Good Samaritan Hospital

PGY-I Pharmacy Residency Program

Manual 2024-2025

Intermountain Health

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Section 1: Program Purpose and Overview

Philosophy:

This residency program has the goal to develop a well-rounded pharmacy practitioner and future leader in pharmacy practice. Upon completing the Good Samaritan Hospital Pharmacy Residency Program, the resident will be an experienced and competent provider of pharmaceutical care. They will be confident in their ability to provide optimal patient care in various settings as well as various disease states. The resident will be skilled in pharmacy practice areas that include, patient centered pharmacotherapy, medication / disease education, pharmacy management and operations. The resident will demonstrate professional maturity by developing and following a personal philosophy of practice, monitoring their own performance, and demonstrating leadership and commitment to the pharmacy profession.

Description:

Our program is a 52 week postgraduate curriculum that offers opportunities in acute care, medication safety, research, clinical services and pharmacy leadership. The residency program is designed to help the resident meet the competency areas, goals, and objectives of PGY1 Pharmacy Residency training. See the "Required Competency Areas, Goals and Objectives of Postgraduate Year One (PGY1) Pharmacy Residencies."

The residency program is designed to offer an individualized training plan for each resident based on their interests, goals and past experiences. Residents are required to complete core rotations in order to build a strong knowledge base and have the opportunity to select elective rotations in many fields of interest.

Residents are required to complete additional program experiences, aimed at developing a skilled and competent practitioner. Required elements of the program include completing a medication use evaluation (MUE), research project, patient education, teaching, providing pharmacy services, and developing leadership and communication skills. Upon successful completion of the program, residents will be awarded a program certificate.

GSH Pharmacy Mission:

To ensure the optimal use of medication for those we serve.

1. Patient Safety -
   To be the pre-eminent resource for medication safety by ensuring the appropriate drug, dose, patient, route, monitoring, and time of administration.

2. Service Excellence -
   To provide service excellence with courtesy, integrity, customer focus, consistency, open and positive communication in an action-oriented manner that exceeds expectations.

3. Medication Experts -
   To serve as medication experts in consultation and education, relating to drug therapy.

4. To support the hospital philosophy that concern for the individual extends beyond those people directly served to include the family members, health professionals, employees and volunteers, and the community.

5. To attract exceptional individuals at all levels of the department.

6. To create an environment that encourages and supports creativity, innovation, continuous learning, and research.

7. To maintain and efficiently utilize resources necessary to fulfill the department mission.

8. To always strive to do better and look for opportunities to improve.

Program Structure

Month / Experience	Activities/ Rotation Options
July: Orientation	• Hospital and Department • Residency Program Overview • EPIC / Omnicell / Dose Edge • Departmental Competencies • Training for staffing (IV Room and Medication Reconciliation) • PharmAcademic
Required Experiences	• Internal Medicine (8 weeks) • Oncology (6 weeks) • Infectious Disease (6 weeks) • Critical Care (6 weeks) • Emergency Medicine (6 weeks)
Longitudinal Experiences	• Administration • Service (staffing) • Research Project • MUE • Core topic and presentations • Case presentations • Meetings • Community service • Teaching certificate program • BLS / ACLS / PALS • Overhead alerts • Precepting IPPE and APPE students
Elective Experiences	• Based on Residents interest • Two elective rotations (4 weeks)

Application and Appointment

Residents are graduates or candidates for graduation of an Accreditation Council for Pharmacy Education (ACPE) accredited degree program or have a Foreign Pharmacy Graduate Equivalency Committee (FPGEC) certificate from the National Association of Boards of Pharmacy (NABP). At a minimum, the program must be a five-year pharmacy degree program.

Residents are to be licensed or eligible for licensure in the State of Colorado as soon as possible up to a maximum of 120 days after the program start date (see "PGY 1 Pharmacy Residency Requirements for Licensure, Completion of, and Dismissal from the Residency Program" policy.

Travel

Travel support for the ASHP Midyear and Residency Conference of the Rockies meetings are paid for by Good Samaritan Medical Center. Residents are paid for meetings and not required to use PTO.

Benefits

$61,000 stipend, Health/Dental/Vision Insurance, 22 paid days off for vacation, sick leave and holidays.

Meetings

To broaden the residency experience, residents are requested to attend a variety of meetings throughout the year. These may be departmental meetings, administrative staff meetings, committee meetings or clinical meetings. Preceptors, pharmacy administration, the program director may request attendance to other specific meetings to broaden the resident's educational experience.

Section 2: Administration of the Residency Program

Organizational and Advisory Structure

Residency Program Director (RPD)

The Residency Program Director is responsible for overseeing all aspects of the residency program. Program goals, objectives and requirements will be the responsibility of the program director in conjunction with the Pharmacy Manager and Director of Pharmacy. The program director will work with other preceptors and pharmacy administration to coordinate schedules, rotations and to track the resident's progress and to resolve any pertinent issues.

Residency Preceptors

Susanne Dyal, Pharm.D., BCPS	Internal Medicine
Emily Miklya, Pharm.D., BCPS	Oncology
Corinne Weinstein, Pharm.D.	Oncology
Andrea Boyce, Pharm.D., BCIDP	Infectious Disease
Ian Kane, Pharm.D., BCPS	Service
Paige Schuenke, Pharm.D., BCCCP	Administration
James Adams, Pharm.D., BCCCP	Critical Care
John Flanigan, Pharm.D.	Critical Care
Mallory McCullough, Pharm.D., BCPS	Emergency Medicine

The rotation preceptor will be responsible for scheduling the resident's activities, assuring the resident's progress toward meeting the objectives of the rotation, and identifying potential problems with the resident's competencies or the residency objectives.

Responsibilities of the Preceptor

• Review learning description with resident by the end of the first day of rotation

• Introduce resident to unit team members and area staff

• Review rotation schedule in advance for days off, meetings etc.

• Discuss the clinical activities/responsibilities of the clinical pharmacist in area

• Attend rounds with resident, if applicable

• Instruct resident how to verify orders, review profiles, identify and make interventions

• Discuss how to identify adverse drug reactions (ADR) and how to report them

• Review clinical activities to be provided/documented by the resident (ie. pharmacokinetics, antibiotic monitoring, formulary interventions, and therapeutic drug monitoring (TDM), parenteral nutrition (TPN), anticoagulation monitoring service (AMS) monitoring)

• Inform the resident of expectations for responding to drug information questions and resolving medication related problems

• Review the learning description with the resident prior to the rotation and ensure that they have been provided with a copy

• Complete rotation evaluations of the resident within 7 days of completion of the rotation

Residency Advisory Committee

The Residency Advisory Committee (RAC) is a standing committee of the Department of Pharmacy. Members include the Residency Preceptor and the RPD. The Director of Pharmacy is also invited to attend. The Committee serves to support the program goals and improve the quality of the residency program. This meeting creates a forum for the preceptors to discuss the residents' progress, projects, concerns or issues regarding the residency schedule, and other components of the program. This group meets monthly to discuss the progress of the residents, any problems with the residents' schedule, ability to achieve goals/objectives, and progress on their project(s). This group also determines the overall plan for the year and if the program needs to make adjustments for the current year and how to restructure for subsequent years.

Additionally, the RAC:

• Discusses the incoming residents' interests, strengths, and professional/personal goals they have outlined during their orientation process

• Discusses the residents' performance on their assigned learning experiences and address any goals and objectives with a "needs improvement"

• Review resident timelines and individualized learning plans quarterly

• Establishes preceptor and mentor responsibilities

• Discusses the overall performance of the residents and identify any areas for improvement • Continuously evaluates the program curriculum, goals and objectives

• Discusses resident recruitment and selection

• Holds an annual preceptor retreat to discuss program improvements, program advancement and reflection on the current year

• Preceptor development initiatives

Section 3: Rotations

Rotations are determined by resident's interests, and personal and professional goals for completing their residency program. Each rotation has its own goals, objectives and schedule, all determined by the preceptor. Residents are expected to function independently and demonstrate proficiency throughout the rotation. Preceptors are responsible for ensuring rotation and program goals are met, provide mentorship and teach principals of pharmacy practice by incorporating the four teaching models. The preceptor is responsible for establishing a schedule and providing ongoing feedback and timely summative evaluations.

Required Rotations

- Internal Medicine (8 weeks)
- Oncology (6 weeks)
- Infectious Disease (6 weeks)
- Critical Care (6 weeks)
- Emergency Medicine (6 weeks)
- Administration (longitudinal)
- Service (longitudinal)

Elective Rotations

- Based on Residents' interest
- Two Electives (4 weeks)

Rotation Schedule

The resident and RPD will establish the rotation schedule and develop a customized training plan within the first month. In the event the resident's program goals change, the resident may request a schedule change. The RPD will make every attempt to adjust the schedule to accommodate both resident and program preceptors. Any schedule changes will be documented in the customized training plan and communicated to program preceptors.

Customization of Residency Program

ASHP requires that the resident's training program must be customized based on their entering interests, skills and experiences. Progress toward achieving program outcomes and requirements should be assessed quarterly by the RPD. Additionally, the customized training plan will be evaluated quarterly to ensure resident's interests and personal goals are consistent with program goals and objectives.

Self-Assessment Form

Prior to the program start, the incoming residents will be given a self-assessment form to complete to assess their abilities, practice interests, skill level, experience and educational background. This information will be shared with the preceptors and RPD to assist in developing a customized training plan and schedule.

ASHP Entering Interests Form

This residency program at uses the standard form created by ASHP to determine the residents' individual professional goals and objectives for their program year. The standard form is completed once during the resident orientation experience. The standardized form addresses Customization of Residency Program, career goals; current practice interests; strengths; weaknesses; and professional and program goals. Residents also address areas of concentration for their program, a strategy for fostering continuing pharmacy education and their involvement in professional organizations. The resident is required to provide a narrative reflecting on these elements in order to provide them with a customized training plan. Residents will identify several areas where improvement is desired, and the RPD will develop a plan to address these areas to achieve professional and personal goals.

Goal Based Residency Evaluation

The Goal-Based Residency Evaluation Form is to collect baseline information for use in the development of individualized educational goals and objectives for the upcoming year in residency. The resident will use this form to perform a self-evaluation on all the program's outcomes and goals. The Goal Based Residency Evaluation Form is completed once as part of the resident's orientation/introductory learning experience. Residents will review the information provided on both forms with their RPD/RPC in order to create a customized schedule and training plan. The RPD will discuss the information gathered for each resident from both forms at the first Residency Advisory Committee to ensure preceptors can assist in facilitating achievement of program goals for the individual resident.

Development Plans

Purpose: to modify the design and conduct of the program to address each resident's unique learning needs and interests. The development plan is used to monitor, track and communicate the residents' overall progress throughout the residency and adjustments made to meet their learning needs. The RAC will meet quarterly to discuss the progress of the residents and agree to development plan adjustments needed for residents.

Initial Development Plan

In the first weeks of the program the resident will complete an initial self-evaluation to identify their short- and long-term goals, their incoming strengths and areas for improvement and incoming interests. The initial development plan created by the RPD/RPC will incorporate the aforementioned information and adjust the following:

- Resident's schedule
- Preliminary determination of elective learning experiences
- Educational goals and objectives to be emphasized during all learning experiences
- Changing evaluation schedule/requirements
- Modify preceptor's use of modeling, coaching and facilitating

Quality Development Plan

On a quarterly basis there will be a review of the residents' progress in achieving competencies, goals and objectives. Adjustments will be made based upon:

- Review of residents' performance relevant to the previous quarter's plan with input from preceptors
- Identification of new strengths or actionable areas for improvement
- Optional changes in short- or long-term career goals and interests and if no changes document accordingly
- Documentation of specific objectives to focus on in the upcoming quarter
- Additional evaluations needed for select objectives Modification to the schedule as needed for the upcoming quarter

Section 4: Meetings

Residents are required to attend and participate in a variety of meetings throughout their residency year, to meet residency learning goals and objectives, and to understand the administrative culture of the department and organization. This may include P&T, pharmacy administration meetings, departmental meetings, residency meetings and committee meetings. A preceptor may require the resident to attend a meeting as part of their learning experience. The resident will be responsible for assisting with leading our P&T meeting during their four quarter of training.

Section 5: PGY-I Residency Evaluation Process

There are four types of required assessments for our PGY1 program to monitor resident's progress and program effectiveness. Residents will be evaluated by rotation preceptors, the RPD, the Director of Pharmacy and themselves. T

The PharmAcademic system is the ASHP approved database used to manage our residency program.

Summative evaluation: Performed by the preceptor and resident at the end of the rotation.

Preceptor evaluation: Performed by the resident at the end of the rotation/experience.

Quarterly evaluation/development plan: Performed by the RPD/RPC each quarter. The RPD/RPC will determine if the resident has demonstrated consistency throughout their learning experiences and mark Achieved for Residency accordingly.

Self-evaluations: To meet the required objective of applying a process of on-going self-evaluation and personal performance improvement, the resident will complete a self-evaluation for all learning experiences. The resident will compare their self-evaluation with the summative evaluation of the preceptor. This objective will also be incorporated into other learning objectives to ensure residents have mastered this skill.

Preceptor (Summative) Evaluation of Residents' Attainment of Goals and Objectives

Preceptors will provide appropriate orientation to the learning experience, including review of educational goals and objectives, learning activities, expectations and evaluation schedule.

• Preceptors will provide ongoing feedback throughout each learning experience. Preceptor should meet with the resident 2-3 times a week in order to keep communication ongoing.

• Written formative evaluation is encouraged. Examples to review include patient monitoring forms, care plans, monographs, MUE's.

• Written formative evaluations need to be completed using PharmAcademic

• Summative evaluations will be completed by the preceptor no later than 7 days after the last day of the learning experience. For longitudinal rotations the evaluation must be done quarterly.

• If evaluations are not submitted within 5 days of the end of the learning experience or the quarterly deadline, the resident will be removed from rotation until the evaluation is completed.

• Criteria-based feedback is essential for summative evaluations, preceptors should include in the comments: The strengths, weaknesses and areas to improve on to provide residents specific feedback to direct them moving forward.

• Preceptors will check the appropriate rating to indicate resident progress and provide narrative commentary for any goal for which progress is “needs improvement” or achieved.

NI: Needs Improvement

▪ Resident’s level of skill on the goal does not meet the preceptor’s standards of achieved or satisfactory progress.

▪ Resident was unable to complete assignments on time and/or required significant preceptor oversight

▪ Resident’s aptitude or clinical abilities were deficient ▪ Unprofessional behavior was noted.

SP: Satisfactory progress

▪ Resident’s skill levels have progressed at a rate that will result in full mastery by the end of the residency program

▪ Resident is able to perform with some assistance from the preceptor

▪ Improvement is evident throughout the experience o ACH: Achieved

▪ Resident has fully mastered the goal/skill based on their residency training

▪ Resident has performed the skill consistently with little or no assistance from the preceptor

ACHR: Achieved for Residency:

▪ RPD will assess all goals and objectives quarterly in PharmAcademic.

▪ When sufficient evidence is presented in the form of feedback from preceptors (summative evaluations, formative) and deliverables (documents uploaded) to indicate that a resident has achieved a residency goal, it will be marked as such in PharmAcademic.

• Summative evaluations must be discussed with the resident and both parties must cosign and acknowledge any additional comments.

Attain “achieved” on at least 75% of all objectives (including 100% of the objectives in competency areas surrounding patient care) within each of 9 listed goal and attain satisfactory progress on all other objectives not documented as achieved by the end of the residency year.

Program Plan for Resident Self Evaluation of Their Attainment of Program Competencies, Goals and Objectives

• Residents perform an initial assessment during their orientation experience.

• Residents will complete a self-assessment following each learning experience, and quarterly with any longitudinal learning experience. These self-evaluations will be reviewed by the RPD and preceptor.

• Residents should review their progress during their learning experience and should compare the summative evaluation completed by the preceptor with their self-evaluation

• For self-evaluations the resident should identify their strengths, areas to improve on and a plan to address them.

• RPD will review and asses the resident's abilities to self-evaluate during their quarterly development plan

• Mentors/preceptors/advisors may discuss self-evaluation skills using formative feedback. Additionally, residents are encouraged to self-evaluate utilizing the formative feedback they have received from the above.

• At the end of the year, each resident should review their goals and objectives and self-evaluate their achievement.

Residents' Evaluation of the Preceptor and Learning Experience

• Evaluations of preceptors and learning experiences must include criteria-based feedback for improvement, or encouragement of continuation of strong practices.

• Residents will complete this evaluation no later than 7 days after the learning experience has been completed.

• If evaluations are not submitted within 5 days of the end of the learning experience or the quarterly deadline, the resident will be removed from rotation until the evaluation is completed.

• Completed evaluations will be discussed with the preceptors and signed by each.

• Completed and signed evaluations will be forwarded to the residency program director to review and cosign.

Resident's evaluation of the residency program

In May of each residency year the current residents will complete a program evaluation based on their personal experiences on all aspects of the program.

• The feedback will be used to improve and direct the program for the following year.

Section 6: Research Project

Background

This Residency program requires the resident to participate in a research project with the goal to educate the resident on the many phases involved with scientific research. The resident will learn about developing a project proposal, collecting data, IRB submission and presenting their findings, and provide recommendations based on those findings to improve clinical services or the medication use process. The resident may decide to do original research, identify a process improvement or establish a new service. Preceptors and residents will collaborate to identify a research question, create a project proposal and establish a timeline to ensure success. In June, preceptors will be surveyed to generate a list of project ideas as potential research MUE projects for incoming residents. Each idea will require at minimum the following information to proceed:

1. Project Advisor(s)/ project team/project sites

2. Title/Idea of the project

3. Rational and brief description of proposed project

4. Proposed study design and anticipated analytical plan 5. Method for data procurement

Based on the resident's interests and professional goals, they will select from the list of projects. If the resident develops their own project, it must be approved by the RPD.

The proposal should outline project goals, objectives and methods used to analyze the data once collected. The proposal should have the following sections:

1. Research question. Should be well defined and feasible to answer in the defined period of time.

2. Objectives. Be specific, you will need to refer back to these at the end to ensure they have been addressed. You may have both primary and secondary objectives depending on your question.

3. Hypotheses. Should be stated as a null hypothesis. What do you expect to happen?

4. Background. Literature review of the question.

5. Methods. What is the study design, what are you going to measure?

6. Data analysis. How are you going to analyze the results?

7. References

General Project Timeline

Project Idea: July

Proposal Development: August

IRB submission: September

Data Collection: October, November, December, January

Data Analysis: February, March

Preliminary Slides for review: April

Platform Presentation Practice: May

Regional conference or equivalent Platform Presentation: June

Section 7: Residency Policies

ADOPTING SITE(S)

CO - Good Samaritan Medical Center (GSMC)

Site Department / Single Discipline Policy: PGY1 Pharmacy Resident Requirement for Licensure, Completion of, and Dismissal from the Residency Program - GSMC (Pharmacy Services)	
Document Owner: Kimberly Tate (Director Pharmacy_COFR)	**Last Review Date:** 05/03/2023
Effective Date: 05/03/2023	**Next Review Date:**
Executive Approver(s): Kimberly Tate (Director Pharmacy_COFR)	**Approval Date:** 05/03/2023

Purpose:

To describe the processes and requirements related to pharmacy residents.

Scope:

This policy applies to specific roles/functions including Accepted (matched) Post Graduate year 1 Pharmacy Resident (PGY1) residents and current PGY1 residents at GSMC.

Definitions:

None

Exceptions:

All completed materials and/or deficiencies will be evaluated by the Residency Advisory Committee and final review by the Residency Program Director (RPD).

Policy:

1. The policy explains the effect, if any, on the Resident's ability to complete the residency program and failure to become licensed in Colorado.

Procedure: Failure to Obtain Colorado Pharmacy Licensure – GSMC (Pharmacy Services)

#	Required Action Step (step by step process)	Performed By	Supplemental Guidance
1	Ensure residents are licensed or eligible for licensure in the State of Colorado as soon as possible, up to a maximum of 120 days after the program start date.	Accepted (matched) PGY1 residents	• If the candidate fails the exam and therefore does not obtain licensure, Good Samaritan, at its sole discretion, may allow the resident to retake the exam one additional time. If the resident is not licensed within 120 days, the residency term with be extended for a maximum of 30 days. This ensures the resident is a licensed pharmacist for two-thirds of their residency training. In the event the residency term is extended, the resident will continue their same salary and benefits. • If following the re-exam, the resident fails to obtain the required license; Good Samaritan will immediately terminate the resident and shall have no further responsibilities to resident.

Site Department / Single Discipline Policy: PGY1 Pharmacy Resident Requirement for Licensure, Completion of, and Dismissal from the Residency Program - GSMC (Pharmacy Services)
Document Owner: Kimberly Tate (Director Pharmacy_COFR)

Procedure: Requirements for Successful Completion of PGY1 Residency Program – GSMC (Pharmacy Services)

#	**Required Action Step** (step by step process)	**Performed By**	**Supplemental Guidance**
1	Complete all required elements established by the residency advisory committee.	Current PGY1 residents	**Required elements:** • Attain "achieved" on at least 75% of all objectives (including 100% of the objectives in competency areas surrounding patient care) within each of the 9 listed goals and attain satisfactory progress on all other objectives not documented as achieved by the end of the residency year. • Residency Conference presentation / manuscript • A minimum of two journal club presentations. • A minimum of two educational presentations • A minimum of two pharmacy clinical pearls. • Resident project completion. • BLS, ACLS, and PALS certification • Teaching Certificate • Medication Use Evaluation • Drug Monograph

Site Department / Single Discipline Policy: PGY1 Pharmacy Resident Requirement for Licensure, Completion of, and Dismissal from the Residency Program - GSMC (Pharmacy Services)
Document Owner: Kimberly Tate (Director Pharmacy_COFR)

Procedure: Residency Time Away, Leave of Absence and Dismissal – GSMC (Pharmacy Services)

#	Required Action Step (step by step process)	Performed By	Supplemental Guidance
1	Follow Intermountain Health Human Resource policies if a leave of absence is requested.	Resident	• The minimum term of the resident appointment is 52 weeks. • Time away from the residency program cannot exceed a total of 37 days per residency appointment. - Time away from the program is defined as the total number of days taken for vacation, sick, interview, and personal days; holidays; religious time; jury duty; bereavement leave; military leave; parental leave; leaves of absence; and, extended leave. - Conference and/or education days, are also defined as "time away" for the purposes of the ASHP Residency Accreditation Standard. - The calculation of time away does *not* include service commitment/staffing days nor are compensatory days for staffing shifts counted in the calculation. - Residents are permitted to use their time off during the residency year when approved by the RPD. This includes leave time granted for interviewing for positions. Accrued, unused PTO will be paid out when a caregiver leaves Intermountain employment. Requested time off should be submitted as far in advance as possible to the RPD/Preceptors (ideally a minimum of 7 days prior to the date the resident will be gone), unless the time off is for legitimate, unexpected

			illnesses, or emergencies. The resident will first discuss the RTO with the affected rotation's preceptor and obtain the preceptor's permission to ensure rotation objectives will be met. • In the event of the need for an extended leave of absence during the residency, Good Samaritan Medical Center will follow the "Time away from work" process outlined in Intermountain Health's HR policies, as amended from time to time. • Personal Leave of Absence – SCL Health • Paid Time Off (PTO) - SCL Health • If the leave of absence has been approved by management, Good Samaritan Medical Center may, at its sole option, accommodate the resident extending their residency at the end of the leave to complete the required work for up to 12 weeks. • All circumstances involving leave will be handled by the RPD and Pharmacy Director on a case by case basis. Please refer to Intermountain Health's employee handbook and consult with the HR Business Partner for additional guidelines and details surrounding leave.
2	Disciplinary Action and Dismissal	Residents and RPD	*Corrective action or dismissal* from the program are actions that are considered when residents do not meet program or rotation expectations and requirements. Residents are informed of the program requirements, expectations, and deadlines. Program expectations, requirements, and deadlines are reviewed and communicated to the residents by the RPD during orientation and by reviewing this manual prior to the

	Disciplinary Action and Dismissal		start of the residency program. Rotation expectations are communicated to the residents by the preceptor at the start of and during each rotation. When issues or problems arise, which jeopardize the resident's successful completion of a rotation or other program requirement, the resident and the preceptor will discuss and attempt to resolve the issues or problems. If resolution is not achieved to the satisfaction of the preceptor, the ongoing concern will be documented and referred to the RPD and Residency Advisory Committee (RAC). The RPD/RAC will discuss the issues with the resident, or others involved if appropriate, and will determine whether corrective action is needed for the resident to successfully complete the rotation or residency requirement. The RPD/RAC will be notified of the issue and involved in the decision for corrective action. When corrective action is indicated, the RPD/RAC (or rotation preceptor in conjunction with the RPD/RAC) will take appropriate action based on the situation and circumstances, while following Intermountain's Employee Corrective Action Policy. Corrective action may include make-up or remedial work, repeated or alternate rotations, or other assignments or actions appropriate to the circumstance and as determined by the preceptor, RPD and RAC. Despite all arrangements, a situation may arise where the resident has not completed the rotation requirements or met the objectives satisfactorily. One rotation may be repeated or one alternate rotation may be assigned for **failure to meet expectations**. Failure to

	Disciplinary Action and Dismissal		meet the requirements of 2 rotations will result in the resident being dismissed from the program. When dismissal from the Good Samaritan Medical Center Pharmacy Residency Program is indicated, the RPD will make recommendations and site Pharmacy Director. The RPD and Pharmacy Director will make the final decision concerning dismissal from the pharmacy residency. The Director of Pharmacy and Human Resource Representative will be involved as necessary.
	Follow the_Employee Corrective Action - Intermountain (HR) policy in the event that dismissal from the residency is required.		If the resident does not adhere to the Code of Conduct - Intermountain (Compliance) or does not perform to expectations, the resident will be put through the corrective action process: • Coaching (Verbal warning) • Written Warning • Final Notice • Termination of employment is the final step The resident may be terminated at will if it is determined that the resident: • Knowingly acts with intent to harm or deceive. • Knowingly chooses to ignore or bypass appropriate policies and procedures. • Cannot practice in a reliably safe manner, in spite of education and counseling. • Is unwilling to participate in the following: 1) Detection and reporting of events, accidents, or near misses, or 2) Implementation of

			system - based activities to prevent events, accidents, or near misses. • The HR business partner and HR Vice President will be involved in any termination of employment.

References:

- None

Other Related Policies:

- Code of Conduct - Intermountain (Compliance)
- Employee Corrective Action - Intermountain (HR)
- Paid Time Off (PTO) - SCL Health

Supporting Documents:

- None

Monitoring:

- Successful licensure in the state of Colorado.
- Monitoring of the residents progress will occur continuously throughout the program to ensure the residents successful completion of the items listed above.
- Monthly, the Residency Advisory Committee will review the progress of the resident. In addition, the resident will monitor their own progress and present their progress at the monthly residency meetings.

Policy Title: Employee Corrective Action - Intermountain (HR)	
Effective Date: 09/18/2023	**Last Review Date:** 09/18/2023
Document Owner: Kendall Simpson (Labor and Employee Relations COE Director)	**Next Review Date:** 09/18/2026
Approver: Tiffiny Lipscomb (VP HR Strategy and Delivery)	

Purpose:

To assist employees in improving performance and behavior according to company values, policies, and Code of Conduct.

Scope:

Intermountain Health, except where otherwise required by an applicable collective bargaining agreement and/or applicable laws or rule.

Entity Type(s):

All

Definitions:

Performance Improvement Plan (PIP) — A specific, time limited plan that identifies performance issues, opportunities for improvement and helps managers to be successful in their roles. Failure to achieve the outlined objectives within the identified timeframes may result in termination. A PIP may be used in lieu of corrective action steps for manager roles.

Policy:

1. General Expectations
    a. Intermountain communicates expectations regarding employee performance and conduct to employees through various methods, including but not limited to job descriptions, department and company policies and procedures, training, coaching, and other communications. Failure to meet performance standards and/or failure to follow Intermountain's policies, values, Compassionate Connections, or Code of Conduct may result in the initiation of corrective action up to and including termination.
2. Manager Expectations
    a. Managers are expected to identify and inform employees of expected behaviors and the performance standards of their job.
    b. Intermountain expects managers to provide feedback to employees regarding job performance in a timely, mutually respectful, and professional manner. Managers should be clear about expectations and how the employee's overall behavior impacts the workplace.
    c. Managers are responsible for accurate and timely documentation of inappropriate behaviors and/or performance issues (see examples of disruptive behavior and/or performance deficiencies below).
    d. Managers should utilize this policy in a fair and consistent manner when an employee is not meeting expectations or when behaviors are not in line with Intermountain's policies, values, Compassionate Connections or Code of Conduct.
3. Employee Expectations

a. Employees are expected to accept correction, direction, and feedback on job performance and demonstrate immediate and sustained improvement.

b. Each employee is expected to be open and responsive to feedback regarding performance and behavior deficiencies.

c. Manager actions regarding workplace issues are a necessary and appropriate step in performance feedback. Corrective action based on performance deficiencies or other valid workplace issues is appropriate and necessary and does not constitute harassment, discrimination, or retaliation.

4. Guiding Principles for Corrective Action

a. Corrective action must be nondiscriminatory and appropriate. The degree of discipline administered in a case should be reasonably related to the seriousness of the problem and the employee's service record. Each situation should be reviewed for the following (this list is not exhaustive):

i. Is the expectation or work standard necessary for the orderly and effective operation of the work unit?

ii. Was the employee informed of the expectation or work standard?

iii. Has the expectation or work standard been applied consistently?

iv. Did the circumstances warrant an investigation and, if so, was an investigation done that was fair and objective?

v. Has the employee had an opportunity to explain their actions and circumstances?

b. Employees are given the opportunity to change or improve performance or behavior unless the employee's misconduct is serious enough to warrant immediate suspension or termination. The manager normally provides counseling or training directed toward helping the employee improve behavior or performance.

c. Employees are given the opportunity to tell their side of the issue and to document it as part of the official record.

d. Where required by collecting bargaining agreement or state or local requirement, an employee may request another Intermountain employee to be present as an observer in corrective action meetings. The observer is for support and should not contribute to the meeting. The observer must be a current employee of Intermountain Health, not a relative, an attorney, nor anyone in the employee's direct line of supervision.

5. Documentation

a. Documentation should be specific, accurate, and timely, and should include what an employee must do to correct the inappropriate behavior and the consequences, if improvement does not occur.

b. Documentation should be written and communicated in a mutually respectful and professional manner.

c. Documentation cannot include protected health information (PHI) such as patient names or other care-related facts specific enough to identify a patient, event reports, attorney client privilege, peer or care review privilege, etc.

d. Documentation should only include the personal identifiers (i.e., employee name) of the employee receiving the corrective action. Other personal identifiers (i.e., names of coworkers, physicians, employees) may be included upon consultation with Human Resources.

e. No documents of an evaluative or disciplinary nature should be placed in an employee's personnel file without the employee's knowledge. An employee's signature on such documents can prove employee awareness without implying agreement.

6. Manager Discretion When Taking Corrective Action

a. Managers are expected to exercise discretion in handling each situation based on the severity of the issue(s) and circumstances involved. Depending upon the seriousness of the issue(s), steps can be repeated or omitted if the facts of the situation warrant it; there may be situations where an employee is terminated without progressing through the steps outlined in this policy. Managers are encouraged to partner with Human Resources in the corrective action process.

b. There are certain actions that each employee must complete in order to offer safe and high-quality care and service and in order to be eligible for continued employment (i.e., immunization, education, and compliance). Any employee who does not complete these actions is subject to Corrective Action according to the applicable sanctions grid and not at the individual manager's discretion.

c. Informal coaching may be used before proceeding to formal documented corrective action stages. The coaching discussion should cover the issue, problems the issue created or will create, expectations for correcting the issue, and the consequences if expectations are not met. Managers should retain notes of an informal counseling session for later reference. Managers may choose to have the employee acknowledge the coaching in writing or via email.

d. Formal Corrective Action provides written documentation to remind employees of job expectations and accountability to correct behavior.

i. Managers may skip levels of corrective action as listed below as appropriate and are encouraged to partner with Human Resources in the corrective action process.

ii. Taking any step in the formal corrective action process requires a manager to complete a Corrective Action Form for each step in the formal corrective action process. Employees are asked to sign this form indicating they have had an opportunity to review it. If an employee elects not to sign, this is noted on the form. Copies are given to the employee and sent to Human Resources for placement in the employee's file.

7. Suspension

a. If an employee commits or appears to commit an act that is serious enough to require the employee's removal from the facility, the employee may be placed on suspension pending an investigation.

b. The decision to suspend an employee is made by a manager, in consultation with Human Resources (see the Employee Suspension—Intermountain (HR) Policy).

8. Levels of Corrective Action

a. Documented Verbal Warning - A manager may involve Human Resources in creating and delivering Documented Verbal Warning but is not required to do so. This step initiates the

formal corrective action process and serves to articulate job expectations and give the employee the opportunity to correct the behavior or issue.

b. Written Warning: A Written Warning serves to reinforce job expectations and give the employee the opportunity to correct the behavior or issue. This step is to address serious or persistent problems and outline expected behaviors. A manager may consult Human Resources in creating and/or delivering a Written Warning.

c. Final Written Warning: A Final Written Warning is used when the prior steps have not resolved performance or behavior issues, or a new problem arises which is of a sufficiently serious nature to warrant a final written warning. A manager should involve Human Resources in creating and delivering a Final Written Warning.

d. Involuntary Termination: This is used when the prior steps have not resolved performance or behavior issues, or a new problem arises, which is of a sufficiently serious nature to warrant termination of employment. A manager should involve Human Resources in creating and delivering an involuntary termination.

e. Performance Improvement Plan (PIP): For manager roles (roles or medical director roles), a PIP may be developed and followed in lieu of the corrective action steps outlined above. If the completion of the PIP does not resolve manager performance concerns or a new problem arises, which is of a sufficiently serious nature, termination of employment may occur.

9. Disruptive Behavior and/or Performance Deficiencies

a. Corrective action is used to address performance and/or behavioral problems in which the employee is not satisfying the requirements of their position, not acting in conformity with applicable policies, procedures, or job expectations, or otherwise acting in an unprofessional or inappropriate manner.

b. Depending upon the seriousness of the act and the surrounding circumstances, a manager may elect to begin corrective action with any step in the formal corrective action process, including termination. Below are examples of performance and behavioral issues that can lead to corrective action. However, the list is not exhaustive, and corrective action may be issues to address other performance and behavioral concerns, regardless of whether they are listed below:

i. Absenteeism or tardiness (including failure to follow applicable requirements for breaks).
ii. Mishandling of confidential information.
iii. Disruption of an employee's own or another employee's work.
iv. Behavior that is disruptive, unsafe, or unfit for the performance of work duties or disruptive to the work environment.
v. Acts that endanger the safety, health, or well-being of another person.
vi. Bullying, threatening, intimidating or coercing behaviors.
vii. Unprofessional conflicts with patients, the public, or other members of the staff.
viii. Criminal conviction relevant to an employee's position.
ix. Failure to complete and/or maintain mandatory training (i.e. Compliance education, immunizations, licensure, certifications).
x. Failure to follow rules, policies, procedures or guidelines or perform work duties.

xi. Falsification, fraud, or omission of pertinent information related to minimum qualifications for a position.
xii. Fighting or making an employee's workplace feel unsafe or uncomfortable.
xiii. Fitness for duty concerns (see Fit for Duty Policy).
xiv. Incomplete or late documentation.
xv. Loitering or loafing during work hours.
xvi. Misrepresentations or dishonesty.
xvii. Not accurately recording time worked, PTO, or other leave hours.
xviii. Possession of firearms, fireworks, explosives, or any other weapon on Intermountain Health property without administrative authorization (with or without legal authorization).
xix. Failure or refusal to carry out work responsibilities or instructions absent an immediate and bona fide threat to health, safety, or integrity.
xx. Reluctance or refusal to answer questions or return communications.
xxi. Sleeping or appearing to be asleep while on duty.
xxii. Smoking, vaping, tobacco, and smokeless tobacco use in unauthorized areas.
xxiii. Stopping work before authorized time or failing to begin work at the proper time.
xxiv. Unauthorized overtime or failure to record overtime worked.
xxv. Theft or misuse of company property, supplies, or funds.
xxvi. Uncivil or disorderly conduct, including horseplay.
xxvii. Use of discriminatory, obscene, abusive, or threatening language or gestures.
xxviii. Willful or careless destruction of property.
xxix. Failure to carry out or complete job responsibilities in a satisfactory manner.

10. Appeal Process

a. For a period of 14 calendar days following corrective action(s), an employee may initiate an appeal under the Employee Complaint Resolution - Intermountain (HR) policy.
b. This policy is intended to comply with the law as of the policy's effective date. In the event that applicable law changes such that one or more of this policy's provisions is overbroad or otherwise interferes with employees' protected rights, this policy will be enforced in accordance with any changes in the law.

Procedure: Employee Corrective Action – Intermountain Health (HR)

#	Required Action Steps (step by step process)	Performed By	Supplemental Guidance
1	Identify and inform employees of expected behaviors and the performance standards of their job.	Manager	

2	Gather information if a performance gap is identified: • How was the employee informed of the expectation or work standard? • Has the expectation or work standard been applied consistently? • What is the gap between the expectation and the employee's performance? • How does the performance or behavior gap impact work?	Manager	
3	Contact Human Resources if an investigation is warranted.	Manager	
4	Gather the employee's side of the story.	Manager	
5	Determine the appropriate level of Coaching, Performance Improvement Plan, or Corrective Action based upon the information gathered in the steps above.	Manager	Refer to: • Code of Conduct - Intermountain (Compliance) • Just Culture Algorithm - Intermountain - Peaks (HR) - Supporting Document (for Peaks only) • Mandatory and Required Elements Accountability and Sanctions Grid - Intermountain (HR) - Supporting Document • Performance Improvement Plan (PIP) Template Form - Intermountain (HR) - Supporting Document • Performance Management Decision Guide - Intermountain - Canyons and Desert (HR) - Supporting Document (for Canyons and Desert only)
6	Create the Corrective Action document. For documented verbal warning and written warnings, this may be	Manager	Refer to:

	submitted to HR for review. For Final Written Warnings, Terminations and Performance Improvement Plans, documents should be reviewed by HR before being issued to the employee.		• Corrective Action Form - Intermountain (HR) - Supporting Document
7	Review and edit the documentation if needed.	Human Resources	
8	Schedule and conduct a meeting with the employee to deliver the corrective action. For Final Written Warnings and Terminations, this should include Human Resources.	Manager	
9	Gather the signed document from the employee and submit to HR. Provide the employee with a copy of the document, as well as a copy of the Corrective Action and Appeal policies.	Manager	

References and/or Primary Sources:

- 42 CFR Section 485.709(b)
- Montana Wrongful Discharge from Employment Act

Related Policies and/or Guidelines:

- Code of Conduct - Intermountain (Compliance)
- Employee Complaint Resolution - Intermountain (HR)
- Employee Suspension - Intermountain (HR)
- Termination Policy – Canyons and Desert

Supporting Documents:

- Corrective Action Form - Intermountain (HR) - Supporting Document
- Just Culture Algorithm - Intermountain - Peaks (HR) - Supporting Document (for Peaks only)
- Mandatory and Required Elements Accountability and Sanctions Grid - Intermountain (HR) - Supporting Document
- Performance Improvement Plan (PIP) Template Form - Intermountain (HR) - Supporting Document
- Performance Management Decision Guide - Intermountain - Canyons and Desert (HR) - Supporting Document (for Canyons and Desert only)

System Policy: Paid Time Off (PTO) - SCL Health	
Department(s) Initiating: Human Resources	
Application: This policy applies to SCL Health and all its Controlled Corporations, as that term is defined in the SCL Health Bylaws, and to any entity owned in part by SCL Health or an affiliate and/or managed by SCL Health or an affiliate, if that entity's governing body has adopted the policy [as its own].	
Document Owner: Susan Schaub (VP Total Rewards_COFR)	**Last Review Date:** 07/01/2019
Effective Date: 03/05/2021	**Next Review Date:** 11/01/2024
Committee/Executive Approver(s): Tammy Saunaitis (SCL-SVP Chief Human Resources Officer)	**Approval Date:** 07/01/2019

Purpose:

To outline the Paid Time Off (PTO) program which is intended to cover time away from work that canbe used for vacations, holidays, personal time, personal illness or time off to care for dependents.

Scope:

This policy applies to all associates, including Directors and Employed Physicians who are benefit eligible with the exception of Contracted Physicians, Physicians on the Physician Approved Time Off(ATO) Policy, Residents, and Executives.

Care Site Exceptions:

Holy Rosary Healthcare, Mount Saint Vincent, PVMC Ambulance Drivers, and St. James HealthcareUnion Associates.

Definitions:

Associates — staff employed by SCL Health and not otherwise designated in Lawson as a Director, Physician, Resident or Executive.

Directors — staff designated in Lawson with a Director level job title.

Employed Physicians — staff designated in Lawson with a Physician level job title. Employed Physicians with employment contracts should review his/her contract to confirm his/her eligibility andapplicable policy. Excludes employed Physicians participating in the Physician ATO policy.

Executives — staff designated in Lawson with an Executive level job title. Executive PTO isaddressed in the Executive Compensation policy.

Legacy Sick Bank or Extended Illness Bank (EIB) or Extended Sick Leave (ESL) — grandfathered accrued sick time. Associates hired prior to January 1, 2012 may use grandfatheredESL/EIB hours during the Short-Term Disability 7-day waiting period. (Previously only PTO hours were allowed during this time.) ESL/EIB and/or PTO hours can be used to "top-up" base salary so Associates receive 100% of pay throughout the duration of his/her short-term disability. "Top-up" isnot available for Long-Term Disability. The disability programs are for Associate extended illnessesonly.

Years of Service — length of employment that is calculated based on the Associate's adjusted hiredate in Lawson.

Policy:

1. Earning Paid Time Off (PTO)
    a. PTO is earned on a per pay period basis and credited to an eligible Associate's PTO bank onthe corresponding payroll pay date.

b. PTO will accrue on hours worked and PTO hours used, up to a maximum of 80 hours perperiod. PTO will not accrue on hours in excess of 80 per pay period.

c. PTO will not accrue on unpaid leave of absence.

d. PTO is calculated based on eligible hours worked each pay period and accrual rate designatedby Years of Service as outlined below.

Associates:

Years of Service	Accrual Rate Per Hour Worked	Maximum Accrual Per Pay Period (80 hours worked)	Maximum Hours Accrued Per Year
0-4 Years	.088462	7.08	184
5-9 Years	.103846	8.31	216
10-14 Years	.119231	9.54	248
15-19 Years	.123077	9.85	256
20+ Years	.126923	10.15	264

Directors and Employed Physicians:

Years of Service	Accrual Rate Per Hour Worked	Maximum Accrual Per Pay Period (80 hours worked)	Maximum Hours Accrued Per Year
0-4 Years	.107692	8.62	224
5-9 Years	.123077	9.85	256
10-14 Years	.130769	10.46	272
15-19 Years	.134615	10.77	280
20+ Years	.138462	11.08	288

e. Maximum PTO Accrual Limit:

i. The Maximum Accrual Limit is 200 hours. Once the Maximum Accrual Limit is met,PTO accrual will stop. PTO accruals will restart once the PTO bank balance is below the designated maximum accrual/PTO balance threshold.

2. Holidays

a. If the Associate, Director or eligible Employed Physician is normally scheduled to work on an observed holiday in which his/her home department is closed or on reduced staffing levels, PTO will be deducted from his/her PTO bank for the holiday.

b. Observed holidays include: New Year's Day, Memorial Day, Independence Day, Labor Day,

Thanksgiving Day and Christmas Day (Midnight to Midnight).

c. Holiday Pay for Associates, Directors or eligible Employed Physicians who work on anobserved holiday is addressed in the Holiday Premium - SCL Health policy.

3. Use of PTO

a. PTO must be used to bring the total worked hours for the pay period to the Associate, Director σ eligible Employed Physician's standard hours, except when on an approved unpaid leave, short-term disability or long-term disability.

b. PTO in combination with hours worked must not exceed the Associate's standard hours.

c. Time off for Bereavement and Jury Duty are addressed in the Bereavement Leave - SCL Health and Jury Duty, Legal Proceedings and Voting - SCL Health polices, are in addition to PTO.

d. Non-exempt Associates may use, but are not required to use, PTO if sent home during a low census day.

e. Non-exempt Associates may not use PTO in less than 15 minute increments.

f. Exempt Associates may not use PTO in less than half day increments, with the exception of approved FMLA and American Disabilities Act (ADA) leave or as otherwise required bylaw.

g. Associates, Directors or Employed Physicians may be allowed, with manager approval, to useup to 16 hours of PTO that has not yet been accrued. If an Associate terminates employment with a negative PTO balance the value will be deducted from his/her final paycheck.

h. Associates may use PTO during the Short-Term Disability benefit elimination period and mayelect to "top up" his/her disability payment to 100% of his/her regular weekly earnings while receiving benefits under Short-Term Disability.

i. Associates are not permitted to use PTO while receiving disability payments under Long-Term Disability or Workers Compensation.

4. Scheduling PTO

a. PTO must be scheduled with the approval of the immediate supervisor as far in advance aspossible.

b. Supervisors are responsible for scheduling time off so each unit/department is adequatelystaffed at all times.

c. Requests for PTO are subject to adjustment based on the business needs of the department.

d. After consultation with Human Resources, departments may establish reasonable guidelinesfor requesting and approving PTO.

5. Payment of PTO

a. PTO payment is considered taxable income.

b. Accrued PTO will be paid out upon status change to an ineligible status or termination of employment.

6. PTO Donation Program

a. Donating Associate:

i. The PTO Donation option is available in the event another Associate must be absent from work for an extended period of time.

ii. The Associate receiving the PTO Donation must have exhausted both his/her PTO and any Legacy Sick Bank (ESL or EIB), if the extended absence is due to a serious health

condition affecting the Associate him/herself, or have exhausted his/her PTO, if the serious health condition is affecting his/her spouse, child (ren), or parents for whom the Associate is needed to provide care.

iii. Donations may not decrease the donating Associate's PTO balance below 80 hours.

iv. Donated hours will not be deducted from the donating Associate's PTO bank until the hours are needed by the receiving Associate.

v. Legacy Sick Bank (ESL or EIB) hours are not eligible to be donated.

vi. Donated hours will be converted to a cash equivalent based on the donating Associate's base rate. This cash equivalent will then be used to calculate the number of PTO hours that will be credited to the recipient's PTO bank.

vii. In order to donate hours, Associates must complete the PTO Donation Form*, and turn the form into HR Services the Wednesday prior to the pay period end date to be applied for the current pay period.

viii. The donating Associate will not be taxed on the transfer of accrued hours.

b. Receiving Associate:

i. Must be on an approved medical leave, for either the Associate's own or family member's serious health condition, in order to receive PTO donations. Use of PTO donation hours does not eliminate any FMLA regulation requirements.

ii. Must be on an approved medical leave at the time the donated hours are used/applied. Donated hours cannot be held and used after the Associate's medical leave ends or returns back to work.

iii. Must have exhausted his/her PTO balance. If the Associate has a legacy sick leave balance and the leave is due to a serious health condition affecting the Associate him/herself, the legacy sick leave balance must also be exhausted.

iv. Will continue to receive and accrue benefits during periods when donated PTO time is being paid.

v. May not be paid for time in excess of his/her standard hours.

vi. Donated PTO hours are paid at the recipient's base hourly rate.

vii. Will be paid as if he/she were a regular Associate with all normal tax/benefit deductions and during normal payroll schedule.

viii. PTO Donation Form can be obtained on The Landing or by contacting HR Services.

7. PTO Donation to Foundation

a. PTO Donation option allows eligible Associates, Directors and Employed Physicians tocontribute the value of PTO hours to an SCL Health Foundation.

b. The PTO hours donated under this option will be credited to an SCL Health Foundation basedon the Associate's base rate at the time of the election.

c. All Associates eligible for PTO may donate hours to an SCL Health Foundation.

d. Associates may elect to donate to an SCL Health Foundation at any time during the year.

e. Associates must have at least 80 hours remaining in his/her PTO bank after transferring PTO to Foundation.

f. Associates may donate a maximum of 80 hours of PTO in any calendar year.

g. The election to donate, once made, is irrevocable.

h. Legacy Sick Bank hours are not eligible to be donated.

i. The donation will be processed as soon as administratively feasible following receipt of therequest in Payroll.

j. The donated hours will be taxed according to IRS guidelines. Applicable Federal, State, Localand FICA taxes will be deducted.

k. In order to donate hours, Associates must complete the PTO Donation Form*, and turn theform into the HR Service Center.

8. PTO Cash out Program

a. Effective July 1, 2015, SCL Health no longer offers the PTO Cash out Program.

References:

- PTO Donation Form can be obtained on The Landing or by contacting HR Services.

Other Related Policies:

- Bereavement Leave - SCL Health
- Employed Physician Approved Time Off (ATO) - MG
- Holiday Premium - SCL Health
- Jury Duty, Legal Proceedings and Voting - SCL Health

Supporting Documents:

- None

Monitoring:

Human Resources and Payroll departments are responsible for monitoring the use and application ofthis policy. On an on-going basis, the Human Resources and Payroll department will run reports and review payments to ensure accuracy of payment to program participants.

System Policy: Personal Leave of Absence - SCL Health	
Department(s) Initiating: Human Resources	
Application: This policy applies to SCL Health and all its Controlled Corporations, as that term is defined in the SCL Health Bylaws, and to any entity owned in part by SCL Health or an affiliate and/or managed by SCL Health or an affiliate, if that entity's governing body has adopted the policy [as its own].	
Document Owner: Scott Day (AVP Labor & Employee Relations_COFR)	**Last Review Date:** 09/08/2020
Effective Date: 09/08/2020	**Next Review Date:** 09/08/2023
Committee/Executive Approver(s): Tammy Saunaitis (SCL-SVP Chief Human Resources Officer)	**Approval Date:** 09/08/2020

Purpose:

To address SCL Health's desire to provide opportunities for a Personal Leave of Absence where appropriate when a regular full time or part time associate requires personal time away from work.

Scope:

This policy applies to: All full time and part time SCL Health associates at all locations.

Care Site Exceptions:

*None

Definitions:

Personal Leave of Absence — excused time off provided for eligible associates for mission, educational opportunities, or other personal circumstances excluding family leave or personal circumstances for medical reasons. Personal Leave of Absence is a minimum of 2 weeks and maximum of 12 weeks per year.

Policy:

1. It is SCL Health's intent to afford opportunities for Personal Leaves of Absence for regular full time and part time associates under a uniform set of guidelines and procedures. The opportunity to request Personal Leaves of Absence are extended for the benefit of the associate. All such requests shall be considered on a case by case basis depending upon the particular circumstances, issue(s) and needs within the department. SCL Health retains full discretion to grant or deny such requests as needed.
2. Terms for Personal Leave of Absence
   a. Associates will not be allowed to accept employment outside of SCL Health while on a Personal Leave of Absence with the exception of military duty and select high level educational opportunities that do not present a potential conflict of interest
   b. Time off for a Personal Leave of Absence cannot be used to extend a termination date.
   c. Intermittent leave under this policy is not allowed.
   d. Associates may request a Personal Leave of Absence once within a rolling year for a minimum of 2 weeks and a maximum of 12 weeks. Approved education leave of absence may be taken for up to one year.

e. To be eligible for a Personal Leave of Absence, associates must not have had any disciplinary action in the past 12 months.

f. While associates remain in a paid status using Paid Time Off (PTO), the length of service credits will not be affected.

g. Paid with PTO accrued and unpaid when PTO depleted.

h. PTO will not accrue during unpaid leave.

i. Merit increases will be delayed while associates are on a Personal Leave of Absence. Once associates return from leave merit increases may occur, when applicable.

j. SCL Health recognizes that associates are invaluable to the organization and, in order for the Department to run effectively during the personal leave, the associate's position may need to be replaced. When a Personal Leave of Absence is afforded there is no guarantee that an associate will be able to return to the position held prior to the leave.

k. If the position is not available upon the associates' return, associates will have ninety (90) calendar days to apply for and obtain a new position before employment will be terminated.

2. Benefits Coverage During Personal Leaves of Absence

   a. Eligible associates will be required to pay the total benefits cost during any unpaid portion of the duration of their personal leave.

3. Associates Responsibilities

   a. Notify department leadership of the associates intent to request a Personal Leave of Absence no less than 30 days prior to the date in which the associate is requesting to start leave, when feasible.

   b. Notify department leadership no later than 2 weeks prior to returning to work. Contact Human Resources to fulfill benefit continuation requirements as necessary

4. Management Responsibilities

   a. Approve or deny an associate's Personal Leave of Absence request based on the operational needs of the organization.

   b. Notify Human Resources of an associate's approved request to take leave.

   c. Submit a Personnel Action Form (PAF) through Lawson Manager Self Service (MSS) indicating approval of start date and known return to work date. If return to work date is unknown, must submit another PAF through Lawson MSS to indicate return to work date.

   d. Enter Kronos code PTO scheduled or unpaid code each pay period.

5. Exceptions

   a. SCL Health maintains separate policies and procedures governing leave that may be afforded under state and federal law. This policy is not intended to cover the types of leave that are afforded under these policies.

References:

- Personnel Action Form (PAF) located on The Landing

Other Related Policies:

- Paid Time Off (PTO) - SCL Health

System Policy: Personal Leave of Absence - SCL Health
Document Owner: Scott Day (AVP Labor & Employee Relations_COFR)

Supporting Documents:

- None

Monitoring:

System Human Resources and Care Site Human Resources will monitor and enforce compliance with this policy.