VA Connecticut Healthcare System
Chiropractic Residency Program

Integrated Clinical Practice Program Handbook

Academic Year 2016

Sponsor: VA Connecticut Healthcare System

Affiliate: University of Bridgeport College of Chiropractic

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Contents

Mission, Goals and Objectives 3
Program Overview 4
Curricular Competencies 5
Location 7
Faculty 8
Duty Hours 8
Moonlighting 10
Compensation and Benefits 11
Resident Appointments 12
Clinic Policies 13
Professional Conduct 15
Evaluation 16
Requirements for Residency Completion 18
Completion Designation 19
Due Process 19
Acknowledgement 25

Mission, Goals and Objectives

Mission

- The Mission of the VA Connecticut Healthcare System (VACHS) chiropractic integrated clinical practice residency program is to enhance the knowledge, skills and behaviors of chiropractic clinicians through hospital-based clinical training, interprofessional education, and scholarly activities.

Resident Goals

- Graduates of this program will possess advanced competence in patient-centered, evidence-based diagnosis and management of complex musculoskeletal and neuromuscular cases
- Graduates of this program will have participated in a wide range of interprofessional education and patient care activities with providers and trainees from medical and associated health disciplines
- Graduates of this program will obtain advanced preparation for practice in VA, other hospitals, other medical settings, and/or academia

Resident Learning Objectives

At the completion of the program, graduates must have reached key objectives in the following categories:

- Clinical service (patient care)
  - Communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their family
  - Gather essential and accurate information about their patients.
  - Make informed decisions about diagnostic and therapeutic intervention based on patient information and preferences, up-to-date scientific evidence and clinical judgment
  - Develop and carry out patient management plans
  - Counsel and educate patients and their families
  - Use information technology to support patient care decisions and patient education
  - Perform competently all clinical treatment procedures considered essential for their area of practice
  - Provide health care services aimed at preventing health problems or maintaining health
  - Work with health care professionals, including those from other disciplines to provide patient- focused care
- Advanced healthcare knowledge
  - Demonstrate an investigatory and analytic thinking approach to clinical situations.
  - Know and apply the basic and clinically supportive sciences which are appropriate to their discipline
- Practice-based learning and improvement
  - Analyze practice experience and perform practice-based improvement activities using a systematic methodology.
  - Locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems.
  - Obtain and use information about their own population of patients and the larger population from which their patients are drawn.

    - Apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness.
    - Use information technology to manage information, access on-line medical information, and support their own education.
    - Facilitate the learning of students and other health care professionals.
- Interpersonal and communication skills
    - Create and sustain a therapeutic ethically sound relationship with patients.
    - Use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills.
    - Work effectively with others as a member or leader of a health care team or other professional group.
- Professionalism
    - Demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society that supersedes self-interest; accountability to patients, society, and the profession; and a commitment to excellence and on-going professional development.
    - Demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices.
    - Demonstrate sensitivity and responsiveness to patients' culture, age, gender, and disabilities.
- Collaborative practice
    - Understand how their patient care and other professional practices affect other health care professionals, and the health care organization, and the larger society, and how these elements of the system affect their own practice.
    - Know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources.
    - Practice cost-effective health care and resource allocation that does not compromise quality of care.
    - Advocate for quality patient care and assist patients in dealing with system complexities.
    - Know how to partner with health care managers and health care providers to assess, coordinate, and improve health care, and know how these activities can affect system performance.
- Evidence-informed advanced chiropractic practice
    - Provide chiropractic clinical management with reference to best practices and recognized clinical guidelines.
    - Integrate findings from current professional peer-reviewed literature into musculoskeletal management as appropriate.
    - Contribute to VHA Chiropractic Journal Club including case and peer-reviewed journal article presentation.

Program Overview

The program provides the resident with extensive clinical experience in hospital-based chiropractic care, including the full scope of diagnosis and treatment of patients with non-operative musculoskeletal and neuromuscular problems. The curriculum is organized into three main categories:

1. Patient care: The resident gains experience in managing complex conditions under the mentorship of senior VA chiropractors. Patient cases include traumatic brain injury, post-operative spine, inflammatory arthritis, radiculopathy, peripheral neuropathy, chronic pain syndrome, neuromuscular degenerative pathology, deformity, and complicated medical and psychosocial co-morbidity. Approximately 65% of the overall residency time (approximately 1,250 hours) is allotted to patient care in the chiropractic clinic.
2. Interprofessional education: The resident rotates through other services to gain exposure to a wider variety of cases, learn about the roles and approaches of other disciplines, and foster interdisciplinary teamwork and collaboration. Learning objectives focus on providing residents a better understanding of clinical practice in various specialties, and facilitating future communication and collaboration in team care settings. Approximately 17% of the overall residency time (approximately 316 hours) is spent in clinical rotations across the following services:
    a. Primary care: internal medicine
    b. Medical/surgical specialties: neurology, neurosurgery, physiatry, pain medicine, geriatrics
    c. Mental health disciplines: pain psychology, addiction medicine
    d. Rehabilitation disciplines: physical therapy, occupational therapy, kinesiotherapy

3. Scholarship: The resident teaches and assesses chiropractic students, attends ongoing scholarly presentations, gives lectures/presentations to other departments, obtains and appraises literature relevant to clinical care, presents critically appraised topics and/or case reports, and assists or participates in ongoing faculty research projects. Approximately 18% of the overall residency time (approximately 340 hours) consists of scholarly activities at VACHS and the academic affiliate, the University of Bridgeport College of Chiropractic (UBCC).
    a. The resident will present a minimum of 2 formal critically appraised topics and/or case reports at various VA and/or UBCC settings including in-person or online meetings, Journal Club sessions, or other relevant venues.
    b. The resident will give at least 2 in-service presentations to staff and trainees at other clinical services in VACHS, and/or to UBCC audiences.
    c. The resident will attend and/or present at a minimum of 8 scholarly presentations among VACHS venues including
        i. Research/scholarly presentations at the PRIME Center
        ii. Clinical/scholarly presentations at the Region 1 SCAN ECHO Multidisciplinary Pain Management Clinic

Curricular Competencies

Consistent with Council on Chiropractic Education (CCE) standards, the residency ensures competency in 7 main areas, listed below along with select representative learning objectives.

1. Patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.
    a. Demonstrate caring and respectful behaviors (verbal and non-verbal) with patients and families
    b. Elicit information using effective questioning and listening skills
    c. Perform comprehensive patient evaluations including history, review of medical records, physical examination, psychosocial assessment, and functional assessment

   d. Integrate and apply knowledge to diagnose and manage complex patient conditions
   e. Formulate a patient-centered, evidence-based treatment plan, including interdisciplinary management strategies as appropriate
   f. Demonstrate the ability to evaluate a patient's decision-making capacity
   g. Integrate facts and data to make clinical decisions
   h. Assess patient outcomes and change treatment plans as indicated
   i. Identify barriers for return to work, incorporating vocational assessments
   j. Consult with other specialty providers as indicated
   k. Counsel patients, families and caregivers about the potential risks, benefits, and alternatives to the plan of care
2. Medical knowledge about established and evolving biomedical, clinical, and cognate (e.g., epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.
   a. Generate a differential diagnosis for musculoskeletal and/or neuromuscular problems
   b. Integrate and apply knowledge to manage complex patient presentations
   c. Demonstrate knowledge of the relevant basic science of the pathophysiology of musculoskeletal and neuromuscular conditions
   d. Incorporate the relevant clinical science in establishing treatment plans
   e. Identify barriers to successful outcomes
   f. Understand biopsychosocial principles in the management of complex patients
   g. Demonstrate knowledge of special emphasis populations such as polytrauma, women's health, PTSD, rural health, and geriatrics
   h. Develop rehabilitation plans to include complex musculoskeletal trauma
   i. Differentiate pain types and generators and describe treatment approach to each
   j. Understand medications commonly used to treat specific pain patterns (i.e. acute, chronic, neuropathic, phantom limb etc.), their common side effects and possible adverse reactions
   k. Know the signs of narcotic abuse
   l. Demonstrate knowledge of musculoskeletal and neuromuscular examination principles
   m. Understand appropriate prescription of therapeutic modalities and orthoses
   n. Recognize possible effects of physical and psychological impairment on activities of daily living, work capacity and social functioning
3. Practice-based learning and improvement that involves appraisal, assimilation and improvement of scientific evidence and investigation in patient care.
   a. Evaluate one's knowledge and incorporate feedback from others
   b. Modify self-directed learning appropriately
   c. Use information technology to access and manage patient information
   d. Use information technology and other resources to support one's own education
   e. Contribute to discussions of patient care with other health care professionals
   f. Attend and participate in teaching conferences and rounds
4. Interpersonal and communication skills that result in effective information exchange and collaboration with patients, their families, and other health professionals.
   a. Establish trust and maintain rapport with patients and families
   b. Complete chart notes in a timely manner
   c. Present material clearly and accurately to patients
   d. Synthesize information and present clearly to colleagues
   e. Utilize effective listening skills
   f. Communicate and interact with staff/team in respectful, responsive manner

    g. Promote teamwork
5. Professionalism, manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to diverse patient populations.
    a. Exemplify respect and compassion toward patients
    b. Exemplify altruism and responsiveness to patient needs that supersedes self-interest
    c. Demonstrate reliability, punctuality, integrity and honesty
    d. Accept responsibility for own actions and decisions
    e. Apply sound ethical principles in practice, including patient confidentiality, informed consent, provision or withholding of care, and interactions with insurance or disability agencies
    f. Consider effects of personal, social and cultural factors in patient management
    g. Demonstrate sensitivity and responsiveness to age, culture, disability, and gender of patients
6. Systems-based practice as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.
    a. Collaborate with and maintain appropriate professional attitudes and behaviors toward other medical professionals and allied health personnel
    b. Coordinate patient care within the given healthcare system
    c. Use diagnostic and therapeutic procedures judiciously
    d. Evaluate risks, benefits, limitations, and costs of patient care
    e. Advocate for patients in dealing with system complexities
    f. Advocate for quality patient care
    g. Work effectively with other services, health care agencies, and case managers
    h. Participate in identifying opportunities for system quality improvement
7. Evidence-based practice
    a. Demonstrate competence in the application of knowledge of accepted standards in chiropractic practice
    b. Appraise and assimilate evidence from scientific studies to enhance patient care
    c. Attend and participate in critical appraisal and journal club presentations
    d. Demonstrate commitment to life-long learning

Location

Training takes place at the VACHS West Haven (950 Campbell Avenue, West Haven, CT) and Newington (555 Willard Avenue, Newington, CT) campuses. VACHS is well-known for its excellence in healthcare provider training. VACHS has academic affiliations with the Yale University School of Medicine, the University of Connecticut Schools of Medicine and Dentistry, and over 200 other health professional schools. Through these academic affiliations VACHS trains more than 600 medical residents and more than 600 associated health trainees annually.

The West Haven chiropractic clinic is composed of four exam/treatment rooms furnished with state of the art exam/treatment tables, computers, and other necessary equipment. Two additional clinician rooms with computers and high-resolution imaging viewing stations are available. The Newington chiropractic clinic is composed of two exam/treatment rooms furnished with state of the art exam/treatment tables, computers, and other necessary equipment. Library support through VACHS and the VISN 1 Online Library is available.

Faculty

The resident is mentored by an accomplished core faculty who are national leaders in integrated chiropractic practice. These clinicians share their expertise in patient care, academics and research to provide a robust educational experience.

Anthony J. Lisi is the residency director of training (DOT). Dr. Lisi received a BA from Fordham University and his DC degree from Palmer College of Chiropractic West. In 2004 he became the first chiropractor appointed to the medical staff of the VA Connecticut Healthcare System, where he developed processes for integrating hospital-based clinical services and interprofessional clinical education. In 2007 Dr. Lisi was named National Director of Chiropractic Services for the Veterans Health Administration. He has been involved in chiropractic academics since 1999, teaching at Palmer West, UBCC, and numerous CE and CME venues. He is a funded clinician-researcher and has authored or co-authored over 30 peer-reviewed publications and presented over 25 abstracts at scientific conferences throughout the U.S. and Canada.

Lauren Austin-McClellan received a BA from Boston University, an MS from the University of Bridgeport, Nutrition Institute and a DC from the University of Bridgeport, College of Chiropractic. In 2013 she began serving as a research clinician at the VA Connecticut Healthcare System, and later joined the medical staff full time in 2015. She additionally holds an adjunct faculty appointment at the University of Bridgeport, College of Chiropractic.

Christopher M. Coulis received a BS from Providence College, an MS from the University of Toronto, Canada and a DC from the University of Bridgeport College of Chiropractic. In 2009 Dr. Coulis joined the medical staff of the VA Connecticut Healthcare System. He additionally holds a faculty appointment at the University of Bridgeport College of Chiropractic and has lectured extensively in both the US and Canada on evaluation and management of spinal conditions. He has also authored or co-authored several peer-review articles.

Todd Kawecki received a BS from Seton Hall University and a DC degree from the University of Bridgeport. Dr. Kawecki also completed a post-doctoral fellowship in Medical Informatics at the Veterans Health Administration and Center for Medical Informatics, Yale School of Medicine. In 2010, Dr. Kawecki was appointed as the Chief Health Informatics Officer for the VA Connecticut Healthcare System, where is also serves as a staff Chiropractor. Additionally, Dr. Kawecki serves on the faculty at both the University of Bridgeport College of Chiropractic and Center for Medical Informatics, Yale School of Medicine.

Duty Hours

The residency is a 1-year program running from July 1 through June 30 of the following year. The tour of duty is full-time (40 hours/week) from 8:00am to 4:30pm Monday through Friday with a 30 minute lunch break each day. The resident's time is allocated in 2-week periods of 80 hours each approximately as follows:

Activity	*Hours per 2-week period*	*% time*
Clinical care at VACHS chiropractic clinic	52	65%
Clinical rotations in other services	14	17%

Scholarly activities at VACHS	10	13%
Scholarly activities at UBCC	4	5%

As shown in the table below, the program schedule runs from 8:00am to 4:30pm Monday through Friday with a 30 minute lunch break each day. On some days the resident attends a scheduled scholarly presentation during the lunch break period. These are often brown bag or lunch provided events. On instances when these events do not allow for lunch, the resident will be given a lunch break either before or after the event.

VACHS Chiropractic Resident Typical Schedule

<table>
<tr><th></th><th>Mon</th><th>Tue</th><th>Wed</th><th>Thu</th><th>Fri</th></tr>
<tr><td>8:00 AM</td><td rowspan="7">Patient Care</td><td rowspan="2">Patient Care</td><td rowspan="8">Patient Care</td><td rowspan="8">Rotations</td><td rowspan="8">Patient Care</td></tr>
<tr><td>8:30 AM</td></tr>
<tr><td>9:00 AM</td><td rowspan="2">A/A/S</td></tr>
<tr><td>9:30 AM</td></tr>
<tr><td>10:00 AM</td><td rowspan="4">Patient Care</td></tr>
<tr><td>10:30 AM</td></tr>
<tr><td>11:00 AM</td></tr>
<tr><td>11:30 AM</td><td>A/A/S</td></tr>
<tr><td>12:00 PM</td><td rowspan="2">PRIME*</td><td></td><td></td><td rowspan="2">SCAN ECHO*</td><td></td></tr>
<tr><td>12:30 PM</td><td rowspan="9">Rotations</td><td rowspan="9">Patient Care</td><td rowspan="6">Patient Care</td></tr>
<tr><td>1:00 PM</td><td rowspan="2">A/A/S</td><td rowspan="2">A/A/S</td></tr>
<tr><td>1:30 PM</td></tr>
<tr><td>2:00 PM</td><td rowspan="6">Patient Care</td><td rowspan="2">RCC</td></tr>
<tr><td>2:30 PM</td></tr>
<tr><td>3:00 PM</td><td rowspan="4">A/A/S</td></tr>
<tr><td>3:30 PM</td><td rowspan="3">A/A/S</td></tr>
<tr><td>4:00 PM</td></tr>
<tr><td>4:30 PM</td></tr>
</table>

Patient Care:	Supervised patient care in the chiropractic clinic
A/A/S:	Academic/Administrative/Scholarly activities
PRIME:	Pain Research Informatics Medical comorbidities and Education seminar
SCAN ECHO:	Interdisciplinary clinical and in-service presentations
RCC:	Resident Conference Call (national call for all 5 residents)

The resident does not have call responsibility outside of duty hours. Infrequently, some additional weekly time may be needed for scholarly or other training activities on an ad hoc basis.

The resident does not have call responsibility outside of duty hours, however some additional weekly time may be needed for scholarly or other training activities on an ad hoc basis.

Moonlighting

1. Residents are not required to moonlight; however second quarter or higher residents may apply for external moonlighting privileges. Internal moonlighting is not allowed in VA.
2. To apply for moonlighting privileges the resident must meet the following criteria:
    a. The resident must be in good standing in the second quarter of the residency or beyond
    b. The resident must hold a valid unrestricted Connecticut chiropractic license
    c. No marginal or low satisfactory evaluations (number 1-4) during the last quarter
    d. No commentary evaluation stating or implying the concern for inadequate knowledge base, poor ethical conducts, work habits, patient care, etc.
    e. No incomplete notes
    f. No issues of tardiness within the last quarter
    g. No delinquencies, delayed, or incomplete scholarly assignments
    h. Passing score on academic course work
3. Interested residents must complete a written request to VACHS Chiropractic Residency Program Director (RPD) with the following information:
    a. Description of the employment
    b. A statement regarding who is responsible for malpractice insurance (VACHS liability protection for residency activities does not cover any moonlighting)
    c. A statement concerning the resident accepting the responsibility of documenting monthly the amount of hours worked. This documentation must be turned into the program director.
4. The VACHS RPD reviews and approves the request before the resident is allowed to moonlight. Approval is reviewed quarterly and may be renewed or revoked. Renewal of moonlighting privileges is contingent upon the following
    a. Time spent moonlighting must not interfere with reading and studying, sleeping, relaxation, and most importantly, residency program requirements and academic performance.
    b. Moonlighting should enhance education, not compromise it. Under no circumstances should patient care at VACHS be jeopardized because of trainee moonlighting activities.
    c. Moonlighting must not adversely affect the interests, objectives or policies of the residency program or VACHS
    d. Other resident scheduled activities should not be manipulated in order to accommodate moonlighting activities
    e. The resident must record and report monthly the hours spent moonlighting to the RPD and track so as not to exceed 20 hours per week. This will be reviewed monthly by the Program Director. Documentation from the external employer (either a pay stub with wages, etc. redacted, or a letter verifying the number of hours worked) may be required.
5. Moonlighting privileges may be revoked at any time under any of the following conditions
    a. The resident fails to meet the criteria in #2 above
    b. The resident receives any disciplinary actions
    c. The resident was noted to be excessively fatigued (regardless of reason) with repeated incidence of falling asleep or inability to focus during the regular hours such as didactics, rounds, and clinics. Monitoring for excessive tiredness or fatigue will be done by attending evaluations, direct observation during rounds, clinic, didactics, and evaluations by colleagues, patient, nursing, administrative and therapy staff.

d. Repeated unexcused tardiness to didactics, clinics or other residency duties
e. Any incident of failure to attend assigned didactics, clinics or other residency duties
f. The resident was unprepared to present during scheduled scholarly activities
g. Any incident of leaving the clinic prior to completion of all needed work and prior to all patients being seen
h. Any incident of leaving early prior to the completion of didactic sessions without prior permission.
i. Difficulty with carrying regular duties or workload expected for the level of training.
j. Major medical illness or more than 5 individual days of sick leave per quarter.

6. Any resident who engages in moonlighting activities without prior written permission may be placed on probation

Compensation and Benefits

Compensation

The resident stipend is established based on geographic location by the VA Office of Academic Affiliations. The compensation for the 2016 academic year is $40,262. This stipend is not contingent upon resident productivity. Residents are paid on a two week salary period.

Health insurance

Residents are entitled to participate in a VA sponsored health insurance plan of their choosing. Any plan premiums will be deducted from the resident's paycheck.

Malpractice

The resident is protected from personal liability while providing professional services at a VACHS health care facility under the Federal Employees Liability Reform and Tort Compensation Act, 28 U.S.C. 2679 (b)-(d).

Leave

Residents accrue 4 hours of annual leave (AL) and 4 hours of sick leave (SL) each 2-week pay period. This yields a total of 13 AL days and 13 SL days per year.

1. All AL must be approved in advance by the DOT. AL may be taken only at those times which will not be disruptive to the program's training schedule. The resident must notify the DOT of his/her request for AL at least 4 weeks in advance of the desired time off. AL during the first or last week of the rotation will not be granted, unless for urgent purposes. At the end of the residency any unused AL days will not be converted to, or compensated by payment.
2. SL is reserved for physical and mental illness only. The resident must notify their attending supervisor or the DOT before 8:00 AM of any unexpected leave due to illness. You must interact with a live person to ensure notification. In the event you are unable to reach a live person, leave a message and continue to call until you are able to contact someone directly. It is not acceptable to send a text, email, or leave a message on an answering machine without speaking to someone directly. Failure to comply will be documented in the resident's main file as AWOL (absent without official leave) and will be recorded as vacation usage. An absence of 3 days or more due to illness (self or

family member) requires the resident to submit a written statement from the treating physician stating the physician has examined and treated resident or ill family member. If sick leave is reported following vacation time or after an out of town trip, the resident must provide documentation of his/her previous intention to return to work upon conclusion of their scheduled vacation dates, in the form of an original trip itinerary (airline ticket, cruise ticket, etc.) Failure to provide the required documentation or any abuse of SL for any other purpose will result in deduction from future vacation time and/or AWOL status.

3. Authorized Absence (AA) may be granted to residents when they are involved in professional development activities consistent with the residency program mission at an off-site location. This can include attending professional conferences or other training opportunities related to the resident's area of interest. AA may be granted for attending a job interview only if at another VA site. The days approved for AA do not deduct from either AL or SL. All AA must be approved by the DOT.

Frequent and/or prolonged absence of any type (AL and/or SL) may result in an extension of the period of time the resident must participate in the program in order to meet the training requirements. If this becomes necessary and the resident has been paid during the period of absence, the extended dates of training may be on a without-compensation basis (that is without salary and benefits.)

Holidays

Residents receive paid time off for US Federal holidays. Only US Federal holidays are recognized; time off for other holidays and/or religious purposes requires the use of AL.

Resident Appointments

Selection

Resident selection is through a competitive process considering factors such as academic background, relevant experience, personal statement, letters of recommendation, and telephone and/or in-person interviews. A call for applications is issued each year on the second Monday of January. Applications are only accepted during the open call. Decisions are made by a selection committee of the facility DOE or designee, residency DOT, and residency faculty.

Eligibility requirements

- Applicants must hold or be scheduled to receive a DC degree from a CCE-accredited school prior to the start of the residency program.
- Applicants must be eligible for, or hold a current, full, active, and unrestricted chiropractic license in a State, Territory or Commonwealth of the US, or in the District of Columbia.
- Applicants must have documentation of at least 3 months of direct patient care activity within the last year. Clinical rotations during chiropractic school will suffice for recent graduates. Observer experiences and non-clinical graduate work do not meet this requirement.
- Applicants must submit 3 reference letters from US chiropractic and/or medical physicians who have personal knowledge of their clinical and personal abilities
- Applicants must meet all VA employment requirements including US citizenship, and Selective Service registration when applicable.
- Applicants must have sufficient written and spoken English language skills as to make patient care safe and effective

Additional eligibility requirements are specified in the annual call for applications.

Clinic Policies

Resident supervision

The Department of Veterans Affairs mandates appropriate supervision for trainees of all disciplines. All clinical care provided by the chiropractic resident is under the supervision of staff attending DCs in accordance with VHA Handbook 1400.04.

The chiropractic attending is the primary provider for each resident patient encounter. At the discretion of the attending, the resident is instructed to perform some or all of the encounter tasks such as case review, history and examination, establishing a management plan, and delivering treatment. The resident completes a note in the electronic medical record, and the attending adds his/her own documentation consistent with the appropriate level of supervision

Attendings follow a graduated responsibility approach to supervision. The resident is gradually granted more autonomy during the course of the residency year as the resident demonstrates competence, and staff doctors become more familiar with and confident in the resident's clinical and case management skills. There are four levels of resident supervision:

Resident Supervision Levels		
Level	***Typical time range***	***Characteristics***
1	Weeks 1-6	This is the entry level for all residents. At this level, residents will perform a complete history and examination of their patient and formulate differential diagnoses and management strategies. The attending doctor will verify the resident's findings and ensure accuracy of the diagnosis and plan by being in the room concurrently with the resident and/or through separate history and examination. Resident responsibility • Residents discuss all aspects of case management with the attending before a plan is implemented o *Attending: Room or area*

2	Weeks 4-16	Typically, residents have demonstrated acceptable competence in straightforward cases, while competence in complex cases may still be emerging and/or unassessed. This level of supervision allows the resident to discuss routine cases without physical examination of the patient by the staff attending. More complex cases require the staff attending to also examine the patient. This level of supervision also allows the resident to rotate outside of the chiropractic clinic in other clinical service rotations.
		
		Resident responsibility
		• Residents can implement plans for cases in which they have demonstrated acceptable competence
		    o *Attending: Room, area, or available*
		• All aspects of case management for instances in which competence has not yet been demonstrated are discussed with attending before a plan is implemented
		    o *Attending: Room or area*

3	Weeks 14-30	Typically, residents have demonstrated acceptable competence in all straightforward and some complex cases, while competence in some rarer

<table>
<tr><td></td><td></td><td>areas may still be emerging and/or unassessed.

<u>Resident responsibility</u>
Residents can implement plans for cases in which they have demonstrated acceptable competence
Attending: Room, area, or available
All aspects of case management for instances in which competence has not yet been demonstrated are discussed with attending before a plan is implemented
Attending: Room, area, or available</td></tr>
<tr><td>4</td><td>Weeks 26-52</td><td>With the approval of the DOT, residents are permitted to assess and mentor 4th year chiropractic students. Such cases must be reviewed with a staff attending and the patient record must be co-signed by the staff attending per VA supervision guidelines.

<u>Resident responsibility</u>
Supervision of the residents’ own cases continues on at Level 3 above</td></tr>
</table>

Infection control

All health care workers in direct patient contact areas must:

- Use an alcohol-based hand rub or antimicrobial soap and water to routinely decontaminate their hands before and after having direct contact with patients
- Wear gloves when contact with blood or other potentially infectious materials, mucous membranes, and non-intact skin could occur. Remove gloves after caring for patient. Do not wear the same pair gloves for the care of more than one patient, and do not wash gloves between uses with different patients.
- Use an alcohol-based hand rub or antimicrobial soap and water to decontaminate hands before and after removing gloves
- Wash hand with non-antimicrobial or antimicrobial soap and water whenever hands are visibly soiled or contaminated with body fluids, before eating, and after using the restroom.
- Not wear artificial fingernails or extenders. Natural nail tips will be kept less than 1/4 inch in length. Nail polish, if worn, must be in good repair with no cracks or chips.

Contaminated sharps will be placed in rigid puncture-resistant containers designed for sharp disposal. Other contaminated instruments will be placed immediately in a puncture-resistant, leak-proof container labeled with a biohazard warning, and then transported to Supply, Processing, and Distribution Section (SPD).

Personal protective equipment is provided by the VA. Gloves are worn for anticipated contact with blood, pus, feces, urine, or oral secretions. Employees with dermatitis, cuts, open areas, etc., should wear gloves when there is risk of drainage. Alternative gloves are available to employees who are allergic to the gloves normally used.

Routine cleaning and disinfection of environmental surfaces (especially frequently touched surfaces) is required. Diagnostic and therapeutic equipment that comes in contact with a patient must be properly disinfected or disposed of in a safe manner.

Facility safety

- Accidents/Injuries: If you are injured, immediately notify your supervisor.

- Electrical safety: Inspect all electrically powered equipment before use. Do not use equipment with frayed cords or broken plugs. Report defective equipment to your supervisor.
- Equipment safety: Know how to use equipment properly and inspect for defects prior to use. Remove any defective/inoperative equipment from use and report it to your supervisor.
- Fire: Upon discovering or suspecting a fire in the area: 1) Rescue anyone in danger from the fire, 2) Activate the nearest fire alarm pull station and have someone call the fire department 3) Confine fire spread by closing all doors, and 4) Extinguish if the fire is small and you are properly trained.
- Hazardous materials: Become familiar with the hazards associated with the chemicals you use before you use them. Ensure all containers are properly labeled with the name of the product, manufacturer's name and address, and appropriate hazard warnings. Know the location of your chemical inventory and material safety data sheets (MSDS).

Professional Conduct

Residents are expected to conduct themselves as professionals. Residents are expected to behave consistent with ethical standards placing the benefit of the patient above all other considerations. Residents should understand and act congruently with the ACA Code of Ethics. Additionally, every resident is responsible for conforming to all other VA regulations concerning conduct and behavior as described in the relevant VA mandatory trainings.

Residents will dress professionally, commensurate with the attire of staff chiropractors. Official ID badges are a VA requirement and must be worn at all times when on station. Any display of potentially controversial opinions or partisan political advertisements on clothing or carried items is prohibited.

Residents should not eat or drink in exam rooms or in front of patients. During working hours, residents will be mentally and physically capable of executing job functions, with no appearance to the contrary. This implies freedom from over-fatigue, illness or intoxicants such as alcohol.

All patients, staff members, and guests shall be treated with dignity and courtesy. Patients should generally be referred to as "Mr. _______" or "Ms. __________" , or by the title "Sir" or "Ma'am", when appropriate. However, you may wish to discuss particular cases with your supervisors.

Chiropractic clinic faculty, and other VACHS doctors, should be addressed as "Dr.______" when in the clinic or around patients or in other encounters on station.

VA and HIPPA regulations will be strictly adhered to, especially in matters of confidentiality of information, non-exploitation of patients and avoiding conflicts of interests. This means that great care must be taken when discussing patient information.

Residents are expected to be punctual. The tour of duty begins at 8:00am and concludes at 4:30pm. It is your responsibility in the morning to prepare your room/equipment and review

necessary records so as to be prepared to start your first scheduled patient. It is the resident's responsibility to arrive as early as necessary to accomplish this.

All work performed by chiropractic residents must be supervised by a staff chiropractor. No clinical work is to be done after hours and/or when there is no covering chiropractor available (this includes phone calls to patients). Residents need to always be aware of who the assigned supervisor is for the particular clinical work that is being accomplished. Generally, this will be consistent throughout the year.

Evaluation

The resident is evaluated via formative and summative processes. Residents will submit time logs every two weeks to the residency director, who will monitor and provide administrative oversight. Assessment input is obtained from multiple stakeholders including chiropractic attendings, program director, other service attendings, support staff, patients, and the resident's own self-assessment. Assessment instruments and schedule are summarized in the tables below.

Assessment Instrument	Description
Evaluation of live clinical performance	A questionnaire evaluating aspects of clinical care using general descriptors (superior/satisfactory/ unsatisfactory) and a numerical 1-9 scale.
Chart-stimulated recall	A standardized oral assessment on clinical case management that covers reasons behind the work-up, diagnosis, interpretation, and/or treatment plan.
Chart review, faculty	Medical records are pulled, reviewed and rated according to a specific protocol and coding form. Interpretation of this exercise is complicated by the fact that the final patient record has already been checked and possibly corrected by an attending.
Chart review, peer	Each residency director sends 3 de-identified files to the chiropractic program director each quarter. These are assigned in sequential fashion to off-site residents, with reviews returned to the program director, who then sends reviews to each residency director.
Other service attending's perception of resident	Qualitative assessment of resident's conduct, professionalism, performance.
Staff perception of resident	5 item numeric scale rating resident's conduct, professionalism, performance.
Patient perception of resident	These assessments allow patients to evaluate their satisfaction with care, their impression of resident competency, etc.
Resident self-assessment	Five-item Likert scales assessing overall competencies, and open ended questions to identify learning goals and professional development targets.
Case log	Documentation of the types and numbers of cases seen by the resident, either in delivering care or observation.
Portfolio	A collection of documents, slide presentations, abstracts or other materials prepared by the resident that gives evidence of learning and achievement. This includes a log of scholarly activities (date of activity, location, type of activity, whether the resident presented or attended) and general comments and

	reflections by the resident. The portfolio is reviewed by the attending.
Milestones assessment	Performance scales and open ended comments assessing competence in domains of patient care, medical knowledge, practice-based learning, interpersonal and communication skills, professionalism, system-based learning, and evidence-based practice.
Resident assessment of rotation	Six-item Likert scales and open ended questions assessing educational experiences in clinical rotations.
Resident assessment of faculty	Six-item Likert scales and open ended questions assessing resident perception of faculty performance.
Resident assessment of program	Six-item Likert scales and open ended questions assessing resident perception of overall program.

Assessment Instrument Frequency and Scheduling												
Residency Month	***1***	***2***	***3***	***4***	***5***	***6***	***7***	***8***	***9***	***10***	***11***	***12***
Calendar Month	***Jul***	***Aug***	***Sep***	***Oct***	***Nov***	***Dec***	***Jan***	***Feb***	***Mar***	***Apr***	***May***	***Jun***
Evaluation of live clinical performance		6			2			2			2	
Chart-stimulated recall		6			2			2			2	
Chart review, faculty		3			3			3			3	
Chart review, peer		3			3			3			3	
Staff perception of resident					3						3	
Patient perception of resident		3			3			3			3	
Milestones assessment				1				1				1
Resident self-assessment*	1			1				1				1
Resident assessment of faculty*				1				1				1
Resident assessment of program*				1				1				1
Resident assessment of rotation*	At the completion of each rotation											
Other attending's perception of resident	At the completion of each rotation											
Case log*	Weekly											
Portfolio*	Weekly											
** Indicates instruments completed by the resident*												

Requirements for Residency Completion

In order to successfully complete the program the resident will:

- Follow all VA policies and procedures as described in the TMS Mandatory Training for Trainees
- Attend and complete all chiropractic clinic sessions with expected competence
- Attend and complete all interdisciplinary rotations in a professional collaborative manner
- Achieve satisfactory performance evaluations
- Appropriately maintain the *Resident Case Log* documenting clinical encounters
- Appropriately maintain the *Resident Portfolio* documenting learning activities including
  - Presentation of at least 2 formal critically appraised topics and/or case reports at various VA and/or UBCC settings including in-person or online meetings, Journal Club sessions, or other relevant venues.
  - Attendance and/or presentation at a minimum of 8 scholarly presentations among VACHS venues including
    - Research/scholarly presentations at the PRIME Center
    - Clinical/scholarly presentations at the Region 1 SCAN ECHO Multidisciplinary Pain Management Clinic
  - Presentation of at least 2 in-service presentations to staff and trainees at other clinical services in VACHS, and/or to UBCC audiences
- Attend and document all other assigned activities, including external rotations, didactic, and scholarly activities
- Complete all assigned evaluations of the residency program and faculty

Completion Designation

Upon satisfactory completion of program requirements the graduate will receive an official Certificate of Residency, and records will be maintained at the VACHS and the VHA Chiropractic National Program Office.

Due Process

This section provides information on problematic behavior or impairment, a process for the remediation of problems, possible sanctions, and due process with respect to grievances.

I. Definition of problematic behavior or impairment

For the purposes of this policy, problematic behavior/impairment is defined broadly as an interference in professional functioning that is reflected in one or more of the following ways: (1) an inability and/or unwillingness to acquire and integrate professional behaviors and ethical standards, (2) an inability to acquire the level of professional skills necessary to reach an acceptable level of competency, (3) an inability to control personal stress, psychological problems, and/or excessive emotional reactions that interfere with professional functioning.

Ultimately, it becomes a matter of professional judgment as to when a resident's behavior is seriously impaired. However, problems typically become identified as impairments when they include one or more of the following characteristics:

1. the resident does not acknowledge, understand, or address the problem when it is identified;
2. the problem is not merely a reflection of a skill deficit that can be rectified by further supervision, academic or didactic training;
3. the quality of the resident's service delivery is negatively affected;
4. the problem is not restricted to one area of professional functioning;
5. a disproportionate amount of attention by training personnel is required;
6. the resident's behavior does not change as a function of feedback, remediation efforts, and/or time.

II. Remediation Alternatives

It is important to have meaningful ways to address problematic behavior once it has been identified. In implementing remediation or sanction interventions, the training staff must be mindful and balance the needs of the impaired or problematic resident, the patients involved, other members of the residency and/or internship class, the training staff, and other agency personnel.

1. Verbal Warning to the resident emphasizes the need to discontinue the inappropriate behavior under discussion. No record of this action is kept.

2. Written Acknowledgment to the resident formally acknowledges:
    a. that the Director of Training (DOT) is aware of and concerned with the performance rating,
    b. that the concern has been brought to the attention of the resident,

c. that the DOT will work with the resident and/or supervisors to rectify the problem or skill deficits, and
d. that the behaviors associated with the rating are not significant enough to warrant more serious action.

The written acknowledgment will be removed from the resident's file when the resident responds to the concerns and successfully completes the residency.

3. Written Warning to the resident indicates the need to discontinue an inappropriate action or behavior. This letter will contain:
   a. a description of the resident's unsatisfactory performance;
   b. actions needed by the resident to correct the unsatisfactory behavior;
   c. the time line for correcting the problem;
   d. what action will be taken if the problem is not corrected; and
   e. notification that the resident has the right to request a review of this action.

   A copy of this letter will be kept in the resident's file. Consideration may be given to removing this letter at the end of the residency by the DOT in consultation with the resident's supervisor and Service Chief. If the letter is to remain in the file, documentation should contain the position statements of the parties involved in the dispute.

4. Schedule Modification is a time-limited, remediation-oriented closely supervised period of training designed to return the resident to a more fully functioning state. Modifying a resident's schedule is an accommodation made to assist the resident in responding to personal reactions to environmental stress, with the full expectation that the resident will complete the residency. This period will include more closely scrutinized supervision conducted by the regular supervisor in consultation with the DOT. Several possible and perhaps concurrent courses of action may be included in modifying a schedule. These include:
   a. increasing the amount of supervision, either with the same or other supervisors;
   b. change in the format, emphasis, and/or focus of supervision;
   c. recommending personal therapy;
   d. reducing the resident's clinical or other workload;
   e. requiring specific academic coursework.

   The length of a schedule modification period will be determined by the DOT in consultation with the relevant supervisor(s). The termination of the schedule modification period will be determined, after discussions with the resident, by the DOT in consultation with the relevant supervisor(s). Remediation alternatives numbered 4 thru 8 will be documented in the resident's file.

5. Probation is also a time limited, remediation-oriented, more closely supervised training period. Its purpose is to assess the ability of the resident to complete the residency and to return the resident to a more fully functioning state. Probation defines a relationship in which the DOT systematically monitors for a specific length of time the degree to which the resident addresses, changes and/or otherwise improves the behavior associated with the inadequate rating. The resident is informed of the probation in a written statement that includes:
   a. the specific behaviors associated with the unacceptable rating;
   b. the recommendations for rectifying the problem;
   c. the time frame for the probation during which the problem is expected to be ameliorated, and

d. the procedures to ascertain whether the problem has been appropriately rectified.
e. If the DOT determines that there has not been sufficient improvement in the resident's behavior to remove the Probation or modified schedule, then the DOT will discuss with the relevant supervisor(s) and the Service Chief possible courses of action to be taken. The DOT will communicate in writing to the resident that the conditions for revoking the probation or modified schedule have not been met. This notice will include the course of action the DOT and Service Chief have decided to implement. These may include continuation of the remediation efforts for a specified time period or implementation of another alternative. Additionally, the DOT will communicate to the Service Chief that if the resident's behavior does not change, the resident will not successfully complete the residency.

6. Suspension of Direct Service Activities requires a determination that the welfare of the resident's patients has been jeopardized. Therefore, direct service activities will be suspended for a specified period as determined by the DOT in consultation with the Service Chief, Hospital Administration, and Human Resources. At the end of the suspension period, the resident's supervisor in consultation with the DOT and Service Chief will assess the resident's capacity for effective functioning and determine when direct service can be resumed.

7. Administrative Leave involves the temporary withdrawal of all responsibilities and privileges in the agency. If the Probation Period, Suspension of Direct Service Activities, or Administrative Leave interferes with the successful completion of the training hours needed for completion of the residency, this will be noted in the resident's file. The DOT in consultation with the Service Chief will inform the resident of the effects the administrative leave will have on the resident's stipend and accrual of benefits.

8. Dismissal from the Residency involves the permanent withdrawal of all agency responsibilities and privileges. When specific interventions do not, after a reasonable time period, rectify the impairment and the resident seems unable or unwilling to alter her/his behavior, the DOT will discuss with the Service Chief the possibility of termination from the training program or dismissal from the agency. Either administrative leave or dismissal would be invoked in cases of severe violations of the ACA Code of Ethics, or when imminent physical or psychological harm to a patient is a major factor, or the resident is unable to complete the residency due to physical, mental or emotional illness.

III. Procedures for Responding to Inadequate Performance by a Resident

If a resident receives an "unacceptable rating" from any of the evaluation sources in any of the major categories of evaluation, or if a staff member has concerns about a resident's behavior (ethical or legal violations, professional incompetence) the following procedures will be initiated:

1. Issues can be discussed with the DOT at any time, but they should first be addressed within the supervisory relationship. The DOT will encourage such direct resolution. (If the resident has a problem that directly involves the DOT, he or she is encouraged to address that problem first with the DOT. If an issue with the DOT is not resolved in a satisfactory fashion, the resident is encouraged to discuss the issue with the Service Chief).

2. If the initial discussions are unsuccessful within a short time (e.g., 1-2 weeks), the DOT will meet with the resident(s) and supervisor(s) to assist in problem resolution. At this point the ACOS for Education and Chief, Physical Medicine and Rehabilitation Service will be apprised of the problem and the steps taken to attempt resolution.
3. If this process does not quickly resolve the problem or the problem promptly recurs, the ACOS for Education and Chief, Physical Medicine and Rehabilitation Service will become formally involved in discussions leading to a solution. The supervisor(s) and resident(s) may be asked to discuss the problem and alternative solutions, especially if the problem involves either ethical issues related to patient care or possible changes in the student's program of training. A remediation alternative may be suggested, as described above.
4. If the problem cannot be resolved through these steps or if the ACOS for Education believes that the nature of the resolution lies outside its scope of authority, the Chief of the Physical Medicine and Rehabilitation Service, Human Resources, and/or other hospital administrators may be consulted to assist in planning and adjustments. If the situation, for example, should involve the health or functioning of a resident, the VA has an active policy in the event of incapacitation.
5. Whenever a decision has been made by the DOT about a resident's training program or status in the agency, the DOT will inform the resident in writing and will meet with the resident to review the decision. This meeting may or may not include the resident's supervisor(s).
6. The resident may choose to accept the conditions or may choose to challenge the action. The procedures for challenging the action are presented below.

IV. Due Process

Due process ensures that decisions about residents are not arbitrary or personally based. It requires that the Training Program identify specific evaluative procedures that are applied to all trainees, and provide appropriate appeal procedures available to the resident. All steps need to be appropriately documented and implemented. General due process guidelines include:

1. During the orientation period, presenting to the residents, in writing, the program's expectations related to professional functioning. Discussing these expectations in both group and individual settings.
2. Stipulating the procedures for evaluation, including when and how evaluations will be conducted. Such evaluations should occur at meaningful intervals.
3. Articulating the various procedures and actions involved in making decisions regarding impairment.
4. Instituting, when appropriate, a remediation plan for identified inadequacies, including a time frame for expected remediation and consequences of not rectifying the inadequacies.
5. Providing a written procedure to the resident that describes how the resident may appeal the program's action. Such procedures are included in the residency handbook. The Residency Handbook is provided to residents and reviewed during orientation.
6. Ensuring that residents have sufficient time to respond to any action taken by the program.
7. Using input from multiple professional sources when making decisions or recommendations regarding the resident's performance.

8. Documenting, in writing and to all relevant parties, the actions taken by the program and its rationale.

V. Grievance Procedure

This document provides guidelines to assist Residents who wish to file complaints against staff members. In general, there are two situations in which grievance procedures can be initiated:

1. In the event a resident encounters any difficulties or problems with staff members (e.g. poor supervision, unavailability of supervisor, evaluations perceived as unfair, workload issues, personality clashes, other staff conflict) during his/her training experiences, a resident can:
    a. Discuss the issue with the staff member(s) involved;
    b. If the issue cannot be resolved after this discussion, the resident should discuss the concern with the DOT;
    c. If the DOT cannot resolve the issue, the resident and DOT should discuss the problem with the Service Chief; or, if the resident has a concern with the DOT that has not been resolved through discussion with the DOT, the resident can discuss the problem with the Service Chief.
    d. If the Service Chief cannot resolve the issue, the resident can formally challenge any action or decision taken by the DOT, the supervisor or any member of the training staff by following this procedure:
    e. In the event that the resident has a concern with the Service Chief, the resident can discuss the problem with the Associate Chief of Staff for Education prior to filing a formal complaint (as noted above).

    The resident should file a formal complaint, in writing and all supporting documents, with the DOT. If the resident is challenging a formal evaluation, the resident must do so within 5 days of receipt of the evaluation.
    Within five days of a formal complaint, the DOT must consult with the Service Chief and implement Review Panel procedures as described below.

2. If a training staff member has a specific concern about a resident (other than inadequate performance), the staff member should:
    a. Discuss the issue with the resident(s) involved.
    b. Consult with the DOT
    c. If the issue is not resolved informally, the staff member may seek resolution of the concern by written request, with all supporting documents, to the DOT for a review of the situation. When this occurs, the DOT will within five days of a formal complaint, the DOT must consult with the Service Chief and implement Review Panel procedures as described below.

3. Review Panel and Process
    a. When needed, a review panel will be convened by the Service Chief. The panel will consist of three staff members selected by the Service Chief with recommendations from the DOT and the resident involved in the dispute. The resident has the right to hear all facts with the opportunity to dispute or explain the behavior of concern.
    b. Within five (5) work days, a hearing will be conducted in which the challenge is heard and relevant material presented. Within three (3) work days of the completion of the review, the Review Panel submits a written report to the Service Chief, including any recommendations for further action. Recommendations made by the Review Panel will be made by majority vote.

c. Within three (3) work days of receipt of the recommendation, the Service Chief will either accept or reject the Review Panel's recommendations. If the Service Chief rejects the panel's recommendations, due to an incomplete or inadequate evaluation of the dispute, the Service Chief may refer the matter back to the Review Panel for further deliberation and revised recommendations or may make a final decision.
d. If referred back to the panel, they will report back to the Service Chief within five (5) work days of the receipt of the Service Chief's request of further deliberation. The Service Chief then makes a final decision regarding what action is to be taken.
e. The DOT informs the resident, staff members involved and if necessary members of the training staff of the decision and any action taken or to be taken.
f. If the resident disputes the Service Chief's final decision, the resident has the right to contact the Associate Chief of Staff for Education to discuss this situation.
g. If the resident disputes the Associate Chief of Education’s decision, the resident has the right to contact the Department of Human Resources to discuss this situation.

Acknowledgement: The Due Process section is substantially based on policy of the VACHS Clinical Health Psychology Intern Program. Elements of VA Associated Health Residency programs in optometry, podiatry and psychology were also used.

Acknowledgement

Date:	July 2, 2015
Resident name:	Brian Giuliani
I acknowledge that I have received and read the VA Connecticut Healthcare System Chiropractic Residency Program Handbook. I have had an opportunity to discuss the contents with the Residency Director and have any questions answered. As a trainee of the VA Connecticut Healthcare System, I understand that I am responsible for complying with the rules and regulations as set forth in this handbook and other VA trainings.	
Resident signature:	
Residency Director name:	Anthony Lisi
Residency Director signature:	