

RESIDENT SUPERVISION

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

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

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

b. Enhances the description of supervision and the documentation requirements in various settings;

c. Reflects new standards for documentation of new outpatient encounters;

d. Reflects the level of documentation needed for intensive care unit inpatient settings;

e. Reflects the level of documentation needed for inter-service or inter-ward transfers and from one level of care to another; and

f. Provides a definition and functional description of the Department of Veterans Affairs (VA)-based designated education officer (DEO) and the ACGME functional description for the designated institutional official (DIO).

3. RELATED ISSUES. VHA Directive 1400. ***NOTE:** See the most current VHA Directive on Billing for VHA policy regarding billing procedures for resident-related care.*

4. RESPONSIBLE OFFICIALS. The Chief Academic Affiliations Officer (14) is responsible for the contents of this Handbook. Questions may be referred to (202) 273-8946.

5. RECISSIONS. VHA Handbook 1400.1, dated May 3, 2004, is rescinded.

6. RE-CERTIFICATION. This VHA Handbook is scheduled for re-certification on or before the last working day of May 2010.

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RESIDENT SUPERVISION

1. PURPOSE

This Veterans Health Administration (VHA) Handbook provides the procedural requirements pertaining to the supervision of residents and focuses on resident supervision from the educational perspective. **NOTE:** *This Handbook applies to residents in medicine, dentistry, optometry, and podiatry. See the most current VHA Directive on Billing for VHA policy regarding billing procedures for resident-related care.*

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 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 on Accreditation of Healthcare Organizations (JCAHO) 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. **NOTE:** *Policy and procedural requirements pertaining to the supervision of medical students and trainees in other disciplines are addressed in VHA Manual M-8, Part II, or superseding Handbook.*

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 supervision of the residents as they acquire the skills to practice independently.

3. SCOPE

The provisions of this Handbook are applicable to patient care services including, but not limited to inpatient care, outpatient care, community and long-term care, emergency 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 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 be sure 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 training program, all residents must function under the supervision of supervising practitioners. Services that provide 24-hour, 7-day a week (24/7) resident coverage and call schedules must be provided to the medical center administration. Call schedules are to delineate both resident and attending coverage.

c. Each training program is constructed to encourage and permit residents to assume increasing levels of responsibility commensurate with their individual progress in experience, skill, knowledge, and judgment. **NOTE:** *The determination and documentation of graduated levels of responsibility are outlined in paragraph 6.*

d. Each facility must adhere to current accreditation requirements as set forth by the ACGME, Commission on Dental Accreditation (CDA), 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. The 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), CDA, 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 a certifying examination.

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 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 the coordination of care that is provided to patients.

g. Facilities must ensure that their training programs 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. DEFINITIONS

a. **Chief Academic Affiliations Officer.** The Chief Academic Affiliations Officer is the national leader of VHA's teaching mission. The Under Secretary for Health appoints the Chief of the Office of Academic Affiliations, VHA, Washington, DC. The Chief Academic Affiliations Officer is responsible for the largest coordinated education and training effort for health care professionals in the nation.

b. **Network Academic Affiliations Officer.** The Network Academic Affiliations Officer is a designated education leader at the Veterans Integrated Services Network (VISN) level with expertise in Graduate Medical Education (GME). Each VISN must appoint a Network Academic Affiliations Officer for coordination of certain regional education activities. This assignment may be collateral, part-time, or full time, depending on the size and complexity of the VISN education programs.

c. **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 title for this education leader may be the Associate Chief of Staff for Education, Director of Education, Chief Education Service Line, or other similar title. *NOTE: 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 GME and other education activities as assigned (see subpar. 5d).*

d. **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.*

e. **Designated Institutional Official (DIO).** The DIO is an individual employed by the sponsoring entity who has the authority and responsibility for the oversight and administration of trainees in discipline-specific programs. 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. *NOTE: 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. 5).*

f. **Residency Program Director.** The Residency Program Director is the education leader with full authority and responsibility for the administration of a single residency program in a specialty or subspecialty. The Residency Program Director is responsible for full compliance with standards of accrediting and certifying bodies (see subpar. 3d).

g. **VA Residency Program Coordinator.** In accordance with accrediting and certifying body requirements, appropriately-credentialed local VA clinicians are appointed as VA residency training program coordinators 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 Coordinator is responsible for the management and monitoring of training program activities at the VA site.

h. **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 VA medical centers in accordance with applicable requirements. A supervising practitioner must be approved by the sponsoring entity in order to supervise residents. In some training settings, 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 for which they have clinical privileges. ***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. In the absence of a formal academic appointment as faculty with the sponsoring entity, written documentation of approval and assignment to supervise residents from the Program Director is required in order to supervise residents. Appointment or assignment of supervising practitioners needs to be coordinated with the Program Director, the VA Program Coordinator, the applicable VA Service Chief, and the affiliated Department Chair as appropriate.*

i. **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 Residency Program Director and may assume advanced administrative responsibilities necessary for the operation of the residency program. Chief residents fall into one of two categories:

(1) **Chief Resident – In Training.** Chief residents who are currently enrolled in an accredited residency program, but who 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.

(2) **Chief Resident – Post Training.** Chief residents who have completed an accredited residency program, but engage in an additional year of training and responsibility. These chief residents are board-eligible or 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.

j. **VA Special Fellow.** The term VA Special Fellow refers to a VA-based physician or dentist trainee who has enrolled in a VA Special Fellowship Program for additional training, primarily in research. Special fellowships are non-accredited training programs that are funded directly from the Office of Academic Affiliations in a separate allocation process from residency

positions. Physicians in VA Special Fellowships have completed an ACGME-accredited core residency (medicine, surgery, psychiatry, etc.) and may also have completed an accredited subspecialty fellowship. They are board-eligible or board-certified, and consequently, are licensed independent practitioners. Dentists in VA Special Fellowships have completed a CDA-accredited residency and are licensed independent practitioners. All VA Special Fellows must be credentialed and privileged in the discipline(s) of their completed (subspecialty-training) programs. VA Special Fellows may function as supervising practitioners for other trainees.

k. **Resident.** The term ‘resident’ refers to an individual who is engaged in a graduate training program in medicine (which includes all specialties like internal medicine, surgery, psychiatry, radiology, nuclear medicine, etc.), dentistry, podiatry, or optometry, and who participates in patient care under the direction of supervising practitioners. Such programs must be accredited or certified as appropriate and as described in subpar. 3d. ***NOTE: The term “resident” includes individuals in their first year of training often referred to as “interns” and individuals in approved subspecialty graduate medical education programs who historically have also been referred to as “fellows” by some sponsoring institutions.***

l. **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 clinical 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.

m. **Supervision.** Supervision is an intervention provided by a supervising practitioner to a resident. This relationship 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 observation, consultation, directing the learning of the resident, and role modeling. ***NOTE: This definition is adapted from Bernard, J. M., & Goodyear, R. K., Fundamentals of Clinical Supervision (2nd ed.). Needham Heights, MA: Allyn & Bacon 1998.***

n. **Documentation.** Documentation is the written or computer-generated medical record evidence of a patient encounter. In terms of resident supervision, documentation is the written or computer-generated medical record evidence of the interaction between a supervising practitioner and a resident concerning a patient encounter.

o. **Electronic signature.** VA’s electronic health record defines three types of electronic signature (see VHA Handbook 1907.1)

(1) A "signer" is the author of the document.

(2) 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.

(3) “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 does not constitute a co-signature. This nomenclature in no way 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)*.

5. ROLES AND RESPONSIBILITIES

Resident training occurs in the context of different disciplines and in a variety of appropriately structured clinical settings, including inpatient, outpatient, long-term care, and community settings. Although specific titles for positions within these settings may vary by facility and VISN, the following functions must be implemented:

a. **Chief Academic Affiliations Officer.** The Chief Academic Affiliations Officer is responsible for defining national policies pertinent to residents in VA medical centers. The Chief Academic Affiliations Officer must complete an annual review of all VISN and facility reports submitted through the Annual Report on Residency Training Programs (ARRTP) process (Report Control Number (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.

b. **VISN Director.** The VISN Director is ultimately responsible for addressing GME and other residency program needs and obligations in VISN planning and decision-making, and making necessary resources available to the respective affiliated medical centers to ensure resident supervision is provided as outlined in this Handbook.

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

(1) Reviewing each facility’s Annual Report on Resident Training Programs (RCN 10-0906) to identify opportunities for improvement or areas that need further review.

(2) Preparing a summary report that is provided to VHA Central Office.

(3) Ensuring that educational needs and obligations are considered in VISN planning and decision-making.

(4) Assisting medical centers in implementing graduate training policies.

(5) Coordinating and overseeing the annual resident allocation process.

(6) Providing guidance to network educational institutions.

(7) Guiding, coordinating, and assisting individual medical centers in negotiating their specific affiliation agreements.

(8) Helping ensure network-wide educational goals are accomplished and comply with system-wide education policies (e.g., resident supervision).

(9) Providing guidance and assistance to individual medical centers in writing and implementing their local monitoring policies and procedures for resident supervision.

d. **Medical Center Director.** The medical center Director is responsible for establishing local policy to fulfill the requirements of this Handbook and the applicable accrediting and certifying body requirements. The medical center Director appoints or assigns the duties of the DEO to the appropriate local education leader. ***NOTE:** When possible, the local policy needs to be consistent with the policies of the affiliated schools or universities. If there is a discrepancy between policies, VA policy takes precedence.*

e. **Chief of Staff (COS).** The medical center 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. 11b for details on quality assessment). ***NOTE:** An ACOS for Education, or DEO, may assist the COS in fulfilling these requirements.*

f. **Designated Education Officer (DEO) or ACOS/E.** 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. This individual is also responsible for ensuring that:

(1) A facility resident supervision policy is in place.

(2) Graduated levels of responsibility are established in each specialty and/or subspecialty.

(3) Facility monitoring and reporting requirements regarding training issues and resident supervision are met.

(4) A process is established for monitoring resident supervision that results in identification of areas for improvement and facility action plans.

***NOTE:** All facilities with more than a single residency program must have one designated responsible individual for these functions.*

g. **Residency Program Director.** The Residency Program Director is responsible for the quality of the overall education and training program in a given discipline (i.e., medicine, dentistry, optometry, and podiatry) and for ensuring that the program is in compliance with the policies of the respective accrediting and/or certifying bodies. The Residency 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 Residency Program Director is customarily at the affiliated institution, but may also be a VA practitioner.*

h. **VA Residency Program Coordinator.** The VA Residency Program Coordinator 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 Residency Program Coordinator is responsible for ensuring that residents function within their assigned graduated level of responsibility, and is responsible for:

- (1) Assessing resident supervision within the program via a systematic review process.
- (2) Structuring training programs consistent with the requirements of the accrediting and certifying bodies identified in subparagraph 3d and the affiliated participating entity.
- (3) Arranging and ensuring that all residents participate in an orientation to VA policies, procedures, and the role of residents within the VA health care system.
- (4) Ensuring 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 center committees.***

i. **Designated Institutional Official (DIO).** The 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 addresses program citations or request changes in the programs that would have an impact on the educational program or the institution.

j. **Supervising Practitioner.** The supervising practitioner is responsible for, and must be personally involved in, the care provided to individual patients in inpatient and outpatient settings as well as long-term care and community settings. When a resident is involved in the care of the 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 of supervision. Determination of this level 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.

(1) **General.** The supervising practitioner directs the care of the patient and provides the appropriate type 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 services must be rendered under the supervision of the responsible practitioner or must be personally furnished by the supervising practitioner.

(2) **Documentation.** Documentation of supervision must be entered into the medical record by the supervising practitioner or reflected within the resident progress note. The medical record needs to reflect the involvement of the supervising practitioner. ***NOTE: Types of documentation are discussed in paragraph 7.***

k. **Chief Resident – In Training.** These chief residents, while quite senior, are still considered residents and must be supervised by a supervising practitioner. Graduated levels of responsibility, however, may allow a wide range of practice.

l. **Chief Resident – Post Training.** These 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 current VHA Directive for billing policy.***

(1) **Option 1. Chief Resident as Trainee.** Chief residents may be paid as trainees at a trainee salary scale and have resident appointments. They do not 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.

(2) **Option 2. Chief Resident as Staff Physician and Supervising Practitioner.** Chief residents may be paid and appointed as staff physicians. They must go through the credentialing process, have full medical licensure, and be granted privileges by VA to function independently within their specialty. These chief residents may countersign other resident and student notes, supervise other trainees, and in general, function as independent practitioners. Supervision of residents is contingent upon assignment as a supervising practitioner or “faculty” by the Residency Program Director.

(3) **Option 3. Chief Resident as Hybrid Trainee and Supervising Practitioner.** 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 go through the credentialing process, have full medical licensure, and be granted privileges by VA to function independently within their specialty. These chief residents may countersign other resident and student notes, supervise other trainees, and function as independent practitioners within the specialty for which they have independent privileges, provided they have been assigned to serve as a supervising practitioner or “faculty” by the Residency Program Director.

m. **Resident.** The 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. Such communication must be documented in the record. Failure to function within graduated levels of responsibility or to communicate significant patient care issues to the responsible supervising practitioner may result in the removal of the resident from VA patient care activities. ***NOTE: In some cases, residents including chief residents have completed one residency program and are board-eligible or board-certified while enrolled in an additional residency training program. These individuals may be credentialed and privileged for independent practice only in the discipline of their board eligibility or certification.***

6. GRADUATED LEVELS OF RESPONSIBILITY

a. As part of their training program, 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, however, residents are allowed to 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.

b. The Residency 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 Residency Program Director makes this list of graduated levels of responsibility available to other 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 Residency Program Coordinator, service chief, and COS. The Residency 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.

7. DOCUMENTATION OF SUPERVISION OF RESIDENTS

a. **Supervising Practitioner Involvement.** The medical record must clearly demonstrate the involvement of the supervising practitioner in each type of resident-patient encounter described in subparagraphs 7c and 7d. ***NOTE:*** *Documentation requirements are outlined in subparagraph 7b.*

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

(1) Types of allowable documentation are:

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

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

(c) Co-signature of the progress note or other medical record entry by the supervising practitioner. ***NOTE:*** *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 CPRS is not an acceptable form of documenting resident supervision. (See VHA Handbook 1907.1)

(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 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 7c . 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). **NOTE:** *An independent note or addendum by the supervising practitioner is required for inpatient admissions, pre-operative assessment, and extended care admissions. 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 or local medical staff bylaws.*

c. Patient Settings

(1) **Inpatient Care**

(a) Inpatient Admission. For patients admitted to an inpatient service of the medical center, 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 by the end of the calendar day following admission. If the specific requirements of the pre-operative notes are included, the admission note (or addendum) may also serve as the pre-operative note. **NOTE:** *The time requirement for seeing and evaluating the patient (per JCAHO guidelines) is different from that of documentation in the medical record by the supervising practitioner. Use of appropriate note titles in CPRS is encouraged.*

(b) Night Float Admissions. For patients admitted to an inpatient service of the medical center, a "night float" resident occasionally provides care before the patient is transferred to an inpatient ward team. In these cases, the supervising practitioner 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, the supervising practitioner for night float admissions must be clearly designated by local policy. **NOTE:** *Documentation requirements are the same as in preceding subparagraph 7c(1)(a).*

(c) Continuing Care of Inpatients. Supervising practitioners are expected to 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 subpar. 7b(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 center is appropriate and based on the specific circumstances of the patient's diagnoses and therapeutic regimen; this may include physical activity, medications, diet, functional status, and follow-up plans. Evidence of this assurance must be documented by the supervising practitioner's countersignature of the discharge summary or discharge note.

(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. 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 subpar. 7c(1)(a) and 7c(3)(a). **NOTE:** *This provision covers transfers into and out of intensive care units or transfers to extended care. The only exception is whenever the same supervising practitioner is responsible for the patient across different levels of care.*

(f) Inpatient Consultations. A supervising practitioner is responsible for clinical consultations from each specialty service. When residents are involved in consultation services, the supervising practitioner is responsible for supervision of these residents. **NOTE:** *Any of the four types of documentation referenced in subpar. 7b(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 center, 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 1 day of admission. Because of the unstable nature of patients in ICUs, frequent evidence of involvement of the supervising practitioner is expected. **NOTE:** *Supervising practitioner involvement is expected on a daily or more frequent basis and may be documented using any of the four types of documentation referenced in subpar. 7b(1).*

(2) Outpatient Clinic

(a) Physical Presence. The supervising practitioner must be physically present in the clinic area during clinic hours.

(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 according to subpars. 7b(1)(a), 7b(1)(b), or 7b(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 clinical consultations from each outpatient clinic to another supervising practitioner within the local facility. When residents are involved in consultation services, the supervising practitioner is responsible for supervision of these residents. **NOTE:** *Any of the four types of documentation referenced in subpar. 7b(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 subpar. 7b(1) is acceptable.*

(e) Discharge from Outpatient Clinic. The supervising practitioner, in consultation with the resident, ensures that the discharge of the patient from clinic is appropriate. **NOTE:** *Any of the four types of documentation referenced in subpar. 7b(1) is acceptable.*

(3) Extended Care (Nursing Homes)

(a) New Extended Care Admissions. Each new patient admitted to an extended care facility must be seen by the responsible supervising practitioner within 72 hours of admission. **NOTE:** *Any of the first two types of documentation referenced in subpar. 7b(1) is acceptable.*

(b) Continuing Care in the Extended Care 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 subpar. 7b(1) is acceptable.*

(4) Emergency Department

(a) Physical Presence. The supervising practitioner for the emergency department must be physically present in the emergency department.

(b) Emergency Department Visits. Each new patient to the emergency department must be seen by or discussed with the supervising practitioner. **NOTE:** *Documentation of supervising practitioner involvement must be according to subpars. 7b(1)(a), 7b(1)(b), or 7b(1)(d).*

(c) Discharge from the Emergency Department. The supervising practitioner, in consultation with the resident, ensures that the discharge of the patient from the emergency department is appropriate. **NOTE:** *Any of the four types of documentation referenced in subpar. h 7b(1) is acceptable.*

(d) Emergency Department Consultations. A 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 are expected to contact their supervising practitioners while the patient is still in the emergency department in order to discuss the case and to develop and recommend a plan of management. The emergency room practitioner is responsible for the disposition of the patient. **NOTE:** *Any of the four types of documentation referenced in subpar. 7b(1) is acceptable. The emergency room 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. 7c(5)(a) – 7c(5)(c)).

(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/or choice of specific procedure to be done. This pre-procedural evaluation and note may be done up to 30 days in advance of the surgical procedure. All applicable JCAHO standards concerning documentation must be met. **NOTE:** *A pre-procedure note may also serve as the admission note if it is written within 1 calendar day 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. 7c(1)(a)). 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 JCAHO, 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 1004.1.

(c) **Veterans Health Information Systems 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 via 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 immediately available for resident supervision or consultation as needed.

5. **Level E: Emergency Care.** Immediate care is necessary to preserve life or prevent serious impairment. The supervising practitioner has been contacted (see par. 8).

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

(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. 7c(1)-7c(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, chemotherapy, radiation therapy) 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. 6). Documentation standards must follow the setting-specific guidelines (see subpars. 7c(1)-7c(5)). ***NOTE: Documentation of the degree of supervising practitioner involvement is encouraged. Any of the four types of documentation referenced in subparagraphs 7b is acceptable. With respect to 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 need to be present during the administration of either chemotherapy or radiation therapy since therapy delivery is a function of associated health personnel.***

8. EMERGENCY SITUATIONS

An “emergency” is defined as a situation where immediate care is necessary to preserve the life of or to prevent serious impairment of the health of a patient. In such situations, any resident, assisted by medical center personnel, is (consistent with the informed consent provisions of VHA Handbook 1004.1) 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.

9. SUPERVISION OF PHYSICIAN RESIDENTS PROVIDING EMERGENCY CARE COVERAGE

a. **Emergency Department Physician (sometimes called the Admitting Officer of the Day)** Physicians providing independent Emergency Department coverage must be credentialed, privileged, and fully licensed. **NOTE:** *PGY-3 and above residents are normally subject to the same supervisory requirements as specified in subparagraph 9b(1). However, in a critical staffing emergency situation, permission to use a PGY-3 and above, non-board-eligible resident for sole, unsupervised coverage may be requested from the respective 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. 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).*

b. Supervision of PGY-4 and above Board-Certified or Board-Eligible Residents

(1) Physician residents who are board-certified or board-eligible may be privileged as independent practitioners for purposes of Emergency Department coverage. Privileges sought and granted may only be those delineated within the general category for which the resident is board-certified or board-eligible.

(2) Residents who are appointed as such, outside the scope of their training program (i.e., fee basis), 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 appointment and are subject to the provisions contained in VHA Handbook 1100.19. Specialty privileges, which are within the scope of the resident's training program, may not be granted. **NOTE:** *Refer to paragraph 6 for assigning, as appropriate, graduated levels of responsibility for activities within the scope of training.*

10. 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 done. Residents may be dismissed from VA assignment in accordance with VA Handbook 5021, Part VI, paragraph 18, 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 the supervising practitioner(s) and the VA training site(s). 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 and/or VA Residency Program Coordinator in a manner and timetable agreeable to both.

11. MONITORING PROCEDURES

a. **Goals and Objectives**

(1) The goal of monitoring resident supervision is to foster a system-wide environment of peer learning 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 basic 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) The quality and safety of patient care involving residents.
- (b) VHA's educational environment and culture of learning.
- (c) The documentation of resident supervision.
- (d) The systems of care involving residents.

(4) The monitoring of resident supervision is a medical 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. **Responsibilities of the VA Medical Center**

Resident training occurs in the context of different disciplines and in a variety of appropriately structured clinical settings, including inpatient, outpatient, extended care, and community 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 center Director is responsible for ensuring that a local monitoring process exists for resident supervision. The monitoring process must include the following:

(a) Creation of 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 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.
5. Consultative care involving residents.
6. Surgical care involving residents including a review of the appropriateness of Levels E and F (see subpar. 7c(5)(i)).

***NOTE:** The first five of the preceding elements (subpars. 11b(2)(a)1 through 11b(2)(a)5) may be monitored using sampling techniques. For element 6, each instance of surgical care performed at levels E and F (as coded in the VistA surgical package) must be reviewed.*

(b) Review of quality improvement data (protected by 38 U.S.C. 5705 and its revised implementing regulations and current VA policy):

1. Results of medical 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

6. Review of reports by accrediting and certifying bodies.

(c) Review of residents' comments related to their VA experience, if available.

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

(e) Completion of the yearly Annual Report on Residency Training Programs (RCN 10-0906).

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. **Responsibilities of the VISN.** VISN monitoring processes for resident supervision are 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 center has a monitoring process in place as detailed in subpar. 11b.

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

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

d. **Responsibilities of VHA Central Office.** 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, develops measures of appropriate and timely resident supervision using methodologically sound sampling and reporting procedures

(2) EPRP and other nationally-contracted abstractors must complete medical record reviews using methodologically sound sampling procedures. Data are reviewed quarterly and evaluated annually.

(3) National Surgical Quality Improvement Project (NSQIP) data are reviewed quarterly and evaluated annually.

(4) Annual Review of Residency Training Programs (RCN 10-0906) is reviewed and evaluated annually.

(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 appropriate.

(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.*

12. ANNUAL REPORT ON RESIDENCY TRAINING PROGRAMS (ARRTP) (RCN 10-0906)

a. **Description.** The AR RTP (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 center's monitoring processes. The information is requested from each affiliated VA facility for all resident training programs (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, and 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.

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. 11).

(5) Facility response to local and/or national information about resident experiences and perceptions.

(6) Identification of opportunities for improvement with action plans.

c. **Responsibilities**

(1) **Medical Center Director.** Where residents are present, the DEO through the COS and the medical center Director, must report annually to the VISN Director, or designee, the status of

resident training programs in that medical center. This reporting must take place through the AR RTP (RCN 10-0906) process.

(2) **VISN Director.** The VISN Director, in conjunction with the Network Academic Affiliations Officer, must complete an annual review of facility residency training activities throughout the VISN, identifying opportunities for improvement or areas that need further review. VISN reviews must be submitted to the Office of Academic Affiliations through the AR RTP (RCN 10-0906) process.

(3) **Chief Academic Affiliations Officer.** The Chief Academic Affiliations Officer must complete an annual review of all VISN and facility reports through the AR RTP (RCN 10-0906) process and share the results of the review with appropriate VHA leaders to demonstrate that VA continuously improves its ability to provide safe and effective patient care while providing excellent educational opportunities for future practitioners. The Chief Academic Affiliations Officer is responsible for presenting pertinent decision-making information to VHA's leaders.