working days of the request. While the request is pending, the staff member will continue to perform other duties if available. If reassignment is not possible, the staff member will continue on leave without pay pending a decision.

Within three working days after the meeting between the staff member and the accountable Executive, a written decision from the Executive will be delivered to the staff member.

STEP 3 If the staff member does not agree with the Executive's decision, he/she may proceed to the third step. Within three days, the staff member should indicate on the Staff Rights Request Form his/her desire to have the decision reviewed by the Ethics Committee and return this to Human Resources.

While this request is still pending, the staff member will either continue to perform the reassigned duties or if reassignment was not possible, to continue on leave without pay pending a decision on his/her request. If there was a replacement for the staff member, this replacement will continue to perform any duties which the staff member is not performing while the request is pending.

A meeting between the staff member and the Ethics Committee will be scheduled within ten working days after the staff member notifies Human Resources that he/she wishes to take this matter to the Ethics Committee. After meeting with the staff member and considering all aspects of the request, the Ethics Committee will make a recommendation to the Chief Executive Officer. The staff member will be notified of the Chief Executive Officer's decision within three working days of the Ethics Committee meeting. Human Resources will communicate the Chief Executive Officer's written decision to the staff member and all other parties concerned. The decision of the Chief Executive Officer will be final and binding.

If the final decision denies the staff member's request, he/she must return to all responsibilities of the job, including the objectionable aspect of patient care. If he/she does not do so, his/her employment will be terminated. If the final decision supports the staff member's request, he/she will be permitted to continue the duties to which he/she was reassigned, if such reassignment was possible. If such reassignment was not possible, he/she will continue to be on leave, without pay, until there is an open position for which he/she is qualified. At that time, he/she will be offered this open position. If the position is refused, his/her employment will be terminated.

While a staff member's request is being considered, every effort will be made to ensure that patient care is not negatively impacted. In deciding whether a staff member who has made a request under this policy will be immediately relived from his/her job duties (or a portion of them) and in deciding who the staff member's replacement will be if the staff member is excused, the treating physician(s) will be consulted, as well as other medical professionals who are involved in the treatment of a particular patient. It is the intent of this policy that no decision will be made which will negatively impact patient care.

When a staff member attends any of the meetings permitted under this policy, his/her regularly hourly rate will be paid. However, all requests to be away from job duties must be approved in advance by the manager.

STAFF RIGHTS REQUEST FORM

Name: _____ Title: _____

Department: _____ Date: _____

STEP 1

Statement of objectionable aspect of patient care and reason it conflicts with or is impacted by cultural values, ethics or religious beliefs.

_____

_____

_____

_____

_____

_____

Signature of Employee: _____

Manager Findings: _____

_____

_____

Decision: ___ Granted ___ Denied

Manager Signature: _____ Date: _____

Employee:

___ I accept the above decision

___ I wish the above decision to be reviewed by the executive (must be made within 3 working days)

Employee Signature: _____ Date: _____

STEP 2

Decision Appealed to the Appropriate Executive

Meeting Date: _____

Findings and Decision:

_____

_____

Executive Signature: _____ Date: _____

Employee:

___ I accept the above decision.

___ I wish the above decision to be reviewed by the Ethics Committee
(Must be made within 3 working days)

Employee Signature: _____ Date: _____

STEP 3

Decision Reviewed by the Ethics Committee

Meeting Date: _____ Time: _____

Ethics Committee Members: _____

_____

Findings & Recommendation:

_____

_____

_____

Chairperson Signature: _____ Date: _____

President's Findings & Decision: _____

_____

_____

Date Employee Notified: _____

Document Metadata

Document Name:	Staff Rights.doc
Policy Number:	HR policy 704
Original Location:	/CHI St. Vincent Hospitals/Human Resources
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Effective on:	05/12/2017
Creator:	Foreman, Michelle *Coordinator*
Committee / Policy Team:	Policy Management
Manager:	Alexander, Sunetta *Director*
Author(s):	Henson, Dalindra *Coordinator*
Reviewer(s):	Alexander, Sunetta *Director*
Approver(s):	Alexander, Sunetta *Director*
Publisher:	Stricklin, Samuel *Regulatory*

CHI St. Vincent

POLICY NUMBER:	**113**
ORIGINAL DATE:	**July 01, 2003**
TITLE:	**INTER-HOSPITAL TRANSFERS**
KEYWORDS:	

ACCOUNTABILITY:
VP of Human Resources

OBJECTIVES:

The Mission of Catholic Health Initiatives is to nurture the healing ministry of the Church, supported by education and research. Fidelity to the Gospel urges us to emphasize human dignity and social communities as we create healthier communities.

POLICY:

It is the Policy of CHI St. Vincent to equitably transfer employees within CHI St. Vincent from one hospital to another while appropriately managing the salary and benefit issues.

COMMENTS:

Any employee of CHI St. Vincent, who transfers from one hospital to another, will follow the same process as is used for employees from one CHI facility to another. Unless addressed within an applicable Collective Bargaining Agreement.

PROCEDURE:

1. The transferring facility will pay out the PTO balance to the employee.

2. The receiving facility will "hire" the employee into that hospital. The service date for pension, PTO accrual level and other seniority purposes will be the hire date of the transferring hospital.

3. The hours worked in the last 12 months prior to the transfer will apply toward the hours required for FMLA qualification in the receiving hospital.

4. All other benefits will go into effect no later than the first of the month following the employee's "hire" date with the hospital.

RESPONSIBILITIES:

The supervisor is responsible for ensuring that Human Resources is notified of the impending transfer and will facilitate the necessary paperwork.

Document Metadata

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Policy Number:	HR Policy 113
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Committee / Policy Team:	Policy Management
Manager:	Alexander, Sunetta *Director*
Author(s):	Henson, Dalindra *Coordinator*
Reviewer(s):	Alexander, Sunetta *Director*
Approver(s):	Alexander, Sunetta *Director*
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CHI St. Vincent

POLICY NUMBER:	**104**
ORIGINAL DATE:	**July 01, 2003**
TITLE:	**PROVISION OF SERVICES**
KEYWORDS:	

ACCOUNTABILITY:
VP of Human Resources

OBJECTIVES:
The Mission of Catholic Health Initiatives is to nurture the healing ministry of the Church, supported by education and research. Fidelity to the Gospel urges us to emphasize human dignity and social communities as we create healthier communities.

POLICY:

It is the policy of CHI St. Vincent to provide all services without discrimination based upon race, religion, color, national origin, sex, age, or handicap.

CHI St. Vincent complies with all applicable federal, state and local laws prohibiting discrimination in the provision of all services including Title VI and Title VII of the Civil Rights Act of 1964, as amended, Section 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act of 1990.

CHI St. Vincent

POLICY NUMBER:	**301**
ORIGINAL DATE:	**July 01, 2003**
TITLE:	**EMPLOYEE APPEALS**
KEYWORDS:	

ACCOUNTABILITY:
VP of Human Resources

OBJECTIVES:

The Mission of Catholic Health Initiatives is to nurture the healing ministry of the Church, supported by education and research. Fidelity to the Gospel urges us to emphasize human dignity and social communities as we create healthier communities.

POLICY:

It is the Policy of CHI St. Vincent to provide all employees with a means to have individual employment related disputes reviewed and responded to in a timely and appropriate manner. Employees are encouraged to make use of this process and will not be subjected to retaliation or be penalized in any way for doing so. This process is to be used to appeal corrective action, Performance Improvement Plans and/or Terminations. Human Resources will serve as the facilitator throughout the process.

PURPOSE:

This process is intended to supplement rather than discourage or replace informal discussion. It is established to open the doors of communication at all levels of the organization and to provide a fair and equitable means to resolve individual employment related disputes at the lowest possible level of the process.

A manager should make every reasonable effort to resolve issues brought forth outside the formal appeals process.

COMMENTS:

This process is available to all non-probationary, non-union employees (*see the Collective Bargaining Agreement regarding the union process*).

PROCEDURE:

Since many issues can be discussed and resolved between the parties, employees are encouraged to direct all their individual disputes to their immediate supervisor. A three-step process has been adopted to ensure a fair, equitable and open discussion of issues unresolved during the normal course of business.

1. An employee appeal should be presented to Human Resources within 10 working days of the incident resulting in the complaint. An attempt will be working days of the incident resulting in the complaint. An attempt will be made to mediate and respond to the situation within 5 working days from notification. If the employee is still dissatisfied following attempts by Human Resources to facilitate/mediate the problem; he/she may obtain an Appeals Form from Human Resources. This form must be completed and returned to Human Resources within 5 working days. This form will be forwarded to the appropriate Senior Vice President, Clinical Administrator or Executive for review. The Executive or Administrator will meet with the employee and provide a written decision within 5 working days after meeting with the employee.
2. If the employee is not satisfied with the decision from Step 2 within working days, he/she must request, in writing, a review of the appeal and the Executive or Administrator's decision by the Appeals Committee. The Appeals Committee will be facilitated by a Human Resources Business Partner and is composed of members who do not know the employee and have not been involved earlier in this process including two Employee Council members,

a Sister or chaplain, a department manager, and a Director, Administrative Staff member or Executive Team member and the Chair. The chair will vote only in the event of a tie. The date is set by the organization. If the employee does not attend the meeting, the committee will review the available information to make a decision.

The appeal meeting is scheduled for two hours. Information regarding the appeal will be provided to the chair in advance of the appeal meeting. Committee members will receive the information when they arrive for the meeting. The meeting will be opened with the chair advising the members of the procedure. The chair will also moderate the meeting. The Human Resource Representative will keep notes of the meeting. Decisions regarding the appeal are based on majority vote. The chair votes only in the event of a tie. An outline of the agenda is as follows:

- 10 Minutes: Committee Chair instructs committee on proceedings, and the Human Resources representative provides copies of the documents to committee.
- 20 Minutes: Committee reviews documents
- 30 Minutes: Grievant states his/her case
- 10 Minutes: Committee is given an opportunity to question the grievant
- 30 Minutes: Supervisor states his/her case
- 10 Minutes: Committee is given an opportunity to question the supervisor
- 10 Minutes: Committee deliberates and makes a decision

The employee may bring one person with him/her who will not take a role in the process. Because this is an internal, non-legal proceeding, no attorneys may participate and no recording devices are permitted. The Appeals Committee will meet within 2 weeks from the date the Human Resources Department receives the employee's request for a review by the Committee. The chair of the Appeals Committee will then review findings with the Vice President of Human Resources prior to communicating the Appeals Committee's decision with the employee. This step concludes the appeals process.

The Vice President of Human Resources will review the decisions of the Appeals Committee with the President/CEO of the Health System as appropriate.

Employee Appeal Form Step1

Name:_____

Date:_____

Department:_____

Title:._____

Mailing Address:_____

Phone:_____

*Email Address: _____

*Alternate Phone:_____

(*Note: Email address and alternate phone are not required.)

I wish to state my intent to appeal the disciplinary action issues to me on _____

Based on the following circumstances (be as specific as possible):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

A just and fair solution to my appeal would be:

_____

Employee Appeals:

_____

_____

Employee Signature:

_____

(Note: This form must be completed and returned to Human Resources within 10 working clays of incident resulting in the complaint.)

Employee Appeal Form Step 2

Name:_____

Date:,_____

I wish to request review of the step 1 appeal decision by the appropriate Executive or Administrator.

(Note: This form must be completed and returned to Human Resources within 5 working days of employee's receipt of step 1 decision.)

Employee Signature:_____

Employee Appeal Form Step 3

Name:_____

Date:_____

I wish to request review of the step 2 appeal decision by the Appeals Committee.

(Note: This form must be completed and returned to Human Resources within 3 working days of employee's receipt of step 2 decision.)

Employee Signature:_____

Document Metadata

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Committee / Policy Team:	Policy Management
Owner/SME:	Henson, Dalindra *Coordinator*
Manager:	Alexander, Sunetta *Director*
Author(s):	Henson, Dalindra *Coordinator*
Reviewer(s):	Alexander, Sunetta *Director*
Approver(s):	Alexander, Sunetta *Director*
Publisher:	Stricklin, Samuel *Regulatory*

and equitable manner.

GUIDELINES FOR REPORTED PHYSICIAN MISCONDUCT:

1. A single egregious incident or repeated incidents shall result in initiation of an assessment of the incident and possible investigatory action pursuant to the Hospital's policy on appointment, reappointment, and clinical privileges. Summary suspension may be appropriate pending this process.
2. The Chief of the Medical Staff will do an assessment of reports. The Chief of the Medical Staff may dismiss reports which are not founded. The individual initiating such report will be apprised. Those reports considered accurate will be addressed as follows:
   - Unless the reported behavior is egregious, a single confirmed incident warrants a discussion with the offending physician: The Chief of Staff or VPMA or designee shall initiate such a discussion and emphasize that conduct is inappropriate and must cease. The initial approach should be collegial and designed to be helpful to the physician and the Hospital.
   - If it appears to the Chief of the Medical Staff or VPMA that a pattern of disruptive behavior is developing, the Chief of Staff or designee shall discuss the matter with the physician as outlined below.
     - Emphasize that if such repeated behavior continues, more formal action will be taken to stop it. The MEC and President will be notified.
     - All meetings shall be documented.
     - A follow-up letter to the physician shall state the problem and that the physician is required to behave professionally and cooperatively within the Hospital.
     - Pursuant to the existing policy, the involved physician may submit a rebuttal to the charge. Such rebuttal will be maintained as a permanent part of the record.
   - If such behavior continues, the President of the hospital shall meet with and advise the physician that such conduct is intolerable and must stop. This meeting is not a discussion, but rather constitutes the physician's final warning. It shall be followed with a letter reiterating the warning.
   - Further unacceptable conduct as defined herein shall be referred to the Medical Executive Committee for action pursuant to Article VIII of the Medical Staff Bylaws.
3. Unacceptable disruptive conduct may include, but is not limited to, behavior such as:
   - Attacks (verbal or physical) leveled at other appointees to the Medical staff, Hospital personnel or patients which are personal, irrelevant, or go beyond the bounds of fair professional conduct.
   - Impertinent and inappropriate comments (or illustrations) made in patient medical records or other official documents, impugning the quality of care in the Hospital, or attacking particular physicians, nurses or Hospital policies.
   - Non-constructive criticism, addressed to its recipient in such a way as to intimidate, undermine confidence, belittle or imply stupidity or incompetence.

- Refusal to accept medical staff assignments or to participate in committee or departmental affairs on anything but his or her own terms or to do so in a disruptive manner.

4. Documentation of disruptive conduct is critical since it is ordinarily not one incident that leads to disciplinary action, but rather a pattern of inappropriate conduct. That documentation shall include:
   - The date and time of the questionable behavior;
   - If the behavior affected or involved a patient in any way, the name of the patient;
   - The circumstances which precipitated the situation,
   - A description of the questionable behavior limited to factual, objective language as much as possible;
   - The consequences, if any, of the disruptive behavior as it relates to patient care or hospital operations;
   - Record of any action taken to remedy the situation including date, time, place, action and name (s) of those intervening.
5. Any physician, employee, patient, or visitor may report potentially disruptive conduct.
6. The report shall be submitted to the Chief Executive Officer, the Chief of Staff, and the VPMA.

Document Metadata

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Creator:	Owens, Jessica *Assistant Staff*
Committee / Policy Team:	Policy Management
Owner/SME:	Johnston, Bonnie *Medical Services Coordinator*
Manager:	Johnston, Bonnie *Medical Services Coordinator*
Approver(s):	Ross, Douglas *Chief Medical Officer* Jenkins, Ashley *Director*
Publisher:	Wilson, Jessica *Regulatory*

POLICY NUMBER:	**FAC034**
ORIGINAL DATE:	**NOVEMBER 2022**
TITLE:	**WORKPLACE VIOLENCE PREVENTION- CHI ST. VINCENT HOT SPRINGS**
KEYWORDS:	Workplace, Violence, Prevention

ACCOUNTABILITY:
Director, Security- Safety Officer
Director, Human Resources
President, Hospital

OBJECTIVES:
As CommonSpirit Health, we make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all. To fulfill this mission, CHI St. Vincent strives to ensure a safe environment for all co-workers, patients, and providers and prevent workplace violence.

POLICY:
It is the Policy of CHI St. Vincent Hot Springs (SVHS) to provide a work environment that is safe, secure and free from violence. CHI St Vincent Hot Springs is committed to providing a work environment that is safe, secure and free from violence by adopting a workplace violence prevention plan to protect patients, visitors, vendors, staff, volunteers, physicians and contract employees from aggressive and violent behavior, and establishing a process to investigate and take corrective action to address the violent behavior of an employee, up to and including termination of employment.

Acts or threats of physical violence, including but not limited to, coercion, intimidation, harassment, or destruction of property that involves or affects patients, visitors, vendors, staff, volunteers, physicians and contract employees of SVHS will not be tolerated.

The CHI St. Vincent Hot Springs Facilities ("Facility" is defined as CHI St. Vincent Hot Springs hospital, offsite centers, CHI St Vincent affiliated clinics and St. Vincent Hospital office buildings/property) understand that hospitalization and outpatient care environments are stressful for patients and their family members/visitors. The Facilities recognize and respect patient rights and are committed to responding appropriately to patient complaints about care. Actions and interactions related to disruptive behavior will include consideration of the patient's health care needs and psychosocial issues as well as the facility's obligations related to the safety of its employees, visitors, vendors and patients and responsible use of institutional resources.

Weapons, and other items that may be used as weapons, other than those required and approved in the course of assigned roles, responsibilities and duties are strictly prohibited within the facilities or property.

The Facility shall not take punitive or retaliatory action against an employee for, seeking assistance and intervention from local emergency services or law enforcement when they perceive that a violent incident has or will occur.

Ongoing conversations about workplace violence are encouraged by leadership in unit huddles and staff meetings. Discussions should include team leaders asking if any team members have been victims of physical or verbal abuse or if any patient/family situations may be prone to violence.

PROCEDURE:

A. Workplace Prevention Plan.

1. Develop and provide a system for responding to, and investigating violent incidents and situations involving violence or the risk of violence involving patients and/or family members.

a. An Emergency Mgmt. team meeting may be requested by any member of the medical team, employee and/or administrative team, Risk Mgmt., Security or designee on an ad hoc basis to evaluate threatening/unsafe situations involving patients. The Facility and outpatient care environments are to manage situations where disruptive behavior continues to escalate despite attempts at intervention. The team will continue to evaluate and develop a plan to address the behaviors. Possible plans for resolution may include:

i. Leadership and Risk Mgmt. (or designee) support for setting limits with patients and/or families.

ii. Team meeting with patient and/or family.

iii. Develop care/behavior modification plan.

iv. Discuss with the patient and/or family any of the applicable patient rights and responsibilities documents that reference rules and regulations affecting patient care and conduct.

v. If no resolution notify nurse manager (or designee) and Security or designee to discuss further action needed (i.e. restriction of visitation and/or discontinuation of care) in conjunction with the attending/primary physician.

b. Medically stable patient and/or family/caregiver refusing discharge.

i. Notify MD, Case Management and Nursing Supervisor.

ii. Security and/or designee may be required to escort through the hospital or care center. Law enforcement may also be required.

c. Violation of Drug & Alcohol Screening policy, Policy# HR-Policy-101

i. Follow procedures set forth in that specific policy.

2. For all potential work place violence events, utilize engineering controls wherever possible to remove a hazard from the workplace or create a barrier between the worker or other person at risk and the hazard including but not limited to: electronic access controls/locks to employee occupied areas; lighting; separate rooms or areas for high risk patients; removing/securing objects with weapon potential; closed circuit television monitoring.

3. Human Resources will follow the CHI St. Vincent background check policy and verification of licensure boards of prospective employees.

4. The Facility shall establish a system to identify patient specific risk factors such as the prior use of drugs or alcohol, psychiatric condition or diagnosis, any condition or disease that would cause confusion or disorientation, have a history of violence and/or who display disruptive behavior which may increase the likelihood or severity of a workplace violence incident and to assess visitors or other persons who display disruptive behavior or demonstrate a risk of committing workplace violence.

a. Patient specific risk factors may be communicated to receiving Facilities by paramedic and other emergency services or law enforcement prior to or upon arrival to the Facility.

B. Response to Actual or Suspected Workplace Violence:

1. Immediate Danger

a. If an emergency exists with the risk of imminent harm, the person shall:

i. Call Security Services. Methods for calling Facility/clinic/site Security or designee may include but is not limited to:

- Direct Security ext. 2323 or designee phone line(s)
- Direct 2-way radios, in areas where used.
- Desk/Fixed Panic Button, in areas where deployed/used.
- Initiate internal emergency codes or other designated alerts by calling switch board ext. 5555
- If outside of building or offsite call 9-1-1

b. If an emergency exists with an extreme level of threat (Combative Person, Active Shooter or threat by deadly weapon, etc.):

i. Call local Law Enforcement immediately by dialing 9-1-1 (from Red phone or cell phone) or 9-9-1-1 (from office/internal phone).

ii. Call Security or designee, using one of the methods described above in section (B.1.a.i).

iii. Take emergency steps to protect oneself from immediate harm, such as the run, hide, fight strategy.

c. Call Security Assistance, using one of the methods described above in section (b.1.a.i), when someone is, or is becoming, verbally aggressive, physically aggressive with a chair or other equipment of any kind. Call Security Alert if someone has a knife, gun, etc.
   i. Code- Security Alert- Active Shooter/Physical Assault, Policy# ON322PCS

d. Facilities operators shall call local Law Enforcement if Security or designee is not on-site by dialing 9-1-1 or 9-9-1-1, and take emergency steps to protect oneself from immediate harm, such as leaving the area.

2. Post-Incident Notification of Assault or Battery:

a. In situations not posing an imminent danger, employees shall immediately notify Security/management/house supervisor of any assaultive conduct so that appropriate action can be taken.

i. Employees responding to acts of aggression/assaultive behavior should utilize de-escalation techniques and defensive logistics.

ii. If self-defense is needed to handle a situation, the least amount of force should utilized.

iii. Assistance from fellow staff should be requested if needed and under certain circumstances leaving the area may be the best course of action.

b. Call Security or designee to inform of the incident and involve them in the initial securing of the area. If Security or designee is not available on site, call 911. At the earliest opportunity thereafter, notify the identified site security leadership of the incident.

c. Examine the workplace for security risk factors associated with the incident to protect employees from imminent hazards

immediately, and to take measures to protect employees from identified serious hazards within seven days of the discovery of the hazard, where there is a realistic possibility that death or serious physical harm could result from the hazard. If immediate resolution is not achievable, implement interim measures to abate the imminent or serious nature of the hazard while completing the permanent control measures.

This may include but is not limited to:

i. Any person who makes substantial threats, exhibits threatening behavior or engages in violent acts on the premises shall be removed from the property as quickly as safety permits, and may be asked to remain away from the premises pending the outcome of an investigation into the incident. SVHS Facilities reserve the right to respond to any actual or perceived acts of violence in a manner sufficient to address the event based on the specific facts and circumstances related to the event.

ii. Identify all employees involved in the incident.

iii. Any staff member assaulted or battered will be relieved of their duties immediately by management/designee while a statement of the incident and assessment of their injuries is completed.

iv. Provision of emergency medical care in the event of any violent act upon an employee.

v. Providing additional employee education/training.

vi. Relocation of a patient to another patient care unit, area or care center.

vii. Reassignment of a staff member.

viii. Assignment of a safety attendant (sitter) or assignment of additional security personnel.

ix. Post-event counseling or debriefing for those employees desiring such assistance.

x. Obtaining a restraining order as appropriate.

xi. Proactive security measures for the involved employee including special parking arrangements, escorts, and modifications to work location and shift.

xii. Post-incident debriefing as soon as possible after the incident with the injured employee, management, and Security or designee, if applicable, involved in the incident.

d. Management will notify Human Resources and Security Leadership of actual or suspected acts of workplace violence.

e. Management will notify Employee Health and facilitate the completion of an Employee IRIS report by the employee. Employees are also permitted to make these notifications directly.

3. Telephone Threats

a. Employees shall immediately inform management and security or designee or call law enforcement if they receive a threat over the telephone. The employee should note the time, date, and the threat was received and phone number of the caller if available.

b. If the threat involves and imminent act of violence, such as a bomb threat, report it **immediately** to Security or designee and activate a facility internal emergency.
   i. Code- Security Alert- Bomb Threat, Policy# ON321PCS

4. Written Threats

a. Employees shall immediately inform management and Security or designee of written threats, whether on paper, via electronic mail or social media

   i. Handle written material and any envelope as little as possible and only by the corners.

   ii. Place both the written material and the envelope in a larger envelope.

   iii. Note the names of anyone who may have handled the material after its arrival.

5. If an employee obtains a restraining order against another person, including another employee, the employee should inform management and Human Resources within a reasonable timeframe, and include a description of the

individual, a photograph, if available, and a copy of the restraining order.

a. A copy of the restraining order and photograph shall be filed with Human Resources and Security or designee.

b. Human Resources and Security or designee will review the situation and take the appropriate steps to ensure a safe environment for all employees.

6. If an employee identifies the unexpected arrival of an individual who has made prior threats, the employee shall inform management of this individual's arrival and notify security or designee if available and/or law enforcement.

C. Management Investigation

1. If the incident complaint is directed at a staff member:

a. The manager, together with Human Resources, will determine if the employee(s) who is the subject of an allegation of workplace violence should be placed on administrative leave pending investigation.

b. Human Resources shall conduct a thorough investigation which may include some or all of the following:

i. Complete a criminal background check on the individual regardless of any prior check being completed.

ii. Review the employee's personnel file, looking for any information that indicates a trend toward violence, and/or other pertinent facts.

iii. Interview all witnesses to the alleged act of violence, including appropriate employees from the work environment of the suspected employee.

2. Based upon the outcome of the investigation, management and Human Resources will determine the appropriate action to be taken, which may consist of corrective action up to and including termination of employment.

3. Employees who are determined to have intentionally falsely accused other of workplace violence may also be subject to corrective action, up to and including termination of employment.

4. Employee reports to supervisor any injury, no matter how small.

a. An injury is reported in IRIS and is filled out in detail by management

and employee.

b. Notification Reports and/or manager's Report (IRIS) form shall be completed on all employees when they have sustained an injury.

c. Completed IRIS reports are to be sent to Employee Health within 24 hours of incident.

D. Record Keeping/Handling

1. All actual or perceived threats of violence will be entered into the IRIS system.

2. All employee injuries resulting from workplace violence will be entered in the Workers' Compensation claims administration system.

a. Information about each incident will be based on information solicited from the employees who experienced the workplace violence.

b. Omit any element of personal identifying information sufficient to allow identification of the person involved in the violent incident, such as the person's name, address, electronic mail address, telephone number, or social security number, or other information that, alone or in combination with other publicly available information, reveals the person's identity.

3. Annual Review of IRIS Work Place Violence with annual security management plan

4. Evidence of annual education will be maintained for a minimum of one year.

5. Security reports are filed within the IRIS system.

E. Administrative Oversight

1. Emergency Mgmt. team shall annually assess and improve upon factors that may contribute to or help prevent workplace violence, including, but not limited to, the following:

a. Security risk assessment to identify locations and situations where violent incidents are more likely to occur.

b. Review and evaluate workplace violence incidents which results in a serious injury or fatality.

c. Staffing, including staffing patterns and patient classification systems

that contribute to, or are insufficient to address, the risk of violence.

d. Sufficiency of security systems, including alarms, emergency response, and security personnel availability.

e. Security risks associated with specific units, areas of the facility with:

- Uncontrolled access
- Late-night or early morning shifts
- Employee security in areas surrounding the facility such as employee parking areas, poor illumination or blocked visibility, lack of physical barriers or effective escape routs
- Obstacles and impediments to accessing alarm systems and/or where alarm systems are not operational
- Presence of furnishings or any objects that could be used as weapons
- Storage of high-value items, currency, or pharmaceuticals

f. Update the Plan whenever necessary as follows:

- Review and respond to information indicating that the Plan is deficient in any area
- To reflect new or modified tasks and procedures which may affect how the Plan is implemented (i.e. changes in staffing, engineering controls, construction, modification of the facility, evacuation procedures, alarm systems and emergency response)
- Include newly recognized workplace violence hazards

2. Consult (individually, in groups or in committee) with affected employees, recognized collective bargaining agents (if applicable) in the development/revision of the workplace prevention plan as appropriate.

3. The Emergency Mgmt (EM) team members may include but not be limited to:

- Safety Officer
- Regulatory
- Risk Mgmt
- Emergency Department
- Facilities
- Security
- Senior Leader

4. Regularly distribute these workplace violence reports/summaries throughout the organization, including to Quality/Risk and up to the executive and

governance levels.

F. Education and Training – training will be provided to employees that address the workplace violence risks they are reasonably anticipated to encounter in their jobs.

1. Employees, including Security, will receive Tier 1 awareness training on workplace violence when newly hired.

2. The education and training shall cover topics that include, but are not limited to, the following:
   a. How to recognize potential for violence, factors contributing to the escalation of violence and how to counteract them, and when and how to seek assistance to prevent or respond to violence.

   b. Strategies to avoid physical harm including Run, Hide, Fight.

   c. How to recognize and respond to alert, alarms, or other warnings about emergency conditions (i.e. active shooter-Run, Hide, Fight), and how to use identified escape routes or locations for sheltering as applicable.

   d. How to communicate concerns about workplace violence without fear of reprisal.

   e. How to report violent threats to law enforcement.

   f. Any resources available to employees for coping with incidents and situations involving violence or the risk of violence.

   g. An opportunity for interactive questions and answers with a person knowledgeable about the workplace violence prevention plan.

   h. Training not given in person shall provide for interactive questions to be answered within one business day by a person knowledgeable about the workplace prevention plan.

   i. The role of private security personnel, if applicable.

3. Employees assigned to respond to alarms or other notifications of violent incidents receive additional training:

   a. Verbal intervention and de-escalation techniques and physical maneuvers to defuse and prevent violent behavior.

   b. Appropriate and inappropriate use of medications as chemical restraints.

4. All training must be documented and maintained in the employee's education training file for a minimum of one year.

5. Employees performing patient contact activities and those employees' supervisors shall be provided refresher training at least annually, applicable to those employees to review topics included in the initial training as well as the results of the annual workplace violence prevention plan effectiveness reviews.

G. Notifications to Law Enforcement and Regulatory Agencies

1. Applicable notifications will be made to law enforcement or The Joint Commission by the Quality (or designee) Management Department in conjunction with Security.

DEFINITIONS:

Assault: Assault is an unlawful attempt, coupled with a present ability, to commit a violent injury on the person of another.

Battery: Battery is any willful and unlawful use of force or violence upon the person of another.

Injury: A fatality or an injury that requires inpatient hospitalization for a period in excess of 24 hours for other than medical observation or in which an employee suffers a loss of any member of the body or suffers any serious degree of permanent disfigurement.

Urgent or emergent threat to the welfare, health, or safety of hospital personnel: Hospital personnel are exposed to a realistic possibility of death of serious physical harm.

Coercion: The practice of persuading someone to do something by using force or threats.

Intimidation: To frighten or threaten someone, usually in order to persuade the person to do something he or she does not want to do.

Harassment: The act of systematic and/or continued unwanted and annoying actions of one party or a group, including threats and demands.

Patient Contact: Providing a patient with treatment, observation, comfort, direct assistance, bedside evaluations, office evaluations, and any other action that involves or allows direct physical contact with the patient.

Threats or Acts of Violence: "Threat of violence" means a statement or conduct that causes a person to fear for his or her safety because there is a reasonable possibility the person might be physically injured, and that serves no legitimate purpose.

Workplace Violence: "Workplace violence" means any act of violence or threat of violence that occurs at the work site. The term workplace violence shall not include lawful acts of self-

defense or defense of others. Workplace violence includes the following:

A. The threat of use of physical force against an employee or other person at the Facility that results in, or has a high likelihood of resulting in, injury, psychological trauma, or stress, regardless of whether the employee or person sustains an injury;

B. An incident involving the threat or use of a firearm or dangerous weapon, including the use of common objects as weapons, regardless of whether the employee or other person sustains an injury;

C. Four workplace violence types:

1. "Type 1 violence" means workplace violence committed by a person who has no legitimate business at the work site, and includes violent acts by anyone who enters the workplace with the intent to commit a crime.

2. "Type 2 violence" means workplace directed at employees by customers, clients, patients, students, inmates, or visitors or other individuals accompanying a patient.

3. "Type 3 violence" means workplace violence against an employee by a present or former employee, supervisor, or manager.

4. "Type 4 violence" means workplace violence committed in the workplace by someone who does not work there, but has or is known to have had a personal relationship with an employee.

Document Metadata

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Approver(s):	Ross, Douglas *Chief Medical Officer* Whatley, Christina *Vice President* Alexander, Sunetta *Director* Bohannan, Crystal *Other Title (Not on List)*
Publisher:	Wilson, Jessica *Regulatory*

CHI St. Vincent

POLICY NUMBER:	**110.5**
ORIGINAL DATE:	**November 15, 2006**
TITLE:	**INTERNAL VOLUNTARY/INVOLUNTARY DEMOTIONS**
KEYWORDS:	

ACCOUNTABILITY:
VP of Human Resources

OBJECTIVES:

The Mission of Catholic Health Initiatives is to nurture the healing ministry of the Church, supported by education and research. Fidelity to the Gospel urges us to emphasize human dignity and social communities as we create healthier communities.

POLICY:

It is the Policy of CHI St. Vincent to establish a consistent and effective mechanism for voluntary/involuntary demotion of staff when requested or when deemed necessary.

PROCEDURE:

1. All demotions, voluntary and involuntary, require a salary quote through Human Resources prior to the demotion. Any "Save Pays" must be authorized by Human Resources.

2. Employees voluntarily/involuntarily demoting to their prior position/job title within a twelve (12) month period will be returned to the salary level they would be at had they not been moved/promoted to the higher level.

3. Employees involuntarily demoting to a lesser position than previously held will have their salary decreased. Salaries shall be determined by calculating years of applicable experience for the new position. Direct and indirect experience may be calculated however salaries shall not be greater than the prior salary, fall below the minimum of the range or above the maximum of the range.

4. Employees voluntarily demoting to a lesser position than previously held within a twelve (12) month period will have their salary decreased to the salary rate they would be at had they not been moved/promoted to the higher level. (*See number 3*)

5. Employees must remain in the reassigned position six (6) months before they are eligible to transfer to another department. Exceptions to this will only occur if all parties involved are in agreement (i.e., receiving leader, sending leader, and employee) and in consultation with Human Resources.

RESPONSIBILITIES:

The supervisor is responsible for ensuring that Human Resources is notified of the impending transfer and will facilitate the necessary paperwork.

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Committee / Policy Team:	Policy Management
Manager:	Alexander, Sunetta *Director*
Author(s):	Henson, Dalindra *Coordinator*
Reviewer(s):	Alexander, Sunetta *Director*
Approver(s):	Alexander, Sunetta *Director*
Publisher:	Stricklin, Samuel *Regulatory*

CHI St. Vincent

POLICY NUMBER:	**708**
ORIGINAL DATE:	**July 01, 2003**
TITLE:	**EMPLOYEE ASSIGNMENTS**
KEYWORDS:	

ACCOUNTABILITY:
VP of Human Resources

OBJECTIVES:
The Mission of Catholic Health Initiatives is to nurture the healing ministry of the Church, supported by education and research. Fidelity to the Gospel urges us to emphasize human dignity and social communities as we create healthier communities.

POLICY:

It is the Policy of CHI St. Vincent to properly assign appropriate staff.

PROCEDURE:

Each employee involved in patient care is assigned to patients depending on the appropriateness of their educational preparation, licensing laws and regulations, competencies and acuity standards of CHI St. Vincent.

CHI St. Vincent does not discriminate in the assignment of patient care due to race, color, religion, sex, national origin, age, physical or mental handicap or veteran status.

Please refer to Patient Care Services Policy ***ON199PCS: Staffing and Scheduling: Accountability, Delegation, and Assignment for more details.***

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CHI St. Vincent

POLICY NUMBER	**ON313PCS**
ORIGINAL DATE:	**December 2017**
TITLE:	**NON-COMPLIANT PATIENT BEHAVIOR**
KEYWORDS:	

ACCOUNTABILITY:
SVP & Chief Medical Officer
SVP & Chief Nursing Executive
Director of Risk Management

OBJECTIVE:

The Mission of Catholic Health Initiatives is to nurture the healing ministry of the Church, supported by education and research. Fidelity to the Gospel urges us to emphasize human dignity and social justice as we create healthier communities. To fulfill this mission, CHI St. Vincent will provide safe care for adult patients who are admitted to the hospital and to identify actions to take in the event of a patient leaving the unit.

PURPOSE: Provide safe, therapeutic environment for patients and visitors.

POLICY: This policy sets forth guidelines for handling mentally capable patients, who engage in noncompliant behavior that may adversely impact patient, visitor, and staff safety.

DEFINITION: "Noncompliant behavior" is inappropriate behavior by a mentally capable patient that is adverse to the prescribed treatment course or medications. Behavior that leads the patient to act against medical advice. These situations can include the following:

- Refusal of patients to comply with reasonable requests from medical or nursing staff member. This includes refusal to comply with medical protocols or hospital rules, such as smoking on hospital premises.
- Leaving patient care areas without approval from hospital staff.
- The use of alcohol and other medications or substances that are not prescribed by the treating physicians.

PROCEDURE:

I. **Documentation**:

A. When noncompliant behavior first occurs, the nursing staff and/or physician should counsel the patient with the intention of correcting the behavior.

1. Patient care staff are to document the noncompliant actions or behavior (including the date and time), as well as record that the patient was informed that such acts or behavior is inappropriate and must cease.

B. Instances of inappropriate or persistent non-compliant conduct should be documented to establish a pattern of repetitive disruptive behavior or non-compliance or otherwise inappropriate conduct.

C. All efforts to establish and maintain a satisfactory hospital/patient or hospital/patient relationship should be documented. (See section II below for further guidance.)

II. **Achieving Compliance**:

A. First concern is always the health and well-being of the patient.
B. Efforts should be made to achieve compliance from the patient to protect the safety to all hospital patients, and staff. As mentioned above, these efforts to de-escalate should be documented in the medical record.
C. In patients may be provided with the Patient's Responsibilities and Code of Conduct. Notices of patients' responsibilities will be posted for outpatients and emergency department patients.
D. Counseling may be provided to the patient, his/her family or others involved in the patient's care.
    i. At least two (2) members from the team should meet with the patient. Counseling should focus on the patient's responsibilities, the Safety Plan for the patient, the need for compliance and the consequences of continued inappropriate behavior.

III. **Violations of No Smoking Policy**:

A. Efforts should be made to achieve compliance from the patient as set forth above. In addition, the attending physician may discuss the potential of use of nicotine substitutes during the patient's admission.

IV. **Alcohol/Drug Use**:

A. If it is witnessed or suspected that the patient may be using alcohol, illegal drugs or medications not approved by the hospital pharmacy:
    i. Staff should call for "Security Assistance" by contacting hospital security immediately. The team may be activated by calling the hospital operator at extension 8500 SVI/SVN, 2204 SVM, 5555 SVHS. (Refer to "Code: Security Assistance" policy)
    ii. The charge nurse, clinical manager and/or Director/nursing supervisor need to be notified. If it is night shift, the administrator on-call or nursing supervisor needs to be notified.
    iii. Room search needs to be performed and completed by Security.
    iv. Any medications found during the room search are to be sent to pharmacy.
    v. Any illegal drugs or drug paraphernalia need to be confiscated and removed. It will be up to Security to decide whether to notify the local Police Department.
    vi. Patients suspected of using alcohol or illegal drugs should not be allowed to leave their room for their safety as well as the safety of others. Patients should be counseled that by leaving the room it is considered against medical advice.
    vii. If the behavior does not stop, Security may notify local law enforcement to report and request their assistance, as deemed appropriate.

V. **Administrative Discharges**:

A. The patient's repeated noncompliant behavior may be considered evidence the patient's intent to terminate the hospital/patient relationship. In these circumstances, the hospital

may consider an administrative discharge if a patient refuses to cooperate or exhibits continued noncompliant behavior, and the patient's medical condition permits.

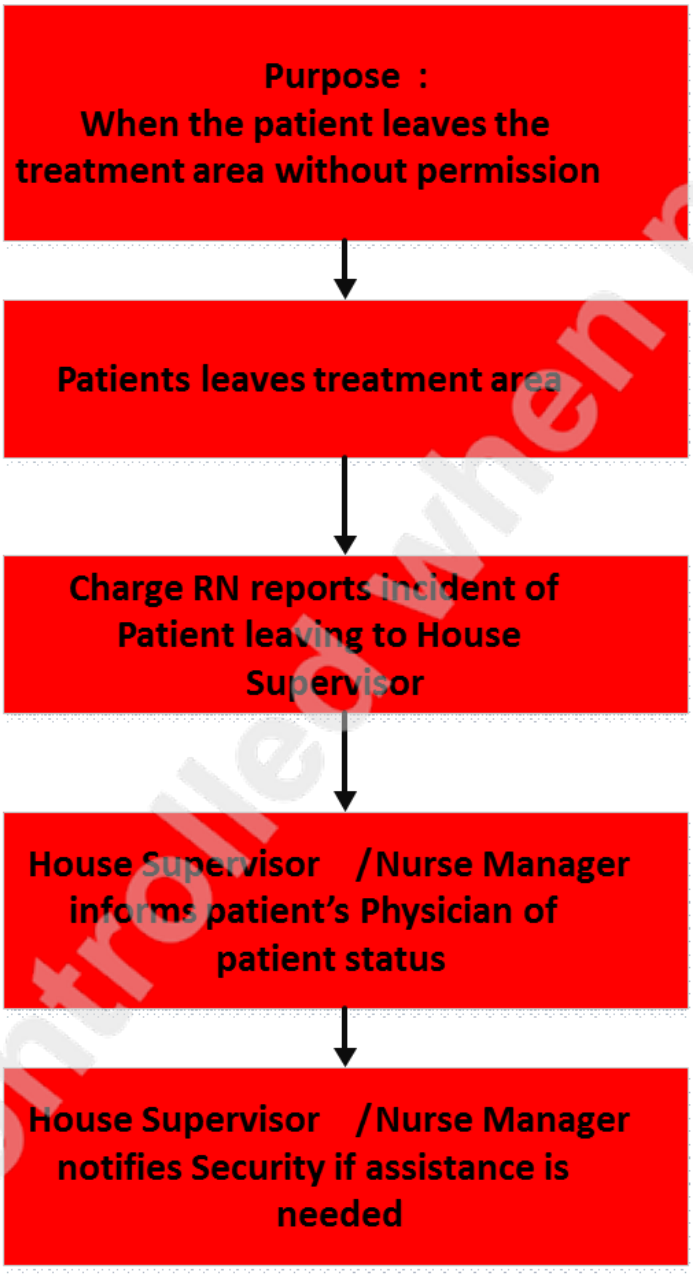
B. Risk Management must be involved in the decision to administratively discharge a patient.
C. Administrative discharge may be pursued only if there is documentation of the patient's disruptive behavior and the attempts of hospital staff to counsel the patient about his/her behavior.
D. The attending or treating physician must determine and document that based on their clinical judgment, the patient's medical condition is such that discharge is not likely to result in serious physical harm to the patient.
    i. The attending physician must conduct a thorough physical assessment of the patient and document the patient's physical and mental condition prior to discharge.
    ii. The attending physician must explain to the patient that the patient's repeated behavior evidences the patient's intent to terminate the hospital/patient relationship. The physician must explain the patient's current medical condition, the type of care which should be sought by the patient, and the timeframe within which such care should be obtained.
    iii. Although the current hospital/patient relationship may be terminated, the patient must be advised that he/she will not be denied emergency medical care in the future.

SOURCE:

Approved by the Market Policy Review November 2023

Appendix

Algorithm for Patients Leaving Treatment Unit



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Manager:	Lambert, Teresa *Vice President*
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Approver(s):	Longing, Angie *Chief Nursing Officer*
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HR A-022 Corrective Action for Privacy and Cybersecurity Violations

KB0011037

COMMONSPIRIT HEALTH ADMINISTRATIVE POLICY

SUBJECT: Corrective Action for Privacy and Cybersecurity Violations **POLICY NUMBER:** Human Resources A-022

EFFECTIVE DATE: May 1, 2021 **ORIGINAL EFFECTIVE DATE:** May 1, 2021

☒ National/System Offices ☒ Acute Care Facilities ☒ Non-Acute Care Facilities

POLICY

CommonSpirit Health adheres to all applicable state and federal laws providing for the privacy and security of protected health information (PHI) and electronic protected health information (ePHI) as defined by the Health Insurance Portability and Accountability Act (HIPAA), as well as other confidential information, in any form, including personally identifiable information (PII).

CommonSpirit will investigate alleged violations of confidentiality, privacy or cybersecurity laws, policies, regulations, standards or procedures and will impose corrective action as outlined in this Policy on employees and non-employees who fail to comply with state and federal laws or with organizational policies, standards or procedures relating to the privacy and security of confidential information, including PHI and ePHI of patients, and PII of employees and non-employees.

APPLICABILITY

This Policy applies to employees of CommonSpirit and its Direct Affiliates[1] employees, as well as employees of its Subsidiaries[2] who are considered CommonSpirit employees. It also applies to non-employees, as defined in this Policy, of Direct Affiliates and Subsidiaries for whom CommonSpirit provides the Privacy Program.

[1] A Direct Affiliate is any corporation of which CommonSpirit Health is the sole corporate member or sole shareholder, as well as Dignity Community Care, a Colorado nonprofit corporation.
[2] A Subsidiary refers to *either* an organization, whether nonprofit or for-profit, in which a Direct Affiliate holds the power to appoint fifty percent (50%) or more of the voting members of the governing body of such organization or holds fifty percent (50%) or more of the voting rights in such organization (as evidenced by membership powers or securities conferring certain decision-making authority on the Direct Affiliate) or any organization in which a Subsidiary holds such power or voting rights.

COLLECTIVE BARGAINING AGREEMENT APPLICABILITY

The Collective Bargaining Agreement shall govern where there is a conflict between this Policy and an applicable Collective Bargaining Agreement.

Levels of Violations

Generally, levels of violation and corrective action are determined according to the severity of the action. CommonSpirit will consider:

- whether the violation was intentional or unintentional,
- the impact on the organization
- the impact on a patient or other employee(s),
- whether the violation indicates a pattern or practice of improper use or disclosure of PHI, ePHI, PII, or other confidential information, and
- any mitigating factors

The three levels of privacy or cybersecurity violations, include:

Type One Violations:

A Type One violation occurs when an employee or non-employee unintentionally or carelessly accesses, reviews, or discloses confidential information to anyone without a legitimate business need to have access to or know the information; when review or disclosure by the employee is unrelated to the performance of their job duties; or when an employee fails to utilize established safeguards. Examples of Type One violations include, but are not limited to:

- Inadvertently e-mailing, faxing, mailing, or distributing PHI or other confidential information to the wrong person;

- Failing to secure e-mail, text message, or other electronic transmission or storage of PHI;
- Unintentional or initial violations of Data Leakage Protection protocols related to email;
- Clicking on phishing emails or malicious links, emails, or websites, excluding those that are CommonSpirit internally initiated for training purposes;
- Discussing patient information in a public area without taking reasonable measures to protect the discussion;
- Failing to properly verify the identity and access rights of a person requesting PHI, whether the person is requesting in person, in writing, or by phone;
- Failing to protect the privacy and confidentiality of medical records or other PHI or ePHI (e.g., leaving PHI exposed in a public area, permitting improper access, or conducting improper distribution or disposal of PHI, downloading to an unapproved or unencrypted drive, website, or location);
- Failing to lock one's computer screen when away from their workstation or failing to appropriately log off the organization's information system;
- Leaving more than the minimum required PHI on a patient's voicemail or via text message;
- Carelessly handling usernames and passwords (e.g., leaving notes with passwords written on them on or near a computer or door keypad);
- Failing to report a lost or stolen portable device (phone, laptop, tablet, camera or any other portable device) containing PHI in a timely manner;
- Failing to meet the requirements of a patient privacy right, such as right to access, amendment, accounting of disclosures or any associated policy, standard, or procedure;
- Failing to complete assigned education or reviews in response to government findings or actions.

Depending on the magnitude of risk created, prior violations, or other corrective actions, CommonSpirit may determine, in its sole discretion, to treat a **Type One violation** as a Type Two or Type Three violation.

Type Two Violations

A Type Two violation occurs when an employee or non-employee intentionally accesses, reviews, or discloses confidential information in an unauthorized manner or for unauthorized purposes. Examples of Type Two violations include, but are not limited to:

- Sharing a computer password or user credentials with another person or group;
- Improper use of CommonSpirit passwords or credentials such as use on non- CommonSpirit websites or locations;
- Improper or unauthorized use of auto-forward for emails;
- Failing to follow device and media control standards, including connecting unapproved devices (e.g., mobile devices, computers, networking equipment, scanners, printers, or external storage devices) to the organization's network;
- Intentionally accessing an employee's family members' records without following Health Information Management (HIM) process or when there is no job-related need to access;
- Sharing or disclosing patient or employee confidential information with any individual who does not have a legitimate need to know the information in performance of their job duties;
- Failing to cooperate with a privacy or cybersecurity investigation;
- Misusing information systems or violation of cybersecurity safeguards including, but not limited to: intentionally placing restricted information in an unauthorized location, unauthorized modification of software, or installing unauthorized or unapproved software;
- Sending CommonSpirit proprietary or confidential information to a personal email;
- Repeated violations of Data Leakage Protection protocols;
- Committing a second or third incident of a Type One violation;
- Intentionally accessing any patient's record without a legitimate job-related reason. A final written warning will occur for this type of violation on a first offense and may result in termination of employment.

Depending on the magnitude of risk created, prior violations, or other corrective actions, CommonSpirit may determine, in its sole discretion, to treat a Type Two violation as a **Type Three violation**.

Type Three Violations

A Type Three violation occurs when an employee or non-employee accesses, reviews, or discloses confidential information for personal or monetary gain or with malice or knowing intent, or when the violation results in a serious risk to the organization, or when the conduct could result in an external investigation. Personal gain or malice includes intentional wrongful actions without justification.

Unless extenuating circumstances are identified and accepted by CommonSpirit in its discretion, Type Three violations are grounds for immediate termination of employment. Examples of Type Three violations include, but are not limited to:

- Inappropriately using or selling confidential information or PHI;
- Using, accessing, or disclosing PHI for personal gain or benefit
  - Examples include, but are not limited to: personal use in personal court matters such as child custody or divorce proceedings; for use in developing a contact list to sell a personal product or service; or any use in a personal relationship.
- A second instance of intentionally accessing any patient's record or information without a job-related reason;
- Disclosing PHI from any source of information, orally, written, or any other format or mechanism, for any reason other than job related;
- Posting PHI on the Internet as part of job-related CommonSpirit purposes without first obtaining a documented, valid HIPAA compliant authorization;
- Posting PHI, PII, or confidential information on personal social media with or without HIPAA authorization;
- Sending CommonSpirit proprietary or confidential information to a personal email for personal gain, or with malicious intent;
- Falsifying or altering patient information;
- Obtaining PHI under false representation;
- Using confidential information to harass, harm, or intimidate other individuals, or to cause harm to the organization, internally or externally;
- Deliberately compromising electronic information security measures or cybersecurity policies and standards;
- Handling confidential information with gross negligence, as determined by CommonSpirit in its sole discretion;
- Subverting network controls or escalating privileges without authorization;
- Committing repeated Type One violations or a second Type Two violation.

Determination of Violation Level and Corrective Action.

After consideration of all relevant facts from the investigation, including aggravating or mitigating factors, if any, CommonSpirit's Privacy Officer or designee (Privacy Officer), or Chief Information Security Officer or designee (Cybersecurity Officer) will provide a recommendation on the Violation Level of the at-issue conduct. The final level of corrective action will be determined by the

Human Resources representative after consideration of the employee's overall performance and disciplinary record. Corrective action(s) that result from a violation will be administered in a timely fashion.

Generally:

i. Type Three violations may result in immediate termination of employment.
ii. Type Two violations may result in a written warning or final written warning in lieu of suspension.
iii. Type One violations may result in either documented education and counseling, removal from schedule for non-compliance, documented verbal warning or a written warning.
iv. CommonSpirit reserves the right to add appropriate additional corrective action to any violation based on the at-issue violation.

Non-employees, as defined, may be subject to loss of access, dismissal from program, or termination of relationship at the discretion of the local entity or CommonSpirit. Violations must be reported to the key contact for the non-employee.

Retaliation

a. Anyone who retaliates against an employee or non-employee making a good-faith report of an actual or suspected violation is subject to discipline, up to and including immediate termination of employment, or termination of a business relationship with CommonSpirit.
    i. The policies that govern non-retaliation do not protect an employee from the employee's own actions that violate standards, guidelines, policies, or applicable laws and regulations.
b. CommonSpirit does not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against an employee who:
    i. Exercises their rights or participates in CommonSpirit's complaint process;
    ii. Files a complaint with the Secretary of Health and Human Services;
    iii. Testifies, assists, or participates in an investigation, compliance review, proceeding, or hearing; or opposes any act or practice unlawful under state and federal law or regulations, provided the individual acts/ed in good faith in reporting the conduct and did not involve disclosure of PHI in violation of regulations.

DEFINITIONS

Employee(s) for purposes of this Policy, includes all W-2 employees and all volunteers of CommonSpirit or its Direct Affiliates and Subsidiaries for whom CommonSpirit provides the Privacy Program.

Non-Employees means non-employed physicians and other non-employed allied health professionals who have been granted medical staff privileges at a CommonSpirit Direct Affiliate or Subsidiary or an Operating Unit of same, as well as students and allied health professional trainees (who are not employees), and contractors whose work for a CommonSpirit Direct Affiliate or Subsidiary or an Operating Unit of same involves the use or disclosure of PHI (including ePHI) or PII.

ASSOCIATED PROCEDURE

CommonSpirit Administrative Procedure
Human Resources A-022P, *Corrective Action for Privacy and Cybersecurity Violations*

STATUTORY/REGULATORY AUTHORITIES

45CFR 164.308 (a)(1)(ii)(c)
45CFR 164.530(e)(1)&(e)(2)
45CFR 164.530(g)
45CFR 160.316

COMMONSPIRIT HEALTH ADMINISTRATIVE PROCEDURE

SUBJECT: Corrective Action for Breach of Privacy and Cybersecurity Violations Procedure **PROCEDURE NUMBER:** Human Resources A-022
EFFECTIVE DATE: May 21, 2021

☒ National/System Offices ☒ Acute Care Facilities ☒ Non-Acute Care Facilities

ASSOCIATED POLICY:

CommonSpirit Administrative Policy Human Resources A-022, *Corrective Action for Breach of Privacy and Cybersecurity Violations*

APPLICABILITY

This Procedure applies to employees of CommonSpirit facilities utilizing the CommonSpirit Human Resource Management platforms and System Office administrative services.

Employees of other facilities should refer to their facility policy or consult with their local Human Resources representative.

COLLECTIVE BARGAINING AGREEMENT APPLICABILITY

The Collective Bargaining Agreement shall govern where there is a conflict between this Procedure and an applicable Collective Bargaining Agreement.

PROCEDURE OR PROCESS:

1. **Investigations**

a. An alleged violation related to protected health information (PHI) or electronic protected health information (ePHI) must be reported to the Privacy Officer.
b. Investigations that involve PHI and are not subject to applicable legal privileges must be supervised and led by the Privacy Officer.
c. The Privacy Officer or Chief Information Security Officer or designee (Cybersecurity Officer) and the Human Resources representative will collaborate to determine who will be involved and the responsibilities of those involved with investigating an alleged violation.
d. The investigation may include, but is not limited to, interviewing the employee or non- employee involved in the violation, interviewing witnesses, analyzing computer drives and data, reviewing audit logs of system user activity, and any other appropriate actions deemed necessary to determine the relevant facts.
e. Legal counsel shall oversee and direct investigation(s) subject to the attorney-client privileges. Legal counsel will coordinate with and involve Common Spirit's Privacy Officer and Human Resources.
f. At the appropriate stage, the investigation will allow for an opportunity for any involved employee or non-employee to be appraised of the alleged violation, ask questions, and provide explanation for any potential violations.
g. CommonSpirit promotes an environment that encourages employees or non-employees to seek clarification of issues and to report questions and concerns to their immediate supervisor or to use other appropriate reporting mechanisms such as a hotline telephone number.

i. Employees are responsible for reporting possible violations of standards, guidelines, or policies. CommonSpirit maintains an anti-retaliation policy that prohibits retaliation by management and other employees, or agents, for good faith report, complaint, or inquiry.

ii. Non-Employees are also encouraged to report possible violations of law, CommonSpirit policies, or CommonSpirit Standards of Conduct.

2. **Recordkeeping**

a. The Human Resources representative and Privacy or Cybersecurity Officer is responsible for maintaining investigatory notes and documentation in accordance with record retention guidelines.

b. Privacy and Cybersecurity Officers must maintain documentation in the designated incident management reporting database in accordance with record retention guidelines.

c. Legal will provide instructions on maintenance of investigative materials generated under legal privilege.

3. **Corrective Action Delivery**

a. Employees

i. Upon conclusion of an investigation, the Privacy or Cybersecurity Officer will provide their investigation results along with a brief summary of their findings and recommended violation level to the assigned Human Resources representative.

ii. The assigned Human Resources representative will review the employee's record for previous or other disciplinary actions in developing the final level of discipline to be given.

i. In accordance with applicable corrective action policies and procedure, prior discipline will be considered when appropriate.

iii. Generally:

a. Type Three violations may result in immediate termination of employment.

b. Type Two violations may result in a written warning or final written warning in lieu of suspension.

c. Type One violations may result in either documented education and counseling, removal from schedule for non-compliance, documented verbal warning or a written warning.\

d. CommonSpirit reserves the right to add appropriate additional corrective action to any violation based on the at-issue violation.

b. Non-Employees

i. For credentialed, non-employed healthcare providers, refer to the applicable local entity Medical Staff Bylaws and Rules and

Regulations.]

ii. Other non-employees, as defined, may be subject to loss of access, dismissal from program, or termination of relationship at the discretion of the local entity or CommonSpirit. Violations must be reported to the key contact for the non- employee.

4. **Responsibilities**

a. Privacy and Cybersecurity Officer Responsibilities

i. Except where stated otherwise in the policy, the Privacy Officer supervises investigations that involve PHI in any form, and the Cybersecurity Officer supervises investigations that involve information cybersecurity violations.

ii. The Privacy or Cybersecurity Officer manages the investigations and recommends a violation level based on investigation results, including mitigating or aggravating factors.

iii. Only the Privacy Officer can determine and confirm if a violation of the HIPAA Privacy Rule, policy, standard, or procedure has occurred.

iv. Only a Cybersecurity Officer can determine and confirm if a violation of the HIPAA Security Rule, policy, standard, or procedure has occurred.

v. The Privacy Officer is responsible for record keeping and required reporting to government entities.

vi. Privacy and Cybersecurity Officers must enter privacy and cybersecurity event cases into the Privacy and Cybersecurity designated incident tracking system and follow the Breach Response Policy to determine if notice must be provided to a patient and the Department of Health and Human Services.

b. Operational Responsibilities

i. The involved staff's leader, in consultation with Human Resources, is responsible for the final dispensation of corrective action in a manner that provides for the consistent application of this Procedure and the associated Policy, based on the investigation results received from the Privacy or Cybersecurity Officer.

ii. The leader, in consultation with Human Resources and the HIPAA Privacy or Cybersecurity Officer, is responsible for delivering any corrective actions to the involved staff.

iii. Completed corrective action documentation will be maintained in the applicable employee personnel file.

iv. The final level of corrective action delivered must be communicated to the Privacy or Cybersecurity Officer for documentation in CommonSpirit's incident tracking system.

v. The leader, in coordination with Human Resources, is responsible for confirming that the appropriate professional designee reports an employee's actions to the appropriate and applicable professional state agency or state board, when applicable (e.g., the organization's risk manager or chief nursing officer).

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Privacy A-1016S Disclosure of Protected Health Information (PHI) to Family and Friends

KB1511209

COMMONSPIRIT HEALTH ADMINISTRATIVE STANDARD

SUBJECT: Disclosure of Protected Health Information to Family and Friends
STANDARD NUMBER: Privacy A-1016S **EFFECTIVE DATE:** April 15, 2021

☒ National/System Offices ☒ Acute Care Facilities ☒ Non-Acute Care Facilities

ASSOCIATED DOCUMENTS

CommonSpirit Governance Policy **Corporate Responsibility G-002 Privacy Program**
CommonSpirit Administrative Addendum **Privacy A-1016A Guidelines for Disclosures to Family and Friends**

PURPOSE

CommonSpirit Health's policy and standard is to comply with the federal laws and regulations associated with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH), enacted as part of the American Recovery and Reinvestment Act (ARRA) of 2009, and all applicable state laws (Applicable Law) regarding Disclosure of PHI to Family and Friends.

STANDARD

This standard describes CommonSpirit requirements for verbally disclosing Protected Health Information (PHI) to a patient's immediate Family Member or other individuals involved in the Patient's care, or Payment for the patient's care, who call about or visit CommonSpirit Entity patients, as well as verbal disclosures by care providers to Family and Friends.

SUPPORTIVE DATA

1. Immediate Family members or other individuals known to have a close personal relationship with the Patient are collectively referred to throughout this standard as "Family, Family member or Friend(s)".

2. The HIPAA Privacy Rule is not intended to impede customary and essential communications and practices and does not require that all risk of Incidental Use or Disclosure be eliminated. Incidental Uses and Disclosures of Protected Health Information are permitted when the CommonSpirit Entity has in place reasonable safeguards necessary to protect a Patient's privacy. Reasonable safeguards shall include a process for Patient's or their Personal Representative to exercise the opportunity to object to these Disclosures e.g., asking the Patient's or their Personal Representative's permission to discuss their care or share Protected Health Information in the presence of others.

3. During disaster relief efforts, Patient information about condition and location may be Disclosed to a Friend or Family member or to an organization assisting in a disaster relief effort, so that a Patient's Family can be notified about the Patient's location and condition.

4. PHI may be Disclosed to avert an imminent threat to safety if made in the good faith belief that the Disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, and is Disclosed to a person reasonably able to prevent or lessen the threat.

5. Refer requests by Patients, Family members, or Friends to Access or Amend medical records to the Health Information Management (HIM) department.

AFFECTED AREAS OR DEPARTMENTS

This Standard applies to CommonSpirit Health and its Direct Affiliates[1] and Subsidiaries,[2] as well as any other related entity whose governing documents expressly require or provide for such entity(ies) to comply with CommonSpirit Health's policies and procedures (Conforming Entity).

[1] A Direct Affiliate is any corporation of which CommonSpirit Health is the sole corporate member or sole shareholder, as well as Dignity Community Care, a Colorado nonprofit corporation.

[2] A Subsidiary refers to *either* an organization, whether nonprofit or for-profit, in which a Direct Affiliate holds the power to appoint fifty percent (50%) or more of the voting members of the governing body of such organization or holds fifty percent (50%) or more of the voting rights in such organization (as evidenced by membership powers or securities conferring certain decision-making authority on the Direct Affiliate) or any organization in which a Subsidiary holds such power or voting rights.

PROCESS

1. Facility Directory information may only be Disclosed to Family and Friends if the patient is not “Confidential” (i.e. not listed in the directory), **and** if the requestor asks for the patient by first and last name.

2. PHI may be verbally Disclosed to a Patient’s immediate Family and other persons involved in the Patient’s care and/or the Payment of the care as long as:

   a. The information is directly relevant to the person’s involvement in the Patient’s care or Payment for care; or
   b. The information is used to notify such persons of the Patient’s location, general condition, phone number or death.

3. When the Patient is available (e.g., in the provider’s office, on the patient care unit, or on the telephone) and is not Incapacitated, PHI may be verbally disclosed as long as:

   a. The Patient verbally agrees or has agreed and/or has been given an opportunity to object to the Disclosure and does not;
   b. The care provider reasonably infers from the circumstances, based on the exercise of professional judgment, that the Patient does not object to the disclosure; or
   c. The information is directly relevant to the person’s involvement in the Patient’s care and the Payment for that care.

4. When the Patient is not available , is Incapacitated, or in an emergency situation, PHI may be verbally Disclosed if the Disclosure is made in the patient’s best interests in accordance with good medical and professional practice and the information Disclosed is directly relevant to the person’s involvement in the patient’s care. The information Disclosed, and the rationale for Disclosure, must be documented in the patient’s record.

5. When the Patient is not present or is otherwise unavailable, the CommonSpirit Entity may use its judgement and experience with common practice or previous engagement patterns to make reasonable inferences about allowing Family or Friends to pick up filled prescriptions, medical supplies, x-rays, or other processes that involve Disclosure of PHI.

6. Disclosures of PHI or status of substance abuse, behavioral or mental health disorders must be in accordance with Applicable Law, as well as all applicable policies or standards.

7. For Deceased Individuals, CommonSpirit Entities may Disclose a decedent's PHI to Family or Friends who were involved in the care or payment of the care of the decedent prior to the death, unless doing so is inconsistent with any prior expressed preference of the Individual that is known by the Covered Entity.

ADDITIONAL CONSIDERATIONS

1. Before Disclosing PHI about a Patient, verify that the Patient has not requested "Confidential" status (i.e. Is not listed in the Facility Directory). Always check for "Confidential" status by using approved facility processes.

2. Respond to incoming calls or to visitors asking for a Patient by first and last name when the Patient is either "Confidential" or does not display in the Facility Directory by answering "I have no information available under that name" or "The computer shows no available information by that name." This includes requests by Family, Friends, florists and all others. However, if the caller / visitor knows the room number, transfer the call or refer/direct the visitor to the Patient's room.

3. Be aware that even though a Patient may elect "Confidential" status, the Patient may contact Family and Friends and invite them to visit. In this situation, the Patient is responsible for providing Family and Friends with their location.

4. Obtain the name of a designated contact (spokesperson) if circumstances indicate that this is the best way to share information with the Family and Friends of a Patient. This is common practice for Patients with many Family members and Friends.

5. hen discussing PHI with a Patient, ask visitors or others not participating in the Patient's care to leave the room during the discussion. This gives the Patient an opportunity to agree to or object to discussions regarding their PHI with Family and Friends who may be present.

6. When an inquiry is made, consider who is requesting the information and why.

a. Direct inquiries to the Patient if condition allows. When Patient condition does not allow, direct inquiries to the Family spokesperson if a spokesperson has been designated.

b. Determine the relationship of the caller or visitor to the Patient. Validate identity using processes established by the unit, or facility.

c. Provide answers to caller and visitor questions only at a general level. The information shared should be relevant to their involvement with Patient's care.

DEFINITIONS:

Capitalized terms are as defined in the Privacy Standards Glossary.

COMMONSPIRIT HEALTH ADMINISTRATIVE POLICY ADDENDUM

ADDENDUM: Privacy A-1016A **EFFECTIVE DATE:** April 15, 2021
SUBJECT: Guidelines for Disclosures to Family and Friends

	Telephone Request for Information	Guidelines
1.	Outside caller asking if patient is in the hospital	Confidential Patient Answer: *"I have no information available und* Not a Confidential Patient Answer: Provide information regarding prese as long as caller provides patient's first and l names.
2.	Outside caller asking if patient is ready to go home	Ask relationship of caller to patient: *"Please t is calling and why you are asking."* Confidential Patient Answer: *"I have no information available und* Not a Confidential Patient Answer: Disclose the information if the caller who needs to know in order to help. If the patient is alert and oriented, the call may be t to the patient.

3.	Outside caller requesting information on a patient's condition	Ask relationship of caller to patient: *"Please t is calling and why you are asking."* Confidential Patient Answer: *"I have no information available und* Not a Confidential Patient Limit the information to the minimum necessa to the family member or friend's involvement patient's care. Typically, provide general leve like *"Your mom had a good / poor night."* If th specific questions that reflect an obvious kno current events like *"Has her pain decreased? change the medication like they were discus doctor decided whether surgery will be necessary?"* It is permissible t questions.

	Telephone Request for Information	Guidelines
4.	Outside caller requesting to speak to a patient	Confidential Patient Answer: *"I have no information available und* Not a Confidential Patient Answer: Transfer call to patient's room
5.	Outside caller requesting information on a patient's treatment plan	Ask relationship of caller to patient: *"Please t is calling and why you are asking."* Confidential Patient Answer: *"I have no information available und* Not a Confidential Patient If at all possible, refer the caller to the patient limit the information to the minimum necessa to the family member or friend's involvement patient's care. Let the caller initiate the specif information requested. Example: *"Has his/he decided whether surgery will be necessary?"*

6.	Emergency Situation: Outside caller requesting information in emergency situations, if the patient is in an incapacitated state, or if the patient's personal representative is not known	Confidential Patient or Not a Confidential Pat Ask relationship of caller to patient: *"Please t is calling and why you are asking."* Use professional judgment to determine whe disclosure to the family member or friend is ir patient's best interest.
7.	Outside caller calling to discuss billing information	After patient's discharge from facility Minimum necessary information may be disc caller's name is on the patient's account or if has not objected to this person receiving info A hospital may discuss a patient's bill with an family member who can confirm that they are designated contact, or legal representative. Example: An adult son calls the hospital with about charges to his mother's account.

	In-Person Visitor Request for Information	**Guidelines**
1.	Visitor requesting to speak to a patient	Confidential Patient Answer: "*I have no information available und* Not a Confidential Patient Refer visitor to patient room.
2.	Visitor asking if patient is in the hospital	Confidential Patient Answer: "*I have no information available und* Not a Confidential Patient Provide information regarding presence of pa as visitor provides patient's first and last nam
3.	Visitor asking if patient is ready to go home	Note applicable to all subsequent items: Onc relationship of visitor to patient. Disclose the information if visitor needs to know whether t ready to go home.

4.	Visitor requesting information on a patient's condition	Not a Confidential Patient Ask relationship of visitor to patient. If patient verbally confirm with patient that it is accepta information. Limit information to the minimum according to the family member or friend's involvement with the patie treatment.
5.	Visitor requesting information on a patient's treatment plan	Not a Confidential Patient Ask relationship of visitor to patient. If patient verbally confirm with patient that it is accepta information. Limit information to the minimum to the family member or friend's involvement with the patient's treatm
6.	Visitor wishing to discuss billing information	Not a Confidential Patient If the patient is present, verbally confirm with acceptable to disclose the information. If the present, minimum necessary information may be disclosed if the visitor's name is on th patient's account.
7.	Visitor requesting information in emergency situations, if the patient is in an incapacitated state, or if the personal representative is not known	Confidential Patient or Not a Confidential Pat staff will use their professional judgment to d whether the disclosure to the family member the patient's best interest.
8.	Family or friend picking up prescriptions, medical supplies, x-rays	Confidential Patient or Not a Confidential Pat professional judgment and experience with c practice along with established Entity proces determine identity and authority of the individ Request identification if a question and then release of items.

	Care Provider Initiated Disclosure of Information	**Guidelines**
1.	Care provider discussing patient's condition, meds or treatment plan when patient family/friends are present	Confidential Patient or Not a Confidential Patier confirm with patient whether they would like the be present during the discussion/exam. Ask visi in a waiting area if patient does not wish for visi present during the discussion.

2.	Care provider discussing patient's condition, or treatment plan with family or friends in an emergency waiting room, surgery waiting room, semi-private patient room, etc…	Confidential Patient or Not a Confidential Patier Utilize appropriate privacy safeguards such as s softly, stepping aside from other visitors if possi the curtain closed between patients, etc.
3.	Care provider stating that they are calling in for a status update on their patient	Confidential Patient or Not a Confidential Patier If the care provider is listed in the patient chart a treating, consulting, primary care, or attending p disclose the information as requested. If the care provider is unknown to you, verificati may be achieved by asking to call them back. V office number is for the care provider and the pa seen by that office/facility. Use professional judgment and experience with practice to make reasonable inferences.
4.	Outpatient Pharmacy distributing and discussing medications to a given patient, patient family or patient friend when other individuals are lined-up waiting to pick-up their medications	Confidential Patient or Not a Confidential Patier Ask waiting customers to stand a few feet back customer who is presently being waited on. Spe audible only to the patient if possible. It may be helpful to post a sign outside the outp window asking customers to wait several feet b customer at the counter
5.	Hospital staff calling family or friend to let them know that the patient is ready to be discharged	Confidential Patient or Not a Confidential Patier It is acceptable to leave a message with design family or friends who have been involved with th care or to leave a brief voicemail. Example of message: *"This is 'Facility Name' Hospital. Please return r* *'phone number'."*
6.	Hospital staff making follow-up calls to a patient	Confidential Patient or Not a Confidential Patier Only talk to the patient or identified personal representative of the patient. Never leave a mes another person or on an answering machine req follow-up information.

	Care Provider Initiated Disclosure of Information	Guidelines
7.	Hospital staff calling patient at home to remind them of an appointment	Confidential Patient or Not a Confidential Patier Use professional judgment to assure that the di the best interest of the patient. A brief message may be left on voicemail or witl member or other person who answers the phon patient is not at home or cannot take the call. However, leave only the minimum necessary int required to confirm the appointment. Each patient care area must consider what infor necessary. Typically, limit the information disclos name, telephone number, and date/time of appo not ever leave diagnosis or type of procedure or with anyone other than the patient
8.	Hospital use of sign-in sheets and subsequent calling out patient name in waiting room	Confidential Patient or Not a Confidential Patier Only the patient name should be written on the sheet if other patients will be signing in on the s It is acceptable to call out a patient name in a w room area. Do not mention diagnosis, procedur treatment when calling out a patient's name.
9	Hospital using overhead paging system to locate patient or patient's family or friends	Confidential Patient or Not a Confidential Patier Use of a paging system for waiting patient famil the acceptable method for notification. It is acceptable to request (by last name only – family of Mr. Jones please come to 3North?") th return to a certain department or area; or to req patient in room number XXX please return to th etc. Avoid mentioning a department name that i specific diagnosis.

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