



VA Connecticut Healthcare System Chiropractic Residency Program



Integrated Clinical Practice Program Handbook

Academic Year 2019

Sponsor: VA Connecticut Healthcare System

Affiliate: University of Bridgeport College of Chiropractic

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Mission, Goals and Objectives

Mission

- The Mission of the VA Connecticut Healthcare System (VACHS) Chiropractic Integrated Clinical Practice Residency is to prepare chiropractic residents for clinical practice in hospitals or other medical settings, and/or academia, through hospital-based clinical training, interprofessional education, and scholarly activities.

Resident Goals/Objectives

- Residents will acquire postgraduate clinical experience in hospital-based chiropractic care
 - Residents will provide supervised patient care at satisfactory levels of competence, to a broad population of musculoskeletal cases, most commonly spinal, in the context of collaborative team-based care
 - Residents will gain experience in managing a range of complex/multimorbidity cases
- Residents will engage in interprofessional educational experiences with relevant medical, surgical and associated health specialties
 - Residents will complete clinical rotations in primary care, physical medicine and rehabilitation, other relevant medical or surgical specialties, behavioral medicine and other associated health disciplines
- Residents will participate in scholarly activities to gain experience relevant to integrated practice and/or academia
 - Residents will complete scholarly assignments, online didactic courses, and collaborate with other chiropractic residents to complete group assignments
 - Residents will attend scholarly presentations among available hospital and/or academic affiliate offerings
 - Residents will engage in research activities, and/or present scholarly material, and/or clinical workshops to staff and/or trainees at VA and/or academic affiliate venues

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 team-based case management including complex conditions under the mentorship of senior VA chiropractors. Patient cases can 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 67% of the overall residency worked 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 opportunities focus on providing residents a better understanding of clinical practice in various specialties, and facilitating future communication and collaboration in team care settings. Approximately 14% of the overall residency worked time (approximately 250 hours) is spent in clinical rotations.

3. **Scholarship:** The resident completes didactic assignments, individual and group projects, 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 19% of the overall residency worked time (approximately 350 hours) consists of scholarly activities at VA and/or the academic affiliate, the University of Bridgeport College of Chiropractic (UBCC).

Curricular Competencies

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

1. **Clinical Service:** residents must be able to diagnose and manage complex, subtle or infrequently encountered clinical presentations by using patient-centered diagnostic and treatment modalities
 - a. The resident demonstrates competence in review of the clinical record and taking a history commensurate with patient age, impairment, and case complexity
 - b. The resident demonstrates competence in performing a physical examination commensurate with patient age, impairment, and case complexity
 - c. The resident demonstrates competence in diagnostic assessment based on history, examination, and appropriate use and interpretation of imaging, laboratory, and special studies
 - d. The resident demonstrates competence in case management including appropriate patient-centered treatment, education, and collaborative decisions commensurate with patient age, impairment, and case complexity
2. **Advanced or Focused Healthcare Knowledge:** residents must research and analyze current scientific information and integrate this knowledge into patient care through evidence-based clinical decision making
 - a. The resident demonstrates competence in accessing relevant scientific knowledge and applying this to inform patient care
3. **Practice-Based Learning and Improvement:** residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve patient care through self-assessment and documented quality assurance activities
 - a. The resident demonstrates competence in analyzing their practice and performing practice-based improvement activities through self-assessment and documented quality assurance activities
4. **Interpersonal and Communication Skills:** residents must be able to demonstrate interpersonal and communication skills through culturally competent patient education, communication and shared decision making
 - a. The resident uses appropriate and culturally competent communication in all patient interactions including education and shared decision-making

5. Professionalism: residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population
 - a. The resident demonstrates compassion, integrity, and respect for others, as well as sensitivity and responsiveness to diverse patient populations.
 - b. The resident demonstrates a commitment to ethical principles pertaining to patient care decisions, confidentiality of patient information, informed consent, and business practices.
6. Collaborative Practice: residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and collaborate with other professionals to assure that appropriate resources are utilized for well-coordinated patient care
 - a. The resident demonstrates appropriate use of system resources in their own practice and with regard to ordering healthcare services and/or consultations
7. Evidence-informed Advanced or Focused Practice: residents must demonstrate competency in the application of knowledge of accepted standards in clinical practice appropriate to their specialty training. The resident must promote and disseminate knowledge through scholarly activities, such as lectures, presentations, publications, posters or research
 - a. The resident provides clinical management consistent with best practices and recognized clinical guidelines
 - b. The resident promotes and disseminates knowledge through attending and/or presenting material at scholarly activities/lectures, and/or through research activities

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 40 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 program director (RPD). 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 numerous peer-reviewed publications and presented 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.

Nathaniel Majoris earned his BS in sports medicine from Mercyhurst University and his DC from Palmer College of Chiropractic. He has maintained a Diplomate with the American Chiropractic Rehabilitation Board since 2012. He received his certification in acupuncture in 2010 and his certification with the National Athletic Training Association in 1999. In 2014, Dr. Majoris joined the medical staff of Bath VA Medical Center and transferred to the VA Connecticut Healthcare System in 2016. Dr. Majoris currently holds adjunct faculty appointments at the University of Bridgeport, College of Chiropractic, and New York College of Chiropractic.

Duty Hours

The residency is a 1-year program (2,080 hours) 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:

<i>Activity</i>	<i>Hours per 2-week period</i>	<i>% time</i>
Clinical care at VACHS chiropractic clinic	52	65%
Clinical rotations in other services	12	15%
Scholarly activities at VACHS/UBCC	16	20%

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

	Mon	Tue	Wed	Thu	Fri	
8:00 AM	Patient Care	Patient Care	Patient Care	Rotations	Patient Care	
8:30 AM						
9:00 AM		A/A/S				
9:30 AM						
10:00 AM						
10:30 AM		Patient Care				
11:00 AM						
11:30 AM	A/A/S					
12:00 PM	PRIME*			SCAN ECHO*		
12:30 PM		Rotations	Patient Care		Patient Care	
1:00 PM	A/A/S			A/A/S		
1:30 PM						
2:00 PM	Patient Care					RCC
2:30 PM						
3:00 PM						
3:30 PM						A/A/S
4:00 PM			A/A/S			
4:30 PM				A/A/S		

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.

Moonlighting

1. Residents are not required to moonlight; however second trimester 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 number 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 2019 academic year is \$41,027. 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 RPD. AL may be taken only at those times which will not be disruptive to the program's training schedule. The resident must notify the RPD 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 RPD 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 RPD.

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 four core faculty plus the current resident.

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	<p>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.</p> <p><u>Resident responsibility</u></p> <ul style="list-style-type: none"> • Residents discuss all aspects of case management with the attending before a plan is implemented <ul style="list-style-type: none"> ○ <i>Attending: Room or area</i>
2	Weeks 4-16	<p>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.</p> <p><u>Resident responsibility</u></p> <ul style="list-style-type: none"> • Residents can implement plans for cases in which they have demonstrated acceptable competence <ul style="list-style-type: none"> ○ <i>Attending: Room, area, or available</i> • All aspects of case management for instances in which competence has not yet been demonstrated are discussed with attending before a plan is implemented <ul style="list-style-type: none"> ○ <i>Attending: Room or area</i>
3	Weeks 14-30	<p>Typically, residents have demonstrated acceptable competence in all straightforward and some complex cases, while competence in some rarer</p>

		<p>areas may still be emerging and/or unassessed.</p> <p><u>Resident responsibility</u></p> <ul style="list-style-type: none"> • Residents can implement plans for cases in which they have demonstrated acceptable competence <ul style="list-style-type: none"> ○ <i>Attending: Room, area, or available</i> • All aspects of case management for instances in which competence has not yet been demonstrated are discussed with attending before a plan is implemented <ul style="list-style-type: none"> ○ <i>Attending: Room, area, or available</i>
4	Weeks 26-52	<p>With the approval of the RPD, 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.</p> <p><u>Resident responsibility</u></p> <p>Supervision of the residents' own cases continues on at Level 3 above</p>

Responsibilities in the Graduated Supervision Process

- **Attendings**
 - Rate the resident's Graduated Responsibility Level on an ongoing basis; communicate expectations clearly to the resident, and notify the resident of any changes
 - Log the rating monthly in the Graduated Responsibility Tracker
 - On a continuous basis assess for resident compliance with graduated supervision levels. If non-compliance is identified 1) immediately discuss the issue and formulate a resolution plan with the resident, 2) inform the RPD, 3) assess outcome and discuss with resident, and 4) document all steps in the Graduated Responsibility Tracker
- **Resident**
 - On a continuous basis, be aware of and comply with graduated supervision level requirements with each attending.
 - During RPD meetings review the Graduated Responsibility Tracker, and document concurrence or non-concurrence with an agreed-upon resolution plan in the meeting minutes
- **Program Director**
 - On a continuous basis, maintain clear direct communication with attendings regarding all aspects of the resident supervision process
 - During RPD meetings review the Graduated Responsibility Tracker, and document concurrence or non-concurrence with an agreed-upon resolution plan in the meeting minutes

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, courtesy and respect for their culture and values. 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 including competency assessment and quantitative measures. The resident maintains a shared Outlook calendar with the RPD to track and monitor time spent in various activities. Assessment input is obtained from multiple stakeholders including chiropractic attendings, program director, support staff, patients, and the resident's own self-assessment. Assessment instruments and schedule are summarized in the tables below.

Summative Assessment	
Milestones assessment	Performance scales and open-ended comments assessing competence in domains of Clinical Service, Advanced Healthcare Knowledge, Practice-Based Learning and Improvement, Interpersonal and Communication Skills, Professionalism, Collaborative Practice, and Evidence-informed Advanced Practice
Qualitative (Formative) Assessments	
Evaluation of live clinical performance	A structured qualitative assessment of performance grounded in operational definitions
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.
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 the residents' care, and their impression of resident competency
Resident self-assessment	Resident self-rating of Milestones competencies, and open-ended reflections to identify learning goals and professional development targets, and for self-assessment (indirect) of resident competence
Quantitative Measures	
Case log	Documentation of the types and numbers of cases seen by the resident, either in delivering care or observation.
Calendar	Description of the resident's patient care, interprofessional rotations, and scholarly activity hours
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 RPD and CCC.

Assessment Instrument Frequency and Scheduling												
Calendar Month	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Residency Trimester	I				II				III			
Milestones assessment				1				1				1
Evaluation of live clinical performance			6				4				4	
Chart-stimulated recall			3				3				3	
Chart review, faculty			4				4				4	
Staff perception of resident			3								3	
Patient perception of resident			4				4				4	
Resident self-assessment ^a	1			1				1				1
Case log ^a	Weekly											
Calendar ^a	Weekly											
Portfolio ^a	Weekly											
Resident assessment of faculty ^{a,b}				1				1				1
Resident assessment of program ^{a,b}				1				1				1
Resident assessment of rotation ^{a,b}	At the completion of each rotation											

a Indicates items completed by the resident

b Indicates items used for program assessment, not resident competency assessment

Clinical Competency Committee

A Clinical Competency Committee (CCC) assesses the resident's performance to provide a consensus summative evaluation of clinical competence. The CCC also functions as an "early warning" system which notifies the resident if he/she is not progressing at the expected level of his/her training.

The CCC is composed of the DC core faculty members. The responsibilities of the RPD and CCC are:

- *Chiropractic Residency Program Director*: Develops and updates the document which describes the roles of the committee members and disseminates it to the members of the committee which he/she appoints. The program director participates in the CCC by the virtue of being core faculty but also assures a balance in his/her roles as an evaluator and as resident advocate and advisor.
- *CCC Chair*: Serves as the chair of the committee and is responsible for unbiased oversight. Shares committee reports with the Program Director to use in tri-annual Milestones evaluations.
- *CCC Members*: Review all the resident's evaluations semi-annually and advise the program director and the CCC Chair regarding resident's progress, including promotion, remediation, probation, and dismissal.

The CCE functions as follows:

- CCC reviews each resident's evaluations tri-annually.
- CCC uses the compiled assessment data and faculty members' direct observations to develop their evaluation of the resident.
- CCC advises the program director regarding resident's progress according to the Chiropractic Integrated Clinical Practice Milestones. Additional input will be provided including promotion, remediation, probation, and dismissal.
- CCC serves as an "early warning system" to identify if a resident is failing to progress in the program and assists in the remediation process if indicated.
- CCC documents the resident's milestone achievement level tri-annually.

Assessment Record Keeping

Hard copy records are maintained by the CCC chair in a binder stored in a cabinet in Building 2, Room 5176 of the West Haven campus. Electronic records are maintained in a folder on the VACHS M Drive, accessible to the resident, program director, CCC and faculty. Any hard copy assessments completed at the Newington campus will be transmitted to the CCC chair by the respective Newington faculty.

Ensuring compliance with the above schedule is a joint responsibility between the CCC chair and the resident. The resident is required to review the hard copy and electronic records monthly, and discuss status with the program director during a given meeting. If any obstacles to timely compliance are identified, the resident, CCC and director will meet to discuss actions needed.

Requirements for Residency Completion

To successfully complete the program, the resident will meet the following requirements:

1. Clinical Competency
 - a. Demonstrate a minimum of Level 4 competence on the Trimester 3 Overall Milestones Assessment¹
2. Quantitative Requirements
 - a. Clinical Care
 - i. Completion of assigned chiropractic clinic sessions, including a minimum of 650 total patient encounters, with a minimum of 100 instances of each of the 4 comorbidity categories: Musculoskeletal, Neurological, Post-operative, and Mental Health^{2,3}
 - b. Interprofessional rotations
 - i. Completion of a minimum of 50 clinic sessions in total across primary care, physical medicine and rehabilitation, pain medicine, behavioral medicine, other relevant medical /surgical specialties, and other relevant associated health disciplines^{3,4}
 - c. Scholarly activities
 - i. Completion of 2 assigned online didactic courses⁴
 - ii. Completion of 2 assigned resident group projects⁴

- iii. Presentation of 2 formal critically appraised topics, case reports, and/or other scholarly work at various VA and/or UBCC settings including in-person or online meetings, Journal Club sessions, or other relevant venues⁴
- iv. Presentation of 2 in-service presentations/workshops to staff and/or trainees at other clinical services in VA, UBCC, and/or external scholarly venues⁴
- v. Attendance at 8 scholarly/research presentations at VACHS venues including the Pain Research Informatics Multi-morbidities and Education (PRIME) Center, and the Region 1 SCAN ECHO Multidisciplinary Pain Management Clinic⁴

Records

1-Milestones Assessment Log

2-Resident Case Log

3-Resident Calendar

4- Resident Portfolio

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 (RPD) 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 RPD 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 RPD 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 RPD. 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 RPD in consultation with the relevant supervisor(s). The termination of the schedule modification period will be determined, after discussions with the resident, by the RPD 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 RPD 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 RPD determines that there has not been sufficient improvement in the resident's behavior to remove the Probation or modified schedule, then the RPD will discuss with the relevant supervisor(s) and the Service Chief possible courses of action to be taken. The RPD 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 RPD 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 RPD 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 RPD 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 RPD 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 RPD

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 RPD 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 RPD at any time, but they should first be addressed within the supervisory relationship. The RPD will encourage such direct resolution. (If the resident has a problem that directly involves the RPD, he or she is encouraged to address that problem first with the RPD. If an issue with the RPD 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 RPD 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 RPD about a resident's training program or status in the agency, the RPD 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 RPD;
 - c. If the RPD cannot resolve the issue, the resident and RPD should discuss the problem with the Service Chief; or, if the resident has a concern with the RPD that has not been resolved through discussion with the RPD, 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 RPD, 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 RPD. 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 RPD 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 RPD
 - 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 RPD for a review of the situation. When this occurs, the RPD will within five days of a formal complaint, the RPD 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 RPD 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 RPD 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

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
Name: _____

Resident
Signature: _____ Date: _____

Residency
Director
Name: Anthony Lisi, DC _____

Residency
Director
Signature: _____ Date: _____