

## RESIDENT SUPERVISION

**1. REASON FOR ISSUE.** This Veterans Health Administration (VHA) Handbook provides the procedural requirements pertaining to the supervision of physician, dentist, podiatrist, and optometrist residents and focuses on resident supervision from the educational perspective.

**AUTHORITY: Title 38 United States Code (U.S.C.) 7301(b).**

**2. SUMMARY OF MAJOR CHANGES.** The Handbook has been rewritten with specific emphasis on areas that:

a. Reflect current accreditation standards of the Accreditation Council for Graduate Medical Education (ACGME) and other relevant accrediting bodies for residency training programs.

b. Enhance the description of supervision and the documentation requirements in common clinical settings.

c. Reflect new standards for supervision and documentation of supervision for telemedicine or telehealth patient encounters.

d. Reflect new standards for supervision and documentation of supervision for home visit encounters.

e. Reflect new standards for supervision and documentation of supervision for “observation” admissions (less than 24 hours).

f. Clarify when supervisors from another discipline may supervise medical, dental, podiatric, or optometric trainees.

**3. RELATED ISSUES.** VHA Directive 1400, Office of Academic Affiliations; and VHA Handbook 1101.04, Medical Officer of the Day.

**4. RESPONSIBLE OFFICIALS.** The Chief Academic Affiliations Officer (10A2D) is responsible for the contents of this Handbook. Questions may be directed to 202-461-9490.

**5. RECISSIONS.** VHA Handbook 1400.1, Resident Supervision, dated July 27, 2005, is rescinded.

**6. RECERTIFICATION.** This VHA Handbook is scheduled for recertification on or before the last working day of December 2017.

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DISTRIBUTION: E-mailed to the VHA Publications Distribution List 12/28/2012

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## RESIDENT SUPERVISION

### 1. PURPOSE

This Veterans Health Administration (VHA) Handbook provides the procedural requirements pertaining to the supervision of physician, dentist, podiatrist, and optometrist residents and focuses on resident supervision from the educational perspective. *NOTE: See the most current VHA Directive on billing relating to guidance for services provided by supervising practitioners and residents.* **AUTHORITY: Title 38 United States Code (U.S.C.) 7301(b).**

### 2. BACKGROUND

In a health care system where patient care and the training of health care professionals occur together, there must be a clear delineation of responsibilities to ensure that qualified practitioners provide patient care, whether they are trainees or full-time staff. As resident trainees acquire the knowledge and judgment that accrue with experience, they are allowed the privilege of increased authority for patient care.

a. VHA follows the institutional requirements of the Accreditation Council for Graduate Medical Education (ACGME) and other accrediting and certifying bodies. ACGME states that the Residency Program Director and faculty are responsible for providing residents with direct experience in progressive responsibility for patient management. The process of progressive responsibility is the underlying educational principle for all graduate medical and health professional education, regardless of specialty or discipline. Supervising clinician educators involved in this process must understand the implications of this principle and its impact on the patient and the resident. *NOTE: Accreditation bodies for the disciplines of dentistry, optometry, and podiatry have similar requirements.*

b. VHA must comply with the institutional requirements and accreditation standards of the Joint Commission and other health care accreditation bodies. Qualified health care professionals with appropriate credentials and privileges provide Veteran patient care and provide the supervision of residents.

c. The intent of this Handbook is to ensure that patients are cared for by clinicians who are qualified to deliver that care and that this care is documented appropriately and accurately in the patient record. This is fundamental both for the provision of excellent patient care and for the provision of excellent education and training for future health care professionals.

d. The quality of patient care, patient safety, and the success of the educational experience are inexorably linked and mutually enhancing. Incumbent on the clinician educator is the appropriate level, intensity, and quality of supervision of residents as they acquire the skills to practice independently.

### 3. SCOPE

The procedures contained in this Handbook are applicable to patient care services including, but not limited to: inpatient care; outpatient care; community and long-term care; emergency care; telehealth; home health care; and the performance and interpretation of diagnostic and therapeutic procedures.

a. Supervising practitioners are responsible for the care provided to each patient and they must be familiar with each patient for whom they are responsible. Fulfillment of that responsibility requires personal involvement with each patient and each resident and/or student who is participating in the care of that patient. Each patient must have a supervising practitioner whose name is identifiable in the patient record. Other supervising practitioners may at times be delegated responsibility for the care of the patient and the supervision of the residents involved. It is the responsibility of the supervising practitioner to ensure that the residents involved in the care of the patient are informed of such delegation and can readily access a supervising practitioner at all times.

b. Within the scope of the accredited training program, all residents must function under the supervision of supervising practitioners. For services that provide 24-hour, 7-day-a-week (24/7) resident coverage, call schedules must be provided to the medical facility administration. Call schedules must delineate both resident and attending coverage for acute and extended care wards, intensive care units, and consultative services.

c. Each training program must be constructed to encourage and permit residents to assume increasing levels of responsibility relative to their individual progress in experience, skill, knowledge, and judgment. *NOTE: The determination and documentation of graduated levels of responsibility are outlined in paragraph 4.*

d. Each facility must adhere to current accreditation requirements as set forth by the ACGME, Commission on Dental Accreditation (CODA), the Executive Committee of the Council on Postdoctoral Training (ECCOPT), the Council on Podiatric Medical Education (CPME), the American Osteopathic Association (AOA), and Accreditation Council on Optometric Education (ACOE) for all matters pertaining to the resident training program, including the level of supervision provided.

e. Requirements of the various certifying bodies, such as the pertinent member boards of the American Board of Medical Specialties (ABMS), Bureau of Osteopathic Specialists (BOS), American Board of Podiatric Surgery (ABPS), CODA, American Board of Podiatric Orthopedics and Primary Podiatric Medicine (ABPOPPM), and ACOE must be incorporated into Department of Veterans Affairs (VA) training programs and fulfilled through local facility policy to ensure that each successful program graduate is eligible to sit for the certifying examination in the graduate's specialty.

f. In order to ensure patient safety and quality patient care while providing the opportunity for maximizing the educational experience of the resident in the ambulatory setting, it is expected that an appropriately-privileged supervising practitioner is physically present and available for supervision during clinic hours. Patients followed in more than one clinic must

have an identifiable supervising practitioner for each clinic. Supervising practitioners are responsible for ensuring that coordinated care is provided to patients.

g. Training programs at each facility must provide appropriate supervision for all residents, as well as a duty hour schedule and a work environment that are consistent with proper patient care, the educational needs of residents, and all applicable program requirements.

#### 4. GRADUATED LEVELS OF RESPONSIBILITY

a. As part of their training programs, residents earn progressive responsibility for the care of the patient. The determination of a resident's ability to provide care to patients without a supervising practitioner present, or to act in a teaching capacity, is based on documented evaluation of the resident's clinical experience, judgment, knowledge, and technical skill. Ultimately, it is the decision of the supervising practitioner as to which activities the resident will be allowed to perform within the context of the assigned levels of responsibility. In general, residents may order laboratory studies, radiology studies, pharmaceuticals, and therapeutic procedures as part of their assigned levels of responsibility. In addition, residents are allowed to certify and re-certify certain treatment plans (e.g., Physical Therapy, Speech Therapy) as part of their assigned levels of responsibility. These activities are considered part of the normal course of patient care and require no additional documentation on the part of the supervising practitioner over and above standard setting-specific documentation requirements. The overriding consideration in determining assigned levels of responsibility must be the safe and effective care of the patient. In order to write prescriptions for patients, residents must have a National Provider Identifier (NPI). *NOTE: See the most current VHA publication regarding National Provider Identifier (NPI).*

b. The Program Director defines the levels of responsibilities for each year of training by preparing a description of the types of clinical activities residents may perform. The Program Director makes this list of graduated levels of responsibility available (i.e., must be accessible 24/7) to appropriate staff. Annually, at the time of promotion or more frequently as appropriate, this document, along with a list of residents assigned to each year or level of training, is provided to the relevant VA Site Director, Service Chief, Chief of Staff (COS), and Designated Education Officer (DEO). The Program Director must include a specific statement identifying the evidence on which such an assignment is made and any exceptions for individual residents, as applicable.

c. For certain aspects of patient care, the supervising practitioner may delegate supervision of more junior residents or students to a more advanced resident or fellow. Nevertheless, the ultimate responsibility for the patient, oversight of the care delivered, and for compliance with the provisions of this Handbook reside with the supervising practitioner. For example, such delegation does not remove the physical presence or documentation requirements of the supervising practitioner as specified in subparagraphs 5b and 5c.

#### 5. DOCUMENTATION OF SUPERVISION OF RESIDENTS

a. **Supervising Practitioner Involvement.** The health record must clearly demonstrate the involvement of the supervising practitioner in each type of resident-patient encounter described in subparagraph 5c. *NOTE: Documentation requirements are outlined in subparagraph 5b.*

b. **Supervision Documentation.** Documentation of supervision must be entered into the patient health record by the supervising practitioner or reflected within the resident progress note or other appropriate entries in the health record (e.g., procedure reports, consultations, discharge summaries). Pathology and radiology reports must be verified by a supervising practitioner.

(1) Types of allowable documentation include:

(a) Progress note or other entry into the health record by the supervising practitioner.

(b) Addendum to the resident admission or progress note by the supervising practitioner.

(c) Co-signature of the progress note or other health record entry by the supervising practitioner. *NOTE: The supervising practitioner's co-signature signifies that the supervising practitioner has reviewed the resident note, and absent an addendum to the contrary, concurs with the content of the resident note or entry. Use of "additional signer" or "identified signer" options in the Computerized Patient Record System (CPRS) is not an acceptable form of documenting resident supervision (see VHA Handbook 1907.01, Health Information Management and Health Records).*

(d) Resident progress note or other medical record entry documenting the name of the supervising practitioner with whom the case was discussed, a summary of the discussion, and a statement of the supervising practitioner's oversight responsibility with respect to the assessment or diagnosis and/or the plan for evaluation and/or treatment. *NOTE: Statements such as the following are acceptable to demonstrate the supervising practitioner's level of supervision or oversight responsibility: "I have seen and discussed the patient with my supervising practitioner, Dr. 'X' and Dr. 'X' agrees with my assessment and plan." "I have discussed the patient with my supervising practitioner, Dr. 'X' and Dr. 'X' agrees with my assessment and plan." "The supervising practitioner of record for this patient care encounter is Dr. 'X'."*

(2) The type of allowable documentation varies according to the clinical setting and kind of patient encounter as outlined in subparagraph 5c . In all cases, the responsible supervising practitioner must be clearly identifiable in the documentation of the patient encounter or report of reviews of patient material (e.g., pathology or imaging reports). An independent note or addendum by the supervising practitioner is required for inpatient admissions, pre-operative assessment, and extended care admissions. *NOTE: The frequency of documentation of involvement of the supervising practitioner depends upon the setting and the patient's condition. The timeframe for signing or co-signing the progress notes, consultations, and reports is delineated in local facility policy, local medical staff bylaws, or accreditation requirements.*

c. **Documentation in Patient Settings**

(1) **Inpatient Care**

(a) **Inpatient Admission.** For patients admitted to an inpatient service of the medical facility, the supervising practitioner must physically meet, examine, and evaluate the patient within 24 hours of admission, including weekends and holidays. Documentation of the supervising practitioner's findings and recommendations regarding the treatment plan must be in the form of

an independent progress note or an addendum to the resident note, which must be entered within 24 hours following admission. If the specific requirements of the pre-operative notes are included, the admission note (or addendum) may serve as the pre-operative note. First post-graduate year (PGY-1) residents must have on-site supervision at all times by either a supervising practitioner or a more advanced resident, with the supervising practitioner being available on-call (on-site or off-site). **NOTE:** *Use of appropriate note titles in CPRS is encouraged.*

(b) “Night Float” and “Over Cap” Admissions. For patients admitted to an inpatient service of the medical facility during evenings or nights, a “night float” or “over cap” resident occasionally provides care before the care of the patient is transferred to an inpatient ward team. In these cases, the supervising practitioner of the inpatient ward team receiving the patient must physically meet and examine the patient within 24 hours of admission by the night float to the inpatient service, irrespective of the time the ward team assumes responsibility for the patient. In addition, appropriate handover procedures and the supervising practitioner for night float admissions must be clearly designated by local policy. On-site supervision of the “night float” or “over cap” resident must be in place, if that resident is a PGY-1 resident. **NOTE:** *Documentation requirements are the same as in preceding subparagraph 5c(1)(a).*

(c) Continuing Care of Inpatients. Supervising practitioners must be personally involved in the ongoing care of the patients assigned to them in a manner consistent with the clinical needs of the patient and the graduated level of responsibility of the resident. **NOTE:** *Any of the four types of documentation referenced in subparagraph 5b(1) is acceptable.*

(d) Discharge from Inpatient Status. The supervising practitioner, in consultation with the resident, ensures that the discharge of the patient from an inpatient service of the medical facility is appropriate and based on the specific circumstances of the patient’s diagnoses and therapeutic regimen; discharge instructions and orders may include physical activity, medications, diet, functional status, and follow-up plans, including coordination with the patient’s primary care team. Evidence of this involvement must be documented by the supervising practitioner’s countersignature of the discharge note and discharge summary.

(e) Transfer from One Inpatient Service to Another, or Transfer to a Different Level of Care (Inter-service or Inter-ward Transfer). The supervising practitioner, in consultation with the resident, ensures that the transfer of the patient from one inpatient service to another or transfer to a different level of care is appropriate and based on the specific circumstances of the patient’s diagnoses and condition. The supervising practitioner from the transferring service must be involved in the decision to transfer the patient and documentation of the appraisal must be entered into the health record using any of the four types of documentation referenced in subparagraph 5b(1). When a patient requires a different level of care within the same ward or unit, the supervising practitioner must be involved in the decision to change the level of care and documentation of the appraisal must be entered into the health record using any of the four types of documentation referenced in subparagraph 5b(1). The supervising practitioner from the receiving service must treat the patient as a new admission and must write an independent note or an addendum to the resident’s transfer acceptance note (see subpars. 5c(1)(a) and 5c(3)(a)). **NOTE:** *This provision covers transfers into and out of intensive care units or transfers to*

*extended care. Exception: If the same supervising practitioner is responsible for the patient across different levels of care, transfer documentation is not required.*

(f) Inpatient Consultations. A supervising practitioner is responsible for clinical consultations for each specialty service. When residents are involved in consultation services, the consultant supervising practitioner is responsible for supervision of these residents. **NOTE:** *Any of the four types of documentation referenced in subparagraph 5b(1) is acceptable.*

(g) Intensive Care Units (ICU), including Medical, Cardiac, and Surgical ICUs. For patients admitted to, or transferred into, an ICU of the medical facility, the supervising practitioner must physically meet, examine, and evaluate the patient as soon as possible, but no later than 24 hours after admission or transfer, including weekends and holidays. An admission note or addendum to the resident's admission note is required within 24 hours of admission. Due to the unstable nature of patients in ICUs, frequent evidence of involvement of the supervising practitioner is required. PGY-1 residents must have on-site supervision at all times by either a supervising practitioner or a more advanced resident, with the supervising practitioner being available on-call. Supervising practitioner involvement is expected on a daily or more frequent basis and must be documented using any of the four types of documentation referenced in subparagraph 5b(1).

(h) Observation Patients. While observation patients are typically coded as outpatients, they are usually admitted to inpatient units. The level of supervision expected depends upon the unit where the patient is being held, e.g., ICU, inpatient ward, or emergency department. If the patient is released before the supervising practitioner has a chance to see the patient, the resident must: contact the on-call attending by phone; discuss the patient's condition, treatment, and follow-up plans; and have the concurrence of that supervising practitioner regarding the plan to release the patient. A summary of the discussion between the resident and the supervising practitioner must be documented in the resident's note as a minimum form of documentation of supervision if the patient was not seen by the attending prior to release. If the supervising practitioner is able to evaluate the patient in person, an independent note or addendum to the resident's note is required. **NOTE:** *Supervising practitioner's co-signature of the resident's note is not sufficient documentation of resident supervision.*

## (2) **Outpatient Clinic**

(a) Physical Presence. The supervising practitioner must be physically present in the clinic area during clinic hours whenever residents are engaged in patient care.

(b) New Outpatient Encounters. New patients to a facility require a higher level of supervising practitioner documentation than other outpatients. Each new patient needs to be seen by or discussed with the supervising practitioner. Documentation of supervising practitioner involvement must be entered in the patient health record according to subparagraphs 5b(1)(a), 5b(1)(b), or 5b(1)(d). **NOTE:** *Supervising practitioner's co-signature of the resident's note is not sufficient documentation of resident supervision.*

(c) Outpatient Consultations. A supervising practitioner is responsible for the decision to initiate clinical consultations from an outpatient clinic to a consultation service. When residents

are involved in delivering consultation services, the consulting supervising practitioner is responsible for supervision of these residents. The consulting attending must be contacted by the resident on the consultation service while the patient is still in the clinic. **NOTE:** *Any of the four types of documentation referenced in subparagraph 5b(1) is acceptable.*

(d) Continuing Care in the Outpatient Setting. The supervising practitioner must be identifiable for each resident's patient care encounter. Return patients must be seen by, or discussed with, the supervising practitioner at such a frequency as to ensure that the course of treatment is effective and appropriate. **NOTE:** *Any of the four types of documentation referenced in subparagraph 5b(1) is acceptable.*

(e) Discharge from Outpatient Clinic. The supervising practitioner, in consultation with the resident, ensures that the discharge of the patient from the clinic is appropriate. **NOTE:** *Any of the four types of documentation referenced in subparagraph 5b(1) is acceptable.*

### (3) **Extended Care or Community Living Centers (CLC)**

(a) New Extended Care Admissions. Each new patient admitted to an extended care or CLC facility must be seen by the responsible supervising practitioner within 72 hours of admission. **NOTE:** *The documentation referenced in either subparagraph 5b(1)(a) or subparagraph 5b(1)(b) is acceptable.*

(b) Continuing Care in the Extended Care or CLC Setting. The supervising practitioner must be identifiable for each resident's patient care encounter. Extended care patients must be seen by, or discussed with, the supervising practitioner at such a frequency as to ensure that the course of treatment is effective and appropriate. **NOTE:** *Any of the four types of documentation referenced in subparagraph 5b(1) is acceptable.*

### (4) **Emergency Department (ED)**

(a) Physical Presence. The supervising practitioner for the ED must be physically present in the ED whenever residents are engaged in patient care.

(b) ED Visits. Each new patient to the ED must be seen by or discussed with the supervising practitioner. **NOTE:** *Documentation of supervising practitioner involvement must be according to subparagraphs 5b(1)(a), 5b(1)(b), or 5b(1)(d).*

(c) Discharge from the ED. The supervising ED practitioner, in consultation with the ED resident, ensures that the discharge of the patient from the ED is appropriate. **NOTE:** *Any of the four types of documentation referenced in subparagraph 5b(1) is acceptable.*

(d) ED Consultations. A consulting supervising practitioner is responsible for clinical consultations from each specialty service. When residents are involved in consultation services, the consulting service supervising practitioner is responsible for supervision of these residents. Residents from a consulting service must contact their supervising practitioners while the patient is still in the ED in order to discuss the case and to develop a recommended plan of management. The ED practitioner is responsible for the disposition of the patient. **NOTE:** *Any of the four*

*types of documentation referenced in subparagraph 5b(1) is acceptable. The ED practitioner is not the supervisor of the consulting resident, but is the responsible practitioner for the patient.*

(5) **Operating Room (OR) Procedures.** Supervising practitioners must provide appropriate supervision for the patient's evaluation, management decisions, and procedures. Determination of the level of supervision is a function of the level of responsibility assigned to the individual resident involved and the complexity of the procedure (see subpars. 5c(5)(a) through 5c(5)(c)). PGY-1 residents must be directly supervised at all times, except for routine bedside or clinic procedures, where on-site supervision is allowed after demonstration and documentation of competence is attained.

(a) **Pre-procedure Note.** The pre-procedure supervising practitioner note requirement applies to OR and same day ambulatory surgical procedures; it does not apply to routine bedside procedures and clinic procedures such as skin biopsy, central and peripheral lines, lumbar punctures, centeses, incision and drainage, etc. For all elective or scheduled surgical procedures, a supervising practitioner must evaluate the patient and write a pre-procedural note or an addendum to the resident's pre-procedure note describing the findings, diagnosis, plan for treatment, and choice of specific procedure to be completed. This pre-procedural evaluation and note may be done up to 30 days in advance of the surgical procedure. All applicable Joint Commission standards concerning documentation must be met. A pre-procedure note may serve as the admission note if it is written within 24 hours of admission by the supervising practitioner with responsibility for continuing care of the inpatient, and if the note meets criteria for both admission and pre-operative notes (see subpar. 5c(1)(a)). **NOTE:** *Use of appropriate note titles in CPRS is encouraged.* Other services involved in the patient's operative care (e.g., Anesthesiology) must write their own pre-procedure notes (such as for the administration of anesthesia) as required by The Joint Commission, but such documentation does not replace the pre-operative documentation required by the surgery supervising practitioner.

(b) **Informed Consent.** Informed consent must be obtained as detailed in VHA Handbook 1004.01, Informed Consent for Clinical Treatments and Procedures.

(c) **Veterans Health Information and Technology Architecture (VistA) Surgical Package.** Staff involvement in procedures as defined in the VistA Surgical Package must be documented in the computerized surgical log (a part of the VistA Surgical Package) and reported to VA Central office by the Surgical Quarterly Report consistent with the following scale:

1. **Level A: Attending Doing the Operation.** The staff practitioner performs the case, but may be assisted by a resident.

2. **Level B: Attending in OR, Scrubbed.** The supervising practitioner is physically present in the operative or procedural room and directly involved in the procedure. The resident performs major portions of the procedure.

3. **Level C: Attending in OR, Not Scrubbed.** The supervising practitioner is physically present in the operative or procedural room. The supervising practitioner observes and provides direction. The resident performs the procedure.

4. **Level D: Attending in OR Suite, Immediately Available.** The supervising practitioner is physically present in the operative or procedural suite and able to provide direct supervision or consultation without delay as needed.

5. **Level E: Emergency Care.** Immediate (i.e., without delay) care is necessary to preserve life or prevent serious impairment. The supervising practitioner has been contacted (see par. 6). *NOTE: "Emergency" surgery may be performed at levels A through D, depending upon the level of supervising practitioner involvement. Level E is appropriate only if a resident is performing the emergency surgery without a supervising practitioner present.*

6. **Level F: Non-OR Procedure.** Routine bedside and clinic procedure done in the OR. The supervising practitioner is identified in the documentation by the resident.

#### (6) **Non-OR Procedures**

(a) **Routine Bedside and Clinic Procedures.** Routine bedside and clinic procedures include: skin biopsies, central and peripheral lines, lumbar punctures, centeses, and incision and drainage. Supervision for these activities is dependent on the setting in which they occur. Documentation standards must follow the setting-specific guidelines (see subpars. 5c(1) through 5c(5)).

(b) **Non-routine, Non-bedside Diagnostic, or Therapeutic Procedures.** Non-routine, non-bedside, diagnostic, or therapeutic procedures (e.g., endoscopy, cardiac catheterization, invasive radiology) are procedures that require a high level of expertise in their performance and interpretation. Although gaining experience in doing such procedures is an integral part of the education of the resident, such procedures may be done only by residents with the required knowledge, skill, and judgment and under an appropriate level of supervision by a supervising practitioner. Supervising practitioners are responsible for authorizing the performance of such procedures and must be physically present in the procedural area. Supervision for these procedures takes into account the complexity and inherent risk of the procedure, the experience of the resident, and assigned graduated levels of responsibility (see par. 4). Documentation standards must follow the setting-specific guidelines (see subpars. 5c(1) through 5c(5)). *NOTE: Documentation of the degree (level and intensity) of supervising practitioner involvement is encouraged. Any of the four types of documentation referenced in subparagraph 5b(1) is acceptable.*

(c) **Chemotherapy and Radiation Therapy.** The supervising practitioner must be present during the treatment planning (i.e., choice of modality and regimen), dosage or dosimetry determinations, and writing of chemotherapy or radiation therapy orders. Neither the supervising practitioner nor the resident needs to be present during the administration of chemotherapy, since therapy delivery is a function of associated health personnel, but there must be a knowledgeable fellow or attending on-site and on-call to the infusion unit. For radiation therapy, irradiation may be off-site and neither the responsible radiation oncology attending nor resident presence is necessary during treatment delivery. An attending note or an addendum to, or co-signature of, the resident's note or consultation documenting the treatment plan is acceptable.

(7) **Home Visits.** Home visits generally occur as a part of VA's Home-Based Primary Care (HBPC) Program. Residents who participate in home visits must have received orientation and

training related to handling of emergency situations and related HBPC policies and procedures. PGY-1 residents may participate in home visits only when accompanied by a supervising practitioner. Although the supervising practitioner need not accompany second post-graduate year or higher (PGY-2+) residents on the home visit (assuming an acceptable, documented level of graduated responsibility), the supervising practitioner must be readily available at an agreed-upon, identifiable phone number for the duration of the time the resident is making home visits. Following home visits, the supervising practitioner must discuss each case with the resident.

*NOTE: Any of the four forms of documentation referenced in subparagraph 5b(1) may be used to record this interaction.*

#### (8) Telemedicine and Telehealth

##### (a) Real-time Videoconferencing.

1. In situations where the supervising practitioner and resident are present at a VA facility delivering telehealth care to a remote patient, resident-provided care is acceptable in all circumstances where VA standards permit the staff practitioner to deliver care remotely. The supervising practitioner must be in the general vicinity and available to the resident for direct supervision without delay, as if the patient were being seen in a clinic.

2. Real-time videoconferencing must not be used to substitute for appropriate supervision, e.g., in situations where the resident is with the patient in a remote setting (e.g., at a Community-Based Outpatient Clinic (CBOC)) and the supervising practitioner is at a parent VA facility with videoconferencing connectivity. Resident-provided care in remote settings without the on-site presence of a supervising practitioner is not acceptable. However, consultation with specialists via remote connections may be handled as any outpatient consultation would be conducted.

(b) Store and Forward Telehealth. In “store and forward” telehealth, the resident and supervising practitioner would not see the patient, except through examination of images or specimens (e.g., teleradiology films, teleretinal scans, or telepathology specimens). The resident reviews the material with or without the supervising practitioner present, and the supervising practitioner reviews the same material. The interpretations and reports on all images and pathology specimens must be verified by the supervising practitioner. In all instances, the resident must receive feedback on the resident’s interpretation of home telehealth for learning purposes.

(c) Home Telehealth. In home telehealth, the supervising practitioner and resident are delivering home care to a patient by videophone or in-home messaging devices. Such an arrangement is acceptable in all circumstances in which VA standards permit the supervising practitioner to deliver care remotely. Residents who are assigned responsibility for home telehealth patients must consult with the supervising practitioner regarding any changes in a patient’s status or proposed changes in the treatment plan. Supervising practitioners are expected to exercise general oversight of the home telehealth care provided by residents.

*NOTE: In documenting supervision in these instances, any of the four types of documentation referenced in subparagraph 5b(1) is acceptable.*

## 6. EMERGENCY SITUATIONS

An “emergency” is defined as a situation where immediate (i.e., without delay) care is necessary to preserve the life of or to prevent serious harm to the health of a patient. In such situations, any resident, assisted by medical facility personnel, is (consistent with the informed consent provisions of VHA Handbook 1004.01) permitted to do everything possible to save the life of a patient or to save a patient from serious harm. The appropriate supervising practitioner must be contacted and apprised of the situation as soon as possible. The resident must document the nature of that discussion in the patient's record.

## 7. SUPERVISION OF PHYSICIAN RESIDENTS PROVIDING EMERGENCY CARE COVERAGE

a. **ED Physician.** Physicians providing independent ED coverage must be credentialed, privileged, and fully licensed. Residents who have not completed core training requirements for board-certification are still subject to the same supervisory requirements specified in this Handbook. However, in a critical staffing emergency situation, permission to use a third post-graduate year (PGY-3) and above, non-board-eligible resident for sole, unsupervised coverage may be requested from the Veterans Integrated Services Network (VISN) Director. When such an emergency exists, the VISN Director may approve the use of a PGY-3 and above, non-board-eligible resident on a short-term, time-limited basis, when truly exceptional circumstances exist and only for the duration of the emergency staffing issue. In these rare instances, the resident must be appropriately credentialed and privileged and be an approved provider of Advanced Cardiac Life Support (ACLS) (see VHA Handbook 1100.19, Credentialing and Privileging).

### **b. Supervision of Residents who have Completed Requirements for Board Eligibility (i.e., Subspecialty Fellows or Chief Residents)**

(1) Physician residents who are board-certified or who have completed the training requirements for board eligibility may be privileged as independent practitioners for purposes of ED coverage. Privileges sought and granted may only be those delineated within the general category for which the resident is board-certified or has completed training.

(2) Subspecialty residents, fellows, or Chief Residents who are appointed to work independently in the ED, outside the scope of their training program (i.e., in areas for which they are fully qualified by virtue of having completed core residency training in either internal medicine, emergency medicine, psychiatry, or general surgery), must be fully licensed, credentialed, and privileged for the duties they are expected to perform. In this capacity, they are not working under the auspices of a training program and must meet the requirements for staff appointment and are subject to the provisions contained in VHA Handbook 1100.19. Specialty or subspecialty privileges which are within the scope of the resident's current training program may not be granted. **NOTE:** Refer to paragraph 4 for assigning, as appropriate, graduated levels of responsibility for activities within the scope of training. “Moonlighting” in ED settings counts against duty hour restrictions as specified by the accrediting body.

## 8. EVALUATION OF RESIDENTS, SUPERVISORS, AND TRAINING SITES

### a. Evaluations of Residents

(1) Each resident must be evaluated according to accrediting and certifying body requirements on patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. Evaluations occur as indicated by the accrediting or certifying body, or at least semiannually, and are communicated to each resident in a timely manner. Evaluations must be accessible to the resident at the end of the resident's rotation or every 6 months, whichever is more frequent. Written evaluations must be discussed with the resident.

(2) When a resident's performance or conduct is judged to be detrimental to patient care, evaluation of the resident, in mutual consultation with the faculty, must be completed. Residents may be dismissed from VA assignment in accordance with VA Handbook 5021, Employee/Management Relations, Part VI, Paragraph 18, Separation of Medical and Dental Residents appointed under 38 U.S.C. 7406, which includes a requirement to notify the Residency Program Director of the affiliated participating institution of a proposed dismissal of a resident in an integrated program.

b. Evaluation of Supervising Practitioner and Training Site. Each resident rotating through a VA facility must be given the opportunity to complete confidential written evaluations of supervising practitioners and VA training sites. Evaluations must be conducted in accordance with the standards of the appropriate accrediting and/or certifying bodies. Evaluations need to conform to program-specific requirements. Academic evaluations are the confidential property of the residency program and Residency Program Director, who may be located at a non-VA site.

c. Storage and Use of Evaluations. Secure storage of evaluations of residents, supervisors, and training sites is the responsibility of the Residency Program Director. The evaluations are aggregated and analyzed in compliance with accrediting and certifying body standards. The evaluations must be communicated to the responsible VHA Service Chief or VA Site Director in a manner and timetable agreeable to both.

## 9. MONITORING PROCEDURES

### a. Goals and Objectives

(1) The goal of monitoring resident supervision is to ensure that Veteran care in which residents are involved is performed in a safe and effective manner and to foster a system-wide environment of quality improvement and collaboration among VHA managers, supervising practitioners, and residents. The monitoring process involves the use of existing information, the production of a series of evaluative reports, the accompanying process of public review of key findings, and discussion of policy implications. *NOTE: This process helps identify key resident supervision issues that now influence the quality of care and suggests effective ways for addressing them.*

(2) The foundation for resident supervision ultimately resides in the integrity and good judgment of professionals (supervising practitioners and residents) working collaboratively in well-designed health care delivery systems. Accordingly, monitoring of resident supervision is a shared responsibility of national, VISN, and local facility leaders.

(3) The key objectives of the resident supervision monitoring process are to continuously improve and enhance:

- (a) Quality and safety of patient care involving residents;
- (b) VHA's educational environment and culture of learning;
- (c) Documentation of resident supervision; and
- (d) Systems of care involving residents.

(4) Monitoring of resident supervision is a health record review process and a quality management activity. Documents and data arising from this monitoring are confidential and protected under title 38 United States Code (U.S.C.) 5705 and its revised implementing regulations.

**b. VA Medical Facility Monitoring and Use of Results**

Resident training occurs in the context of different disciplines and in a variety of structured clinical settings. Although specific titles for positions within these settings may vary by facility and VISN, the following functions must be assigned:

(1) The VA Medical Facility Director is responsible for ensuring that a local monitoring process exists for resident supervision. The monitoring process must occur at the institutional level and must include the following:

(a) Creating a local policy entitled "Monitoring of Resident Supervision." This policy must define the procedures that are to be followed for the monitoring of resident supervision. The assignment of facility-level responsibility for monitoring must be specified, i.e., services may not monitor the adequacy of supervision of their own attending staff members. The policy must include procedures for monitoring the following elements:

- 1. Inpatient care involving residents;
- 2. Outpatient care involving residents;
- 3. Procedural care involving residents;
- 4. Emergency care involving residents; and
- 5. Consultative care involving residents.

*NOTE: These five elements may be monitored using sampling techniques. Facilities are encouraged to monitor surgical care performed at levels E and F (as coded in the VistA surgical package) for appropriateness.*

(b) Reviewing of patient safety, risk management, and quality improvement data (protected by 38 U.S.C. 5705 and its revised implementing regulations and current VA policy), to include:

1. Results of health record reviews and other locally-derived quality management data concerning patient care involving residents;

2. Incident reports and tort claims involving residents;

3. Risk events including adverse events and “near misses” involving residents;

4. Patient complaints involving residents;

5. Review of externally-derived quality management data such as External Peer Review Program (EPRP) data; and

6. Review of reports by accrediting and certifying bodies.

(c) Reviewing of residents’ comments related to their VA experience, if available.

(d) Identifying opportunities for improvement in resident supervision and creation of action plans.

(e) Completing the Annual Report on Residency Training Programs (ARRTP) (Report Control Number (RCN) 10-0906).

(f) Engaging the DEO in the review of all risk events involving residents in order to determine the adequacy of resident supervision in these events.

(g) Ensuring the use of medical staff peer review processes is inappropriate for trainees in medical, dental, optometry, or podiatry programs as they are not licensed independent, privileged practitioners. The DEO must be furnished a list of all cases reviewed that involve residents in order to provide input on the adequacy of the attending’s supervision of the resident.

(h) Sharing all results of monitors with clinical leadership at the facility on a regular basis.

*NOTE: The local monitoring process will be most successful if it is a collaborative activity among the medical staff, education leadership, and quality management.*

c. **VISN-level Oversight and Procedures.** VISN oversight of monitoring processes for resident supervision is designed to meet VISN and VHA strategic goals, identify VISN trends, practices and areas for improvement, and support formulation of appropriate action plans. The VISN Director or designee (chief medical officer, network academic affiliations officer, or other designee), is responsible for:

(1) Ensuring that each affiliated VA medical facility has a monitoring process in place as detailed in subparagraph 9b;

(2) Reviewing the annual reports of all affiliated facilities in the VISN to identify opportunities for improvement or areas that need further review; and

(3) Submitting the VISN reviews to the Chief Academic Affiliations Officer through the RCN 10-0906 (ARRTP) process.

d. **VHA Central Office Oversight.** National monitoring processes for resident supervision are designed to meet VHA strategic goals and identify national trends, practices, and areas for improvement. National monitoring processes include the following:

(1) The Office of Academic Affiliations, in collaboration with the Office of Quality and Performance, may develop measures of appropriate and timely resident supervision using methodologically sound sampling and reporting procedures.

(2) EPRP and other nationally-contracted abstractors may be used to complete health record reviews using methodologically sound sampling procedures.

(3) National Surgical Quality Improvement Project (NSQIP) data are reviewed quarterly and evaluated annually by the VHA Surgery Office.

(4) ARRTP (RCN 10-0906) is reviewed and evaluated annually by Office of Academic Affiliations.

(5) VHA Learners' Perceptions Survey and other qualitative and quantitative reviews of resident's experiences and perceptions are reviewed and evaluated annually.

(6) Special reviews including site visits are conducted as needed.

(7) Applicable feedback is provided to VISNs and their respective facilities.

*NOTE: Future national monitoring efforts will be focused on automating and systematizing data collection and documentation.*

## **10. ANNUAL REPORT ON RESIDENCY TRAINING PROGRAMS (RCN 10-0906)**

a. **Description.** The Annual Report on Residency Training Programs (ARRTP) (RCN 10-0906) is a Web-based registry of residency education that is updated annually by each facility with residents and by each VISN. The report identifies medical, dental, optometric, and podiatric school affiliations, facility and educational program leadership, and includes any actions taken by accrediting or certifying bodies, any changes in the status of affiliations, and a specific analysis of resident supervision issues that are identified by the medical facility's monitoring processes. The information is requested from each affiliated VA facility for all resident training programs covered in this Handbook (i.e., medical (allopathic and osteopathic), dental, optometric, and podiatric programs). Many elements of this report are confidential and

privileged under the provisions of 38 U.S.C. 5705, its implementing regulations, and current VA policy. Protected material cannot be disclosed to anyone without authorization as provided for by that law and its regulations. Summary results may be shared with VHA leadership and other groups as appropriate.

b. **Content of the AR RTP RCN 10-0906.** RCN 10-0906 includes:

- (1) Identification of medical, dental, optometric, and podiatric school affiliations;
- (2) Identification of facility and program leadership;
- (3) Accreditation status of programs and citations or concerns, if applicable;
- (4) A summary of facility monitoring activities for resident supervision (see par. 9);
- (5) Facility response to local and/or national information about resident experiences and perceptions;
- (6) Identification of opportunities for improvement with action plans; and
- (7) Other queries pertaining to the conduct of resident education in VA facilities.

## **11. ROLES AND RESPONSIBILITIES**

Resident training occurs in the context of different disciplines and in a variety of structured clinical settings including inpatient, outpatient, long-term care, community clinics, and in newer modalities such as telemedicine settings. Although specific titles for positions within these settings may vary by facility and VISN, paragraphs 12 through 23 must be implemented.

## **12. RESPONSIBILITIES OF THE CHIEF ACADEMIC AFFILIATIONS OFFICER**

The Chief Academic Affiliations Officer is responsible for defining national policies pertinent to residents in VA medical facilities. The Chief Academic Affiliations Officer must complete an annual review of all VISN and facility reports submitted through the AR RTP process (RCN 10-0906). These results are shared with appropriate VHA leadership to ensure that VA continuously improves its ability to provide safe and effective patient care, while providing excellent educational opportunities for future practitioners. Applicable feedback is provided to VISNs and their respective facilities. The Chief Academic Affiliations Officer must present pertinent decision-making information to VHA's leadership.

## **13. RESPONSIBILITIES OF THE VETERANS INTEGRATED SERVICE NETWORK (VISN) DIRECTOR**

The VISN Director is ultimately responsible for addressing residency program needs and obligations in VISN planning and decision-making, and for making necessary resources available to the respective affiliated medical facilities to ensure resident supervision is provided

as outlined in this Handbook. Each VISN Director must appoint a Network Academic Affiliations Officer for coordination of regional education activities.

#### **14. RESPONSIBILITIES OF THE NETWORK ACADEMIC AFFILIATIONS OFFICER**

The Network Academic Affiliations Officer is responsible for assisting the VISN Director by:

- a. Completing a VISN-level AR RTP assessment of facility residency training activities identifying opportunities for improvement or areas that need further review, after a review of each facility's AR RTP (RCN 10-0906);
- b. Ensuring educational needs and obligations are considered in VISN planning and decision-making;
- c. Assisting medical facilities in implementing policies relating to health professions training;
- d. Coordinating and overseeing the annual resident allocation process;
- e. Providing guidance to VISN educational institutions;
- f. Guiding, coordinating, and assisting individual medical facilities in negotiating their specific affiliation agreements;
- g. Helping ensure VISN-wide educational goals are accomplished and that facilities comply with system-wide education policies (e.g., resident supervision); and
- h. Providing guidance and assistance to individual medical facilities in writing and ensuring implementation of local monitoring policies and procedures for resident supervision.

#### **15. RESPONSIBILITIES OF THE MEDICAL FACILITY DIRECTOR**

The Medical Facility Director is responsible for establishing local policy to fulfill the requirements of this Handbook and the applicable accrediting and certifying body requirements. The Medical Facility Director appoints and assigns the duties of the DEO to the appropriate local education leader and ensures that appropriate staff is available for monitoring resident supervision at the facility-level. The Medical Facility Director, through the DEO, must report annually to the VISN Director, or designee, the status of resident training programs in that medical facility. This reporting must take place through the AR RTP (RCN 10-0906).

#### **16. RESPONSIBILITIES OF THE FACILITY CHIEF OF STAFF (COS)**

The medical facility Chief of Staff (COS) is responsible for assessing the quality of residency training programs at the VA medical facility, and the quality of care provided by supervising practitioners and residents (see subpar. 9b for details on quality assessment).

*NOTE: An Associate Chief of Staff for Education (ACOS/E), or DEO, may assist the COS in fulfilling these requirements.*

### **17. RESPONSIBILITIES OF THE DESIGNATED EDUCATION OFFICER OR THE ASSOCIATE CHIEF OF STAFF FOR EDUCATION**

The DEO or the ACOS/E assists the COS in assessing the quality of residency training programs and the quality of care provided by supervising practitioners and residents. All facilities with more than a single residency program must have one designated responsible individual for these functions. This individual must ensure that:

- a. A facility resident supervision policy is in place;
- b. Graduated levels of responsibility are established in each specialty and/or subspecialty and the information regarding these levels is accessible to ward and clinic staff with a need to know;
- c. Facility monitoring and reporting requirements regarding training issues and resident supervision are met; and
- d. A process is established for monitoring resident supervision that results in identification of areas for improvement and facility action plans.

### **18. RESPONSIBILITIES OF THE PROGRAM DIRECTOR**

The Program Director is responsible for the quality of the overall education and training program in a given discipline (i.e., medicine, dentistry, optometry, or podiatry) and for ensuring that the program is in compliance with the policies of the respective accrediting and/or certifying bodies. The Program Director defines the levels of responsibilities for each year of training by preparing a description of the types of clinical activities residents may perform. *NOTE: In affiliated programs, the Program Director is customarily at the affiliated institution, but may also be a VA practitioner.*

### **19. RESPONSIBILITIES OF THE DEPARTMENT OF VETERANS AFFAIRS SITE DIRECTOR**

The VA Site Director is responsible for ensuring that supervising practitioners are appropriately fulfilling their responsibilities to provide supervision to residents and that ongoing evaluation of supervisors, residents, and the VA site are conducted. The VA Site Director:

- a. Ensures that residents function within their assigned graduated level of responsibility;
- b. Assesses the documentation and monitoring of resident supervision on VA rotations within the program by a systematic review process.

c. Structures training programs, in collaboration with the Program Director, consistent with the requirements of the accrediting and certifying bodies identified in subparagraph 3d and the affiliated participating entity.

d. Arranges and ensures that all residents participate in an orientation to VA policies, procedures, and the role of residents within the VA health care system; and

e. Ensures that residents are provided the opportunity to give feedback regarding their supervising practitioners, the training program, and the VA site. *NOTE: Facilities are encouraged to include resident representation on appropriate medical facility committees.*

## 20. RESPONSIBILITIES OF THE DESIGNATED INSTITUTIONAL OFFICIAL

The Designated Institutional Official (DIO) has the authority and responsibility for the oversight and administration of the sponsoring institution's ACGME accredited programs and is responsible for ensuring compliance with ACGME institutional requirements. The DIO reviews and co-signs all program information forms and documents submitted by the program directors that either address program citations or request changes in the programs that would have an impact on the educational program or the institution.

## 21. RESPONSIBILITIES OF THE SUPERVISING PRACTITIONER

The supervising practitioner is responsible for, and must be personally involved in, the care provided to individual patients in all clinical settings. Whenever a resident is involved in the care of a patient, the responsible supervising practitioner must continue to maintain a personal involvement in the care of the patient. A supervising practitioner must provide an appropriate level and intensity of supervision. Determination of the level and intensity of supervision is a function of the experience and demonstrated competence of the resident and of the complexity of the veteran's health care needs.

a. **General.** The supervising practitioner directs the care of the patient and provides the appropriate level and intensity of supervision based on the nature of the patient's condition, the likelihood of major changes in the management plan, the complexity of care, and the experience and judgment of the resident being supervised. All patient care services must be rendered under the supervision of the responsible practitioner or must be personally furnished by the supervising practitioner.

b. **Documentation.** Documentation of supervision must be entered into the health record by the supervising practitioner or reflected within the resident progress note. The health record must reflect the involvement of the supervising practitioner. *NOTE: Types of documentation are detailed in paragraph 5.*

## 22. ROLE OF THE CHIEF RESIDENT – IN TRAINING

In-training chief residents, while senior, are still considered residents and must be supervised by a supervising practitioner. Graduated levels of responsibility, however, may allow a wider scope of practice.

### 23. ROLE OF THE CHIEF RESIDENT – POST TRAINING

Post-training chief residents may function either as a trainee, as a staff physician and supervising practitioner, or as a hybrid trainee and supervising practitioner, depending on the type of personnel appointment, salary level and source, and privileges according to the following three options. *NOTE: The requirements for billing are outside the scope of this resident supervision Handbook. Refer to the most current VHA Directive on billing relating to guidance for services provided by supervising practitioners and residents.*

a. **Option 1. Chief Resident as Trainee.** Post-training chief residents may be paid as trainees at a trainee salary scale and have resident appointments. They neither need to go through the credentialing process nor have a full license to practice. These chief residents are bound by this Handbook and resident supervision standards.

b. **Option 2. Chief Resident as Staff Physician and Supervising Practitioner.** Post-training chief residents may be paid and appointed as staff physicians. They must go through the credentialing process, have full medical licensure, and be granted clinical privileges by VA to function independently within their specialty. These chief residents are authorized to:

- (1) Countersign other resident and student notes
- (2) Supervise other trainees; and in general;
- (3) Function as independent practitioners.

*NOTE: Supervision of residents is contingent upon assignment as a supervising practitioner or “faculty” by the Residency Program Director.*

c. **Option 3. Chief Resident as Hybrid Trainee and Supervising Practitioner.** Post-training chief residents may be paid as trainees, but also credentialed and privileged for independent practice. Intermittently, they may be allowed and/or required to function as supervising practitioners in either an inpatient or outpatient setting. In order to function as licensed independent practitioners, they must:

- (1) Go through the credentialing process;
- (2) Have full medical licensure; and
- (3) Be granted privileges by VA to function independently within their specialty.

Provided they have been assigned to serve as a supervising practitioner or “faculty” by the Residency Program Director, these chief residents are authorized to:

- (1) Countersign other resident and student notes;
- (2) Supervise other trainees; and

(3) Function as independent practitioners within the specialty for which they have independent privileges.

## 24. ROLE OF THE RESIDENT

Residents, as individuals, must be aware of their limitations and not attempt to provide clinical services or do procedures for which they are not trained. They must know the graduated level of responsibility described for their level of training and not practice outside of that scope of service. Each resident is responsible for communicating significant patient care issues to the supervising practitioner. Circumstances warranting immediate resident communication with the supervising practitioner include, *but are not limited to*: significant changes in patient status (e.g., requiring transfer to an intensive care unit); end of life decisions; use of restraints; and “near misses” or adverse events that may occasion a patient safety incident report. Such communication must be documented in the record. Residents must function within graduated levels of responsibility and communicate significant patient care issues to the responsible supervising practitioner. **NOTE:** *In some cases, residents, including chief residents, have completed one residency program and required training for board eligibility or board-certification while enrolled in an additional residency training program. These individuals (i.e., “fellows” or post-training chief residents) may be credentialed and privileged for independent practice only in the discipline in which they have attained board certification or have completed the training for board eligibility.*

## 25. REFERENCES

- a. Title 38 United States Code (U.S.C.) 7301(b).
- b. VHA Directive 1400, Office of Academic Affiliations.
- c. VHA Handbook 1101.04, Medical Officer of the Day.
- d. VHA Handbook 1907.01, Health Information Management and Health Records.
- e. VHA Handbook 1004.01, Informed Consent for Clinical Treatments and Procedures.
- f. VHA Handbook 1100.19, Credentialing and Privileging.
- g. VA Handbook 5021, Employee/Management Relations, Part VI, Paragraph 18, Separation of Medical and Dental Residents appointed under 38 U.S.C. 7406.
- h. Title 38 United States Code (U.S.C.) 5705.
- i. Bernard, J. M. and R. K. Goodyear. *Fundamentals of Clinical Supervision*. 2<sup>nd</sup> ed. Needham Heights, MA: Allyn & Bacon, 1998.
- j. Kashner, T. Michael et al. “Measuring Progressive Independence With the Resident Supervision Index: Empirical Approach.” *Journal of Graduate Medical Education*, 2 (2010): 17-30.

k. Accreditation Council of Graduate Medical Education's Common Program Requirements (effective July 1, 2011; see: <http://www.acgme.org/acgmeweb/>).

## GLOSSARY

1. **Chief Academic Affiliations Officer.** The Chief Academic Affiliations Officer is the national leader of Veterans Health Administration's (VHA) teaching mission. The Under Secretary for Health appoints the Chief Academic Affiliations Officer. The Chief Academic Affiliations Officer is responsible for the largest coordinated education and training effort for health care professionals in the Nation.
2. **Network Academic Affiliations Officer.** The Network Academic Affiliations Officer is the designated education leader at the Veterans Integrated Service Network (VISN) level with expertise in health professions education, who coordinates regional education activities. The assignment may be collateral, part-time or full-time, depending on the size and complexity of the VISN education programs.
3. **Department of Veterans Affairs (VA) Designated Education Officer (DEO).** The DEO is the single designated VA employee who has oversight responsibility for all clinical training at each VA facility that either sponsors or participates in accredited training programs. The DEO describes a functional assignment and not an organizational title. Each facility involved with residency programs must appoint a DEO for coordination of local graduate medical education (GME) and other education activities as assigned (see par. 15).
4. **Associate Chief of Staff for Education (ACOS/E).** The ACOS/E is a designated education leader with expertise in GME and health professions education. *NOTE: ACOS/E is the preferred organizational title for individuals assigned the responsibilities of the DEO role.*
5. **Designated Institutional Official (DIO).** The DIO is an individual employed by the sponsoring entity who has the institutional authority and responsibility for the oversight and administration of training in discipline-specific programs. Accreditation Council for Graduate Medical Education (ACGME) requires that each institution sponsoring ACGME-accredited programs have an individual appointed as the DIO. The DIO is responsible for ensuring compliance with ACGME institutional requirements. A VA facility that sponsors ACGME-accredited programs independently must have a DIO, although the responsibilities and functions overlap with those described for the DEO (see par. 17 and par. 20).
6. **Program.** A program is a structured, accredited educational experience in graduate medical, dental, podiatry, or optometry education designed to conform to the program requirements of a particular specialty/subspecialty, the satisfactory completion of which may result in eligibility for board certification.
7. **Program Director.** The Program Director is the one person designated with authority and accountability for the operation of the accredited residency or fellowship program. The Program Director is responsible for full compliance with standards of accrediting and certifying bodies (see subpar. 3d).
8. **VA Residency Program Site Director.** In accordance with accrediting and certifying body requirements, appropriately-credentialed local VA clinicians are appointed as VA

residency training program site directors for each residency training program. In affiliated programs, these designations must be made with the concurrence of the sponsoring entity of the residency program. The VA Residency Program Site Director (henceforth referred to as the VA Site Director) is responsible for the management and monitoring of training program activities at the VA site.

9. **Supervising Practitioner.** Supervising practitioner refers to licensed, independent physicians, dentists, podiatrists, and optometrists, regardless of the type of appointment, who have been credentialed and privileged at a VA facility in accordance with applicable requirements. A supervising practitioner must be approved by the sponsoring entity in order to supervise residents. In some training settings and according to the requirements of the accrediting body, other health care professionals with documented qualifications and appropriate academic appointments (i.e., psychologists, audiologists), may function as supervising practitioners for selected training experiences. Supervising practitioners can provide care and supervision only for those clinical activities and in those clinical settings for which they have clinical privileges and for residents in programs with whom they have a clearly documented relationship. For example, while a rheumatologist could supervise a podiatry resident on a rheumatology clinic elective or on an inpatient internal medicine rotation, a rheumatologist could not be the supervising practitioner for a podiatry resident in podiatry clinic or in the operating room. Likewise, an oral surgery resident rotating on an internal medicine service could not provide oral surgery services when under the supervision of a general internist. Also, a hospitalist, emergency department physician, or anesthesiologist may directly supervise a first post-graduate year (PGY-1) (see subpar. j(1) of this Appendix) surgery resident for non-surgical patient management when there are appropriately documented relationships in place. **NOTE:** *The term “supervising practitioner” is synonymous with the term “attending” or “faculty.” ACGME defines supervising “faculty” as “any individuals who have received a formal assignment to teach resident physicians.” Per accreditation requirements, the Program Director at the sponsoring entity determines the assignment to teach and supervise residents. Appointment or assignment of supervising practitioners needs to be coordinated with the Program Director, the VA Site Director, the applicable VA Service Chief, and the affiliated Department Chair as appropriate. The specific VA staff approved to supervise residents should be delineated in the Program Letter of Agreement.*

10. **Resident.** The term “resident” refers to an individual who is engaged in an accredited graduate training program for physicians, dentists, optometrists, and podiatrists, and who participates in patient care under the direction of supervising practitioners. **NOTE:** *For the purpose of this Handbook, the term “resident” includes individuals in their first year of training, who are sometimes referred to as “interns,” and individuals in approved subspecialty graduate medical education programs, who are also referred to as “fellows.”*

(a) **PGY-1 resident.** PGY-1 residents are in their first post-graduate year (PGY) of training. **NOTE:** *Sometimes referred to as “interns.”*

(b) **Intermediate Resident.** Intermediate resident refers to a second post-graduate year (PGY-2) or higher resident through the next to final year of core training.

(c) **Senior Resident.** Senior resident refers to residents in their final accredited year of core residency training.

(d) **Fellow.** Fellow refers to a physician, dentist, podiatrist, or optometrist in a program of accredited graduate education who has completed the requirements for eligibility for first board certification in the specialty. The term “subspecialty residents” is also applied to such physicians. Other uses of the term "fellow" require modifiers for precision and clarity, e.g., research fellow. **NOTE:** *The terms “fellow” and “resident” in this Handbook do NOT refer to VA Advanced Fellows or fellows in non-accredited programs.*

#### 11. **“Night Float” and “Over Cap” residents**

(a) **“Night float.”** In some programs, residents are assigned to cover evening or night admissions for an entire shift. Such residents may be called “night floats.” “Night float” may be an assigned rotation with the number of consecutive nights on duty not to exceed accreditation standards.

(b) **“Over Cap” residents.** An “over cap” resident (or similar designation) is on-call (generally from home) to come to the medical facility to admit patients when the number of admissions exceeds the limits (or “caps”) set by the accrediting body.

12. **Chief Resident.** The Chief Resident is an individual who is considered senior in the training program and who may or may not be a licensed independent practitioner. Chief residents are designated by the Program Director and may assume advanced administrative responsibilities necessary for the operation of the residency program. Chief residents fall into one of two categories:

(a) **Chief Resident – In Training.** In-training chief residents are currently enrolled in an accredited residency program, but have not completed the full academic program leading to board eligibility. These chief residents are not independent and cannot be privileged to work in the discipline for which they are being trained. This model is common in surgery programs. **NOTE:** *Such chief residents are sometimes referred to as “Embedded Chief Residents.”*

(b) **Chief Resident – Post Training.** Post-training chief residents have completed an accredited residency program and engage in an additional year of training and responsibility. These chief residents have completed training for board-eligibility or are board-certified and are able to be privileged in the discipline of their completed specialty-training program. These chief residents are frequently licensed independent practitioners. This model is common in internal medicine programs.

13. **VA Advanced Fellow.** VA Advanced Fellow refers to a VA-based physician or dentist trainee who has enrolled in a VA Advanced Fellowship Program for additional training, primarily in research. Advanced fellowships are non-accredited training programs that are funded directly from the Office of Academic Affiliations in a separate allocation process from accredited residency positions. Physicians in VA Advanced Fellowships have completed an ACGME-accredited core residency (medicine, surgery, psychiatry, etc.) and may also have

completed an accredited sub-specialty fellowship. They are board-eligible or board-certified, and consequently, are licensed independent practitioners. Dentists in VA Advanced Fellowships have completed a Commission on Dental Accreditation (CODA)-accredited residency and are licensed independent practitioners. Similar requirements apply to any optometrist or podiatrist VA Advanced Fellows. All VA Advanced Fellows must be credentialed and privileged in the discipline(s) of their completed programs. VA Advanced Fellows may function as supervising practitioners for other trainees.

14. **Graduate Medical Education (GME).** GME programs focus on the development of clinical skills, attitudes, and professional competencies, and an acquisition of detailed factual knowledge in a medical specialty. GME is the process by which clinical and didactic experiences are provided to residents enabling them to acquire those skills, knowledge, and attitudes, which are important in the care of patients. The purpose of GME is to provide an organized and integrated educational program providing guidance and supervision of the resident, to facilitate the resident's professional and personal development, and to provide safe and appropriate care for patients.

15. **Patient Care.** Patient care is the performance of patient-related services (including but not limited to preventive services, evaluation and management, diagnostic and therapeutic procedures, and examination of patient specimens or images) for the purpose of improving health or enhancing patient and population health outcomes.

16. **Supervision.** Supervision is an intervention provided by a supervising practitioner (attending) that occurs as residents provide patient care through direct or indirect contacts with patients. The relationship of the supervising practitioner to the resident is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the resident while monitoring the quality of professional services delivered. Supervision is exercised through direct involvement with the patient and resident, observation of care provided by the resident, oversight of patient care, directing the learning of the resident, and role modeling communication and professional skills. *NOTE: This definition is adapted from Bernard, J. M., & Goodyear, R. K., Fundamentals of Clinical Supervision (2<sup>nd</sup> ed.). Needham Heights, MA: Allyn & Bacon 1998. Supervision occurs in the context of the provision of patient care and implies responsibility for patient care. In contrast, didactic teaching, mentoring, and evaluation, even when based on consideration of patient cases or other clinical material (e.g., non-current imaging or case files), are not considered to involve "supervision" for the purpose of this Handbook. Level of supervision refers to the type of involvement of the supervising practitioner with the resident during the patient encounter, procedure, or episode of care.*

(a) "Direct Supervision" means the supervising practitioner is either physically present with the resident and the patient or is included in direct forms of communication with the resident and patient, such as voice and tele-video conferencing. In direct supervision, the supervising practitioner is a party to the patient encounter between the patient and a resident even if the "encounter" with the patient is non-face-to-face. *NOTE: Text messaging, voice messaging, emails, or written letters, are not considered supervision.* Direct supervision can be further characterized by the level of attending involvement according to whether the supervising practitioner:

1. Provides care with the resident observing or assisting;
2. Participates in care which is provided by the resident; and
3. Observes while the resident provides care.

(b) “Indirect supervision” is defined as supervision exercised by a supervising practitioner who is not physically present with the resident and the patient during the patient encounter, procedure, or episode of care. In all such instances, the supervising practitioner is either located in the same site of patient care or is on-call by means of telephonic and/or electronic modalities for consultation. In such instances, the supervising practitioner must be available in a timely manner to participate in patient care or direct supervision, as needed. The supervising practitioner may be:

1. In the same site of patient care (i.e., clinic, inpatient unit, imaging, laboratory, surgical, or procedural suite) in which the resident is engaged in patient care;
2. In another location within the VA medical facility or its clinical campus, generally referred to as “in-house” or “on-site;” or
3. Not present in the VA medical facility or its clinical campus, generally referred to as “off-site.”

(c) “Oversight” refers to information-gathering activities on the part of the supervising practitioner, such as review of procedures, documentation of encounters, imaging, laboratory, and consultation with other practitioners or clinical personnel. Oversight is intended to gather information either before or after resident-delivered care, in order to assess the patient’s clinical progress, or to evaluate the performance and professional development of the resident as pertaining to the care the patient received or to provide information that is likely to inform and guide the resident’s patient encounter.

***NOTE:** The definitions of levels and intensity of supervision are adapted from VA’s Resident Supervision Index (Kashner, et al., JGME 2: 17-30, 2010), currently called the VA’s Clinical Supervision Index, and ACGME’s Common Program Requirements (effective July 1, 2011).*

17. **Documentation.** Documentation is the written or electronic patient health record evidence of a patient encounter. In terms of resident supervision, documentation is the written or electronic health record evidence of the interaction between a supervising practitioner and a resident concerning a patient encounter.

18. **Electronic signature.** VA’s electronic health record defines three types of electronic signature (see VHA Handbook 1907.01, Health Information Management and Health Records).

- (a) A "signer" is the author of the document.

(b) A "co-signer" is the supervising practitioner. A co-signer may also be a service chief, or designee, as defined by the organization's bylaws and/or policies.

(c) "Identified signer" and "additional signer" are synonymous and either is a communication tool used to alert a clinician about information pertaining to the patient. This functionality is designed to allow clinicians to call attention to specific documents and for the recipient to acknowledge receipt of the information. Being identified as an additional signer neither constitutes a co-signature nor implies responsibility for the content of or concurrence with the note. **NOTE:** *"Identified signer" is nomenclature used by the Computerized Patient Record System (CPRS), Veterans Health Information Systems and Technology Architecture (VistA), and Text Integration Utilities (TIU); "additional signer" is nomenclature used by graphic user interface (GUI).*

19. **Observation Patient.** An observation patient is one who presents with a medical condition showing a significant degree of instability, needs to be monitored and evaluated, receives ongoing short-term treatment, assessment, and re-assessment while a decision is being made as to whether the patient requires further treatment as a medical facility inpatient, and is held in an "observation bed" for less than 24 hours.