ATTACHMENT B

MEMORANDUM OF UNDERSTANDING AMONG THE BOARD OF REGENTS OF THE UNIVERSITY SYSTEM OF GEORGIA BY AND ON BEHALF OF GEORGIA STATE UNIVERSITY AND KAISER FOUNDATION HEALTH PLAN OF GEORGIA, INC. AND THE SOUTHEAST PERMANENTE MEDICAL GROUP, INC.

This Memorandum of Understanding ("Agreement") is entered into effective **August 15, 2021** on the part of Kaiser Foundation Health Plan of Georgia, Inc. ("Health Plan") and The Southeast Permanente Medical Group, Inc. ("Medical Group") (hereinafter collectively or individually referred to as "Kaiser Permanente") and Georgia State University, Byrdine F. Lewis College of Nursing & Health Professions ("School").

WHEREAS, the School desires to obtain and Kaiser Permanente desires to provide high quality clinical/occupational experiences ("CE/ALE") for the School's students; and

WHEREAS, the parties recognize the mutual benefit they will derive from the use of Kaiser Permanente's Facilities by the Students for their clinical/occupational experiences; and

NOW, THEREFORE, in consideration of the mutual covenants and promises contained herein, the parties agree as follows:

1) GENERAL INFORMATION.

a) This Agreement applies to the following CE/ALE programs:

- **Associate Degree in Nursing**
- **Bachelor of Science in Nursing**
- **Master of Science in Nursing**
- **Doctor of Nursing Program**

The following are specific requirements imposed by Kaiser Permanente for this particular CE/ALE program:

- **N/A**

b) The following individuals will respectively serve as the faculty/staff representative(s) for the School and the contact person for Kaiser Permanente and Facility to the extent that this Agreement requires the parties to give notices in writing:

i) <u>School Faculty/Staff Representative(s)</u>:

Program: Georgia State University
Byrdine F. Lewis College of Nursing & Health Professions
Name: Wanda Little, BA
Clinical Coordinator
Address: 140 Decatur Street
Atlanta, Georgia 30303
Telephone: (404) 413-1181
Fax: (404) 413-1001

ii) <u>Kaiser Permanente Representatives</u>:

Program: Kaiser Foundation Health Plan of Georgia, Inc.
Name: Jonna Kirkwood
VP & Chief Operating Officer
Address: 3495 Piedmont Rd., NE
Atlanta, Georgia 30305
Telephone: (404) 364-3721
Fax: (404) 365-4136

Program: The Southeast Permanente Medical Group, Inc.
Name: Angela Ippolito
Vice President of Administrative Services
Address: 3495 Piedmont Rd., NE
Atlanta, Georgia 30305
Telephone: (404) 504-5674

In the event that School or Kaiser Permanente contact person changes, the appropriate party hereby agrees to promptly notify the other party of such change.

c) The following individuals will coordinate the planning and operation of the CE/ALE for Kaiser Permanente and the School:

Georgia State University Representative

Name: Lisa Williams, BA
Clinical and Residency Placement Coordinator
Address: 140 Decatur Street
Atlanta, Georgia 30303
Email: lwilliams106@gsu.edu
Telephone: (404) 413-1100
Fax: (404) 413-1090

Kaiser Permanente Facility Representative

Name: Lesia Jackson, MSA, RN
Lead Professional Development Specialist
Address: 3495 Piedmont Rd., NE
Atlanta, Georgia 30305
Email: lesia.jackson@kp.org
Telephone: (404) 695-1043

d) The CE/ALE will be of such content and cover such periods of time as may from time to time be mutually agreed upon by the School and the Facility Representative. The starting and ending date for each CE/ALE shall be agreed upon at least one month before the CE/ALE commences. CE/ALE implementation at the Facility shall be subject to final approval by the Facility Representative.

e) The number of students designated for participation in the CE/ALE will be [Click **here** and type number of participants]. The number of students may at any time be altered by mutual agreement.

f) All student participants must be acceptable to the parties. Either Kaiser Permanente or the School may withdraw any student from a CE/ALE at the Facility based upon a lack of competency on the part of the student, the student's failure to comply with the rules and policies of the Kaiser Permanente, or for any other reason where any party believes that it is not in their best interest for the student to continue. Such party shall provide the other party and the student with immediate notice of the withdrawal and written reasons for the withdrawal.

2) SCHOOL AGREES:

a) School will use its best efforts to provide Kaiser Permanente information concerning the number of students, students' department/college, course of instruction, and dates of participation, two-weeks prior to the commencement of the CE/ALE. When available, student and faculty names, addresses and telephone numbers shall be provided prior to participation at a Facility. The School shall provide the number of faculty participants and the faculty department/college at least two-weeks prior to the commencement of the CE/ALE.

b) School will verify that all students participating in the CE/ALE have executed or provided the following document(s):

   i) Authorization for Release of Records and Information (An example of the release is set forth as Exhibit 1).

   An example authorization form is set forth as Exhibit 1 to this Agreement and is incorporated herein.

c) The School will not knowingly assign any faculty member to the Facility in connection with the operation of the CE/ALE who is not appropriately licensed or certified and will make evidence of the licensure or certification of all assigned faculty available to the Facility Representative upon request.

3) KAISER PERMANENTE AGREES:

a) Upon receipt of the information identified above in Section "2", paragraph "a":

   i) Kaiser Permanente may decline the acceptance of student(s) or faculty at its sole discretion and will promptly notify the School of all students or faculty who are accepted in the CE/ALE. Further, Kaiser Permanente shall provide the School with written reasons for the non-acceptance of student(s) or faculty.

   ii) Kaiser Permanente shall, if possible, designate the classroom or conference space, Facility personnel, and other facilities or equipment appropriate for the CE/ALE and agrees to inform the School of same. Kaiser Permanente agrees to use its best efforts to provide additional facilities, equipment and personnel as reasonably requested by the School, so long as such use does not interfere with the regular activities of the Facility. The availability of additional facilities, equipment and personnel will be subject to availability, prior requests for those resources, and Kaiser Permanente's obligations regarding operation of the Facility.

b) If Medical Group preceptors are used as an integral part of the CE/ALE evaluation(s), the preceptor(s) will contribute to the evaluation of participating student practice competency. The preceptor will have appropriate licenses and degrees. The following, if any, are specific preceptor requirements:

Program: Preceptor
Pharmacy: Appropriately licensed and in good standing with their Board

_____

_____

c) When requested Kaiser Permanente staff designated to work with students shall assist the School in the evaluation of the learning and performance of participating students, provided the student has signed a consent to exchange of educational information in accordance with the Family Educational Rights and Privacy Act of 1974, as amended. An example of an Authorization acceptable to all parties is set forth as Exhibit 1 to this Agreement and is incorporated herein. Unless otherwise specified in the Agreement, any evaluation of students by Kaiser Permanente staff shall relate only to general student participation in the CE/ALE, and shall in no way be construed as a certification by Kaiser Permanente staff as to the competence of any student or a representation by Kaiser Permanente staff of any student's ability or competence in connection with the practical implementation of any knowledge gained through the CE/ALE. Kaiser Permanente hereby agrees to keep confidential any student records or information they may obtain, unless they have otherwise obtained prior written consent of the student. Although the School shall obtain all required consents, Kaiser Permanente shall have the right to rely on such consents and to obtain copies of such consents upon request.

4) TERM, TERMINATION, RENEWAL AND AMENDMENT.

a) This Agreement shall become effective **August 15, 2021** and will extend one full year expiring on **August 14, 2022**. After that, if this Agreement is renewed, it shall extend from the beginning to the end of the School's academic year, or as agreed by the parties. Either party may terminate this Agreement, with or without cause, upon sixty (60) days written notice.

b) This Agreement does not renew automatically. The parties may extend this Agreement by letter signed by all parties.

5) INCORPORATION OF AFFILIATED CLINICAL EDUCATION & APPLIED LEARNING EXPERIENCE AGREEMENT.

a) It is understood and agreed that all terms and conditions forming a part of the Affiliated Clinical Education & Applied Learning Experience Agreement by and between Health Plan and Medical Group and BOR entered into effective **August 15, 2021** are hereby incorporated by reference and shall remain in full force and effect during the term of this Agreement.

6) MISCELLANEOUS.

a) **Execution.** This Agreement may be executed in counterparts, and all such counterparts together shall constitute the entire agreement of the parties hereto.

b) **Severability.** The provisions of this Agreement are specifically made severable. If any clause, provisions, right and/or remedy provided herein is unenforceable or inoperative, the remainder of this Agreement shall be enforced as if such clauses, provision, right and/or remedy were not contained herein.

c) **Authority.** The undersigned individuals represent that they are fully authorized to execute this Agreement on behalf of the named parties.

SIGNATURE PAGE FOLLOWS

AGREED TO BY:

Georgia State University Byrdine F. Lewis College of Nursing & Health Professions

Wendy F. Hensel
Provost & Senior VP for Academic Affairs

6 July 2021

Date

Kaiser Foundation Health Plan of Georgia, Inc.

Jonna Kirkwood
VP & Chief Operating Officer

July 7, 2021

Date

The Southeast Permanente Medical Group, Inc

Angela Ippolito
Vice President of Administrative Services

July 7, 2021

Date

EXHIBIT 1
AUTHORIZATION FOR RELEASE OF CONFIDENTIAL RECORDS AND INFORMATION

TO: Georgia State University Byrdine F. Lewis College of Nursing & Health Professions or any of its member institutions (hereinafter referred to collectively as "School"), and Health Plan/Medical Group facility where I participate in or request to participate in a clinical or applied learning experience (hereinafter referred to as the "Facility").

RE: _____ (Print Name of Student)

As a condition of my participation in a clinical or applied learning experience and with respect thereto, I grant my permission and authorize School to release my educational records and information in its possession, as deemed appropriate and necessary by the School, including but not limited to academic record and health information to any Facility where I participate in or request to participate in a clinical or applied learning experience. I further authorize the release of any information relative to my health to the Facility for purposes of verifying the information provided by me and determining my ability to perform my assignments in the clinical or applied learning experience. I also grant my permission to and authorize the Facility to release the above information to the School. The purpose of this release and disclosure is to allow the Facility and the School to exchange information about my medical history and about my performance in a clinical or applied learning experience.

I further understand that I may revoke this authorization at any time by providing written notice to the above stated person(s)/entities, except to the extent of any action(s) that has already been taken in accordance with this "Authorization for Release of Confidential Records and Information."

I further agree that this authorization will be valid throughout my participation in the clinical or applied learning experience. I further request that you do not disclose any information to any other person or entity without prior written authority from me to do so, unless disclosure is authorized or required by law. I understand that this authorization shall continue in force until revoked by me by providing written notice to the School and the Facility, except to the extent of any action(s) that has already been taken in accordance with this "Authorization for Release of Confidential Records and Information."

In order to protect my privacy rights and interests, other than those specifically released above, I may elect to not have a witness to my signature below. However, if there is no witness to my signature below, I hereby waive and forfeit any right I might have to contest this release on the basis that there is no witness to my signature below. Further, a copy or facsimile of this *Authorization for Release of Confidential Records and Information* may be accepted in lieu of the original.

I have read, or have had read to me, the above statements, and understand them as they apply to me. I hereby certify that I am eighteen (18) years of age or older, or my parent or guardian has signed below; that I am legally competent to execute this *Authorization for Release of Records and Information*; and that I, or my parent and/or guardian, have read carefully and understand this *Authorization for Release of Confidential Records and Information*; and that I have freely and voluntarily signed this *Authorization for Release of Confidential Records and Information*.

This the _____ day of _____, 2020.

Participant Signature	Witness Signature
Name (Please Print)	Name (Please Print)
Parent/Guardian Signature (if applicable)	Witness Signature
Name (Please Print)	Name (Please Print)