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# VA Central Iowa Health Care System: Chiropractic Residency Handbook

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Sponsor: VA Central Iowa Health Care System

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Academic Affiliate: Palmer College of Chiropractic

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# Program Overview

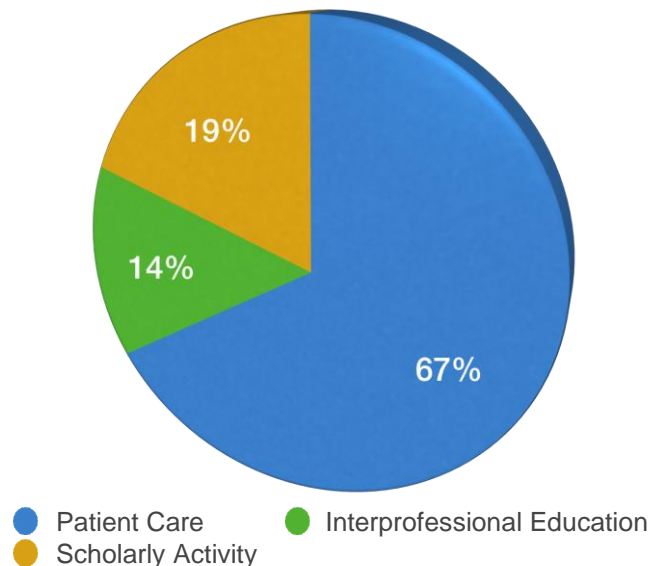
The VA Central Iowa Health Care System (VACIHCS) Chiropractic Integrated Clinical Practice Residency Program provides the resident with extensive clinical experience in hospital-based chiropractic care, including the full chiropractic scope of diagnosis and treatment of patients with musculoskeletal and neuromuscular conditions.

The curriculum is organized into three primary activities and encompasses approximately 1850 contact hours.

## Patient Care (≈ 1,250 hours)

The resident gains experience in team-based case management, including evaluation and management of complex conditions under the mentorship of senior VA chiropractors/attendings. Typical patient cases include, but are not limited to

to the following: degenerative or inflammatory arthritis, chronic pain syndrome, fibromyalgia, structural deformities, radiculopathy, peripheral neuropathy, neuromuscular degenerative pathology, traumatic brain injury, post-operative spine complications, and other medical and psychosocial co-morbidities.



## Interprofessional Education (≈ 250 hours)

The resident has an opportunity to rotate through other healthcare specialties to observe a wider variety of cases, learn about the roles and approaches of other disciplines, and is exposed to interdisciplinary teamwork and collaboration. Examples of Interprofessional Education include: 50 rotations throughout different hospital services with a variety of healthcare providers. Areas range from primary care to specialty medicine and include a greater emphasis on interdisciplinary pain care. The resident also has a unique opportunity to participate in the Interdisciplinary Pain Team (IDT) evaluation. This allows the resident to work directly with a physical medicine and rehabilitation (PM&R) provider, pain pharmacist, physical therapist, pain psychologist, and a social worker on complex cases that need a more collaborative treatment plan.

## Scholarly Activity (≈ 350 hours)

A component of the residency program will require the resident to complete didactic assignments, participate in individual and group projects with other residents within the cohort, and attend

meetings/presentations organized within the national program. In addition, the resident has the opportunity present to students and clinicians, engage in research, and participate in scholarly lectures offered by other departments/specialties. Other scholarly activities may include obtaining and appraising literature relevant to clinical care to allow time for self-directed learning. These activities may take place at VACIHCS and/or the academic affiliate, Palmer College of Chiropractic in Davenport, Iowa.

## Mission, Goals, and Objectives

### Mission:

The mission of the VACIHCS Chiropractic Integrated Clinical Practice Residency prepares chiropractic residents for clinical practice in hospitals or other medical settings and/or academia, through hospital-based training, interprofessional education, and scholarly activities.

- **Goals/Objectives** Provide residents postgraduate clinical experience in hospital-based chiropractic care.
  - o At the end of the residency the resident should:
    - Provide competent patient care to a broad population of musculoskeletal cases, most commonly spinal, while engaging in collaborative team-based care.
    - Competently manage a range of complex/multimorbidity cases
- Provide residents interprofessional educational experiences with relevant medical, surgical, and associated health specialties.
  - o Provide clinical rotations in primary care, pain management, other relevant medical and surgical specialties, behavioral medicine, and other associated health disciplines.
- Provide residents opportunities to participate in scholarly activities to gain experience relevant to integrated practice and/or academia.
  - o Residents will complete scholarly assignments, online didactic courses, and collaborate with other chiropractic residents to complete group assignments.
  - o Residents will attend scholarly presentations from other specialties and/or academic affiliate offerings.
  - o Residents will be provided opportunities to engage in research activities and/or present scholarly material to other students, faculty members, or clinical staff..

# Residency Program

A chiropractic residency accredited by the Council of Chiropractic Education (CCE) is a post-doctoral education program centered on clinical training that results in the resident attaining advanced competencies. The residency programs expands and builds on competencies attained through completion of the Doctor of Chiropractic degree program. All accredited chiropractic residencies must meet the following seven core competencies and learning objectives. The VACIHCS chiropractic residency is accredited by the CCE.

## Chiropractic Residency Curricular Competencies

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

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

## Curriculum

The curriculum is organized around three main activities: patient care, interprofessional rotations and scholarship.

**PATIENT CARE (approximately 27 hours/week):** The VACIHCS chiropractic clinic has sufficient staffing and patient caseload to provide a robust learning environment for residents. Unique to VACIHCS is the opportunity for residents to deliver care not only at the main Medical Center within the pain clinic but also to rural populations within a primary care setting located in community-based outpatient clinics (CBOCs). The resident will manage each case in collaboration with the attending. There may also be opportunity to co-manage cases with other disciplines. Patients are referred from numerous services, including primary care, pain management, emergency department, physical therapy, spinal cord injury, traumatic brain injury clinics and more. The most common patient complaints seen in the clinic are musculoskeletal conditions of the low back, neck, thoracic spine, extremities, and headache. The most common clinical services delivered are a combination of evaluation and management, spinal manipulation, manual therapies, acupuncture,

therapeutic exercise, and patient education. Residents engage in delivery of these services under graduating levels of supervision.

**Resident Supervision:** The Department of Veterans Affairs mandates appropriate supervision for trainees of all disciplines. All clinical care provided by the chiropractic resident is under the supervision of staff attending DCs in accordance with [VHA Handbook 1400.04](#). For all associated health trainees, the types and characteristics of allowable supervision are generally prescribed in Table 2.

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

Attendings follow a four-level graduated responsibility approach to supervision (Table 3). The resident is gradually granted more autonomy as they demonstrate competence and attendings become more familiar with and confident in the resident's clinical and case management skills.

**Table 2. General Supervision of Resident**

<i>Supervision Type</i>	<i>Characteristics</i>
<b>Room</b>	<ul style="list-style-type: none"> <li>Supervising provider is physically present in the same room while the trainee is engaged in health care services</li> </ul>
<b>Area</b>	<ul style="list-style-type: none"> <li>Supervising provider is in the same physical area and immediately accessible to the trainee</li> <li>Supervising provider meets and interacts with Veterans as needed</li> <li>Supervising provider and trainee discuss, plan, or review evaluation or treatment plans</li> </ul> <p><i>Available only when the trainee has been assessed and assigned a commensurate Graduated Level of Responsibility</i></p>
<b>Available</b>	<ul style="list-style-type: none"> <li>Services delivered by the trainee under the supervising provider's guidance</li> <li>Supervising provider's presence not required during services, but must be in the facility, available immediately by phone or pager, and able to be physically present as needed</li> </ul>





**Table 3. Specific Supervision of Resident Example**

<i>Level</i>	<i>Typical Time Frame</i>	<i>Characteristics</i>
<b>1</b>	Weeks 1-6	<p>This is the entry level for all residents. At this level, residents will perform a complete history and examination of their patient and formulate differential diagnoses and management strategies. The attending doctor will verify the resident's findings and ensure accuracy of the diagnosis and plan by being in the room concurrently with the resident and/or through separate history and examination.</p> <p><u>Resident responsibility</u></p> <ul style="list-style-type: none"> <li>Residents discuss all aspects of case management with the attending before a plan is implemented <ul style="list-style-type: none"> <li><i>Attending: Room or area</i></li> </ul> </li> </ul>
<b>2</b>	Weeks 4-16	<p>Residents will have demonstrated acceptable competence in straightforward cases, while competence in complex cases may still be emerging and/or unassessed. This level of supervision allows the resident to independently perform routine physical examination of the patient without staff attending and discuss routine cases with the staff attending.. More complex cases require the staff attending to also examine the patient. This level of supervision allows the resident to rotate outside of the chiropractic clinic in other clinical service rotations.</p> <p><u>Resident responsibility</u></p> <ul style="list-style-type: none"> <li>Residents can independently implement plans for cases in which they have demonstrated acceptable competence <ul style="list-style-type: none"> <li><i>Attending: Room, area, or available</i></li> </ul> </li> <li>All aspects of case management for instances in which competence has not yet been demonstrated are discussed with attending before a plan is implemented <ul style="list-style-type: none"> <li><i>Attending: Room or area</i></li> </ul> </li> </ul>
<b>3</b>	Weeks 14-30	<p>Residents will have demonstrated acceptable competence in all straightforward and some complex cases, while competence in some rarer case presentation areas may still be emerging and/or unassessed.</p> <p><u>Resident responsibility</u></p> <ul style="list-style-type: none"> <li>Residents can independently implement plans for cases in which they have demonstrated acceptable competence <ul style="list-style-type: none"> <li><i>Attending: Room, area, or available</i></li> </ul> </li> <li>All aspects of case management for instances in which competence has not yet been demonstrated are discussed with attending before a plan is implemented <ul style="list-style-type: none"> <li><i>Attending: Room, area, or available</i></li> </ul> </li> </ul>
<b>4</b>	Weeks 26-52	<p>With the approval of the DCRP director, residents are permitted to assess and mentor chiropractic students participating in on-site clerkships. Such cases must be reviewed with a staff attending and the patient record must be co-signed by the staff attending per VA supervision guidelines.</p> <p><u>Resident responsibility</u></p> <p>Supervision of the residents' own cases continues at Level 3 above</p>

### ***Responsibilities in the Graduated Supervision Process:***

#### **Attending:**

1. Rate the resident's graduated responsibility level on an ongoing basis, communicate expectations clearly to the resident, and notify the resident of any changes.
2. Log the rating monthly in the Graduated Responsibility Tracker.
3. Continually assess for resident compliance with graduated levels of supervision:
  - a. Discuss immediate issues and formulate a resolution plan with resident
  - b. Inform the RPD
  - c. Assess outcome and discuss with resident
  - d. Document all steps in the graduated responsibility tracker.

#### **Resident:**

1. Be aware of and comply with the graduated supervision level requirements with each attending could vary based on time with attending and other circumstances.
2. Review the Graduated Responsibility Tracker during RPD meetings and document concurrence or non-concurrence agreed upon resolution plan.

#### **Program Director:**

1. Maintain clear direct communication with attendings and resident regarding all aspects of the resident supervision on a continual basis.
2. Review Graduated Responsibility Tracker and document concurrence or non-concurrence with agreed upon resolution plan in the meeting minutes during RPD meetings.

**INTERPROFESSIONAL ROTATIONS (5 hours/week):** Interprofessional rotations provide the resident with practical experience in diagnostic and therapeutic procedures and medical decision-making employed by other related healthcare providers. The resident learns the indications, contraindications, and processes for referral for various medical procedures related to the management of musculoskeletal and other conditions. By working directly with attendings and trainees in other disciplines, residents gain valuable experience in communicating and collaborating with other healthcare providers toward the goal of high-quality, team-based patient care. Rotations facilitate future teamwork with the involved providers and departments.

Rotations are strategically designed to mimic the VA's stepped-care model. VACIHCS has set up rotations in three distinct blocks of 16 weeks (Table 4) culminating in an opportunity to lead the Pain Management Interdisciplinary Group Visit for the final two weeks. The interprofessional blocked rotations mirrors the stepped care model by sequencing rotations in Block 1 with a veteran's primary point of entry into the system, (e.g., primary care and the emergency department), followed by pain clinic and physical medicine and rehabilitation in Block 2, and ultimately through inpatient and other specialty care in Block 3.

During some rotations, the resident's activities may be limited to observation and discussion with the given provider only. In other instances, the resident may perform various elements of patient history, examination, review of imaging/labs/records, diagnosis, and management under the direct supervision of the given attending. Below is a list of typical rotations which may change in a given year depending on availability of providers and other learners.

**Table 4. Interprofessional Block Rotations**

Block 1	Department	Discipline
Primary Care	Primary Care	DO
	Primary Care	MD
	Primary Care	PA
	Dietetics	RD
	Mental Health	Psy. D.
	PACT Pharmacy	Pharm. D.
	Geri-Pact	MD
	Home-Based Primary Care	MD
	Radiology X-Ray	MD
	Radiology MRI	MD
	Emergency Dept	MD
	Emergency Dept	DO
	Urgent Care	PA
	Suicide Prevention	LISW

Block 2	Department	Discipline
Pain Clinic	Pain Medicine	PA
	Pain Physiatry	MD
	Interventional Pain	MD
	Pain Psychology	Ph. D.
	Pain Pharmacy	Pharm. D.
	Acupuncture	LAc.
	Interdisciplinary Team	Group
	EMG Clinic	MD
	SUD	LISW
	Traumatic Brain Injury PMR	DO
	Spinal Cord Injury	MD

Block 3	Department	Discipline
Specialty	Domiciliary	NP
	Domiciliary Psychology	Ph. D.
	Acute Inpatient	DO
	General Surgery	MD
	Orthopedic Surgery	MD
	Hospice and Palliative Care	NP
	Long-Term Stay CLC	NP
	Inpatient Acute Psychiatry	MD
	Inpatient Psychology	Ph. D.
	Cardiology	MD
	Inpatient Chronic Psychiatric	

**SCHOLARSHIP (8 hours/week):** Residents engage in activities aimed to build their competence as clinician-scholars. These activities involve skills in literature review, data synthesis, presentation preparation, and communication. Several specific scholarly tasks will be assigned, including:

1. Completing didactic courses defined by VA DC Resident National Common Curricular Workgroup;

2. 2 assigned group projects in collaboration with other VA chiropractic residents; (These activities are aimed at building competence in given content areas, developing team-based peer collaboration and providing opportunities for comradery.)
3. Various presentations will be given to VA and/or Palmer College of Chiropractic clinicians, trainees, and/or students.
4. Attendance and/or presentations at scholarly VACIHCS venues, including
  - a. VACIHCS Continuing Medical Education Programming.
  - b. participation in the Pain Board.
  - c. participation in Inpatient Pain Rounds.
  - d. participation in the Internal Medicine Residency Didactic.
  - e. participation in Pain Grand Rounds for V23.
  - f. participation in the University of Iowa Grand Rounds at Unity Point Hospital.
5. Ad hoc assignments related to the residents area of interest or growth such as the application of evidence to given patient cases, quality management, and/or attending educational/research activities;
6. Mentor 9-10th trimester Palmer College of Chiropractic (PCC) students.
7. Other.

Scholarship opportunities are matched with interprofessional clinical blocks to help build consistency, experience, and relationships among the resident(s) and other health professionals within the respective areas.

**Duty Hours:** The residency is a 12-month program running from July 1 through June 30 of the following year. The tour of duty is full time (40 hours/week) from 0630-1530 Monday-Friday. The resident will not have call responsibility outside of duty hours. While time is scheduled for academic engagement (interprofessional rotations and scholarship work), Off-duty time may be necessary to in order to complete some documentation, projects, and additional work. Table 5 is a sample schedule showing blocks of time allocated per week for clinical care, interprofessional interaction, and scholarly activities. Please note that this schedule is a sample and variations will occur based on rotation availability, a resident's ability to complete the mandatory requirements, clinic needs, and resident preferences.

**Table 5. Sample Resident's Schedule**

Time	Monday	Tuesday	Wednesday	Thursday	Friday			
630-0700	Review	Review	Review	Review	Review			
700-0730								
730-0800								
800-0830								
830-0900								
900-0930								
930-1000								
1000-1030								
1030-1100								
1100-1130								
1130-1200								
1200-1230								
1230-1300								
1300-1330								
1330-1400								
1400-1430								
1430-1500								
1500-1530								

Patient Care

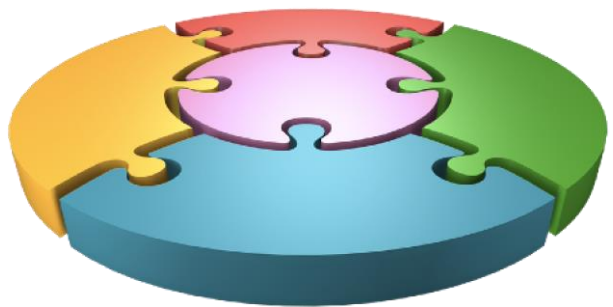
Lunch/Documentation

Rotations

Scholarship

## Assessment Plan

**Overview:** The VACIHCS assessment plan includes formative and summative assessments of resident performance based on defined competencies and objectives. Assessments are conducted by attendings with input from ad hoc faculty, staff, patients, and other medical residents as well as the resident self-assessment.. A description of the assessment structure and instruments used are linked below in Table 6. Program competencies, outcomes, and qualitative and quantitative assessments are presented in a crosswalk to the assessment instruments in Table 7. The frequency of formal assessment is found in Table 8, and the program completion requirements are in Table 9.



**Table 6. Assessment Structure**

Summative Assessment	
<a href="#"><u>Milestone Assessment</u></a>	Performance scales and open-ended comments assessing competence in domains of Clinical Service, Advanced Healthcare Knowledge, Practice-Based Learning and Improvement, Interpersonal and Communication Skills, Professionalism, Collaborative Practice, and Evidence-informed Advanced Practice
Qualitative	
<a href="#"><u>Evaluation of Live Clinical Performance</u></a>	A structured qualitative assessment of clinical performance conducted during a patient encounter.
<a href="#"><u>Chart-Stimulated Recall</u></a>	A standardized oral assessment during which the resident reviews a clinical case to discuss the medical decision making related to the patient assessment, diagnosis, interpretation, and treatment plan.
<a href="#"><u>Patient Perception of Resident Quality</u></a>	Patient assessment of satisfaction with the resident care.
<a href="#"><u>Resident Self-Assessment</u></a>	Resident self-rating of Milestones competencies, with open-ended reflection prompts to identify learning goals and professional development targets. Used for self-assessment (indirect) of resident competence.
Quantitative	
<a href="#"><u>Case Log</u></a>	Tracking mechanism of the cases seen by the resident in the chiropractic clinic and in other clinical rotations.
<a href="#"><u>Calendar</u></a>	Tracking mechanism of the resident's time spent in patient care, interprofessional rotations, and scholarly activity.
<a href="#"><u>Portfolio</u></a>	A collection of documents, slide presentations, abstracts or other materials prepared by the resident that gives evidence of learning and achievement. This includes a log of scholarly activities (e.g., presentations with date of activity, location, type of activity, whether the resident presented or attended) and general comments and reflections by the resident.

**Table 7. Assessment Crosswalk**

Competency	Milestone Assessments	Qualitative (Formative)					Quantitative	
	Outcome	Evaluation of Live Clinical Performance	Chart Simulated Recall	Patient Perception of Resident Quality	Resident Assessment	Case Log	Resident Calendar	Resident Portfolio
<b>Clinical Service</b>	The resident demonstrates competence in review of the clinical record and taking a history commensurate with patient age, impairment, and case complexity.	X	X		X	X		
	The resident demonstrates competence in performing a physical examination commensurate with patient age, impairment, and case complexity.	X	X		X	X		
	The resident demonstrates competence in diagnostic assessment based on history, examination, and appropriate use and interpretation of imaging, laboratory, and special studies.	X	X		X			
	The resident demonstrates competence in case management including appropriate patient-centered treatment, education, and collaborative decisions commensurate with patient age, impairment, and case complexity.	X	X		X	X		
<b>Advanced Healthcare Knowledge</b>	The resident demonstrates competence in accessing relevant scientific knowledge and applying this to inform patient care.	X	X		X			X
<b>Practice-Based Learning and Improvement</b>	The resident demonstrates competence in analyzing their practice and performing practice-based improvement activities through self-assessment and documented quality assurance activities.	X	X		X			X
<b>Interpersonal &amp; Communication Skills</b>	The resident uses appropriate and culturally competent communication in all patient interactions including education and shared decision-making.	X	X	X	X			
<b>Professionalism</b>	The resident demonstrates compassion, integrity, and respect for others, as well as sensitivity and responsiveness to diverse patient populations.	X		X	X	X		
	The resident demonstrates a commitment to ethical principles pertaining to patient care decisions, confidentiality of patient information, informed consent, and business practices.	X	X	X	X			
<b>Collaborative Practice</b>	The resident demonstrates appropriate use of system resources in their own practice and about ordering healthcare services and/or consultations.	X	X		X	X		
<b>Evidence-Informed Advanced Practice</b>	The resident provides clinical management consistent with best practices and recognized clinical guidelines.	X	X		X			
	The resident promotes and disseminates knowledge through attending and/or presenting material at scholarly activities/lectures, and/or through research activities.				X		X	

## Assessment Schedule

The frequency of resident assessment is outlined in Table 8. Milestone assessments are determined by the Clinical Competency Committee (CCC) comprised of faculty members. The CCC provides a consensus summative evaluation of the resident's clinical performance each term. The summative evaluations notify residents of their progress toward end of program goals and serves as an "early warning" for areas that need development to reach goals. Participation in rotations and case log, portfolio and calendar entries are viewed by the CCC as part of the assessment and tracking toward program completion. Operational details of the CCC are provided below.

**Table 8. Assessment Frequency and Totals**

Assessment Frequency													
Trimester	I				II				III				
Month	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
Assessment of Resident:													
Milestone Assessment				1				1				1	3
Evaluation of Live Clinical Performance	6				4				4				14
Chart-Stimulated Recall	3				3				3				9
Patient Perception of Resident Quality	4				4				4				16
Self-Assessment	1			1				1				1	4
Resident Assessment of:													
Faculty				1				1				1	3
Program				1				1				1	3
Rotation	weekly												50
Resident Record Entries:													
Case Log	weekly												50
Portfolio	weekly												50
Calendar	weekly												50

## Program Completion Requirements

The requirements for program completion are provided in Table 9. All quantitative and qualitative requirements for each area of emphasis and domain must be met at the time of graduation.



**Table 9. Program Completion Requirements**

<b>Area of Emphasis</b>	<b>Domain</b>	<b>Threshold</b>	<b>Records</b>
<i>Clinical Competence</i>	Patient Care	Level 4 competence on the Overall Milestone Assessment	Milestone Assessment
	Patient Care	Completion of assigned chiropractic clinic sessions, including a minimum of 650 total patient encounters, with a minimum of 20 patient encounters from 4 diagnostic categories: Musculoskeletal, Neurological, Post-operative, and Mental Health	Resident Case Log and Calendar
	Interprofessional Rotations	Completion of a minimum of 50 clinic rotations across primary care, physical medicine and rehabilitation, pain medicine, behavioral medicine, other relevant medical/surgical specialties, and other relevant associated health disciplines	Resident Calendar and Portfolio
<i>Quantitative Requirements</i>	Scholarship	10 assigned online didactic course	Resident Portfolio
		2 assigned group projects	
		2 formal presentations of one of which is a presentation during the VA Journal Club and another is a Grand Rounds presentation during a regional chiropractic call.	
		2 in-service presentations/workshops to staff and/or trainees at other clinical services in VA, PCC, and/or external scholarly venues	
		8 scholarly research presentations at VA and affiliated venues	

## Assessment Record Keeping

Documentation of the resident's performance is collated in a separate Microsoft TEAMS channel and stored on ONEDRIVE. Electronic records are maintained in a folder on the VACIHCS ONEDRIVE, accessible to the resident, Program Director, Clinical Competency Committee (CCC) and Faculty. Ensuring compliance with the above schedule is a joint responsibility between the RPD and the resident. If any obstacles to timely compliance are identified, the resident and director will meet to discuss actions needed.

## Residency Clinical Competency Committee

A Clinical Competency Committee (CCC) conducts interviews and assesses resident performance throughout the residency and provides a consensus summative evaluation of clinical competence at the end of the program. The CCC term-based evaluations also serve as an “early warning” system to alert residents if they are not progressing at the expected level of training.

The CCC is composed of the the faculty members. CCC roles include:

- **Chiropractic Residency Program Director:** Develops and updates the document which describes the roles of the committee members and disseminates it to the members of the committee which he/she appoints. Apart from participating in the CCC as faculty, the program director also serves as resident advocate and advisor during assessments.
- **CCC Chair:** Chairs the committee and is responsible for oversight. Completes committee reports and provides them to the program director to use in tri-annual Milestones evaluations.
- **CCC Members:** Reviews the resident's evaluations and advise the program director and the CCC Chair regarding resident's progress, including promotion, remediation, probation, and dismissal.

The CCC functions as follows:

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



## Location

VACIHCS is located in Des Moines, Iowa, a growing Midwest city of roughly 700,000 people that serves as host to many corporate headquarters. The VACIHCS Residency Program provides a unique training experience in two different settings, a traditional primary medical center (hospital-based) setting and a community-based outreach clinic (CBOC) that provides care to a large population living in rural settings..

### Primary Medical Center: Des Moines

The majority of training will take place at VA Central Iowa Health Care System Medical Center located in Des Moines, IA. At this location, chiropractic services serves the following two roles:



1. Chiropractic services in Interdisciplinary Pain Management results in a collaboration among professionals that comanages complex chronic pain patients
2. Chiropractic care serves as a first-line treatment option. Primary Care and Emergency Department providers collaborate with the clinic for walk-in or immediate appointments for Veterans who have more acute need for chiropractic consultation. This role is carried out in the CBOC's as well as the Medical Center.



## Community-Based Outpatient Clinics (CBOCs)

The outpatient clinics offer both primary care and specialty health services, such as audiology, cardiology, chiropractic, mental health, optometry, physical therapy, podiatry, and telehealth visits.

Chiropractic services are currently in 4 CBOCs within VACIHCS including: Fort Dodge, Knoxville, Marshalltown, and Mason City. The resident will have the opportunity to rotate within these CBOCs to experience the complexities and differences between a rural health care setting and the main medical

center. Within this environment, the chiropractor serves as one of the key subject matter experts in musculoskeletal care.

# Faculty



Nathan Hinkeldey, D.C., DACRB  
Residency Program Director (RPD)

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Dr. Hinkeldey received his B.S. degree from Iowa State University, and his doctorate from Palmer College of Chiropractic (Davenport, Iowa). He has earned Diplomate Status through the American Chiropractic Rehabilitation Board and is certified in Acupuncture. He currently serves as a trustee on the Palmer College of Chiropractic Board of Trustees and has been an adjunct faculty at Palmer. Internal to the VA, Dr. Hinkeldey serves as the Clinical Director of Whole Health and Pain Management, is the VACIHCS Point of Contact for Pain Management, Chairs the local Pain Management Committee and is the VISN 23 Co-Chair of the Pain Management Committee. His passions include teaching, patient care, and program learning development.



Juli Olson, D.C., D.A.C.M. F.A.I.H.M.  
Residency Attending

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Dr. Olson holds doctoral degrees in Chiropractic from the Southern California University of Health Sciences, and Acupuncture and Chinese Medicine from Pacific College of Health Sciences. She is Fellowship trained in Integrative Medicine by the Academy of Integrative Health and Medicine. Dr. Olson is a clinical chiropractor and acupuncturist in the Pain Clinic at the VA Central Iowa and serves as the National Lead for Acupuncture in the Veterans Health Administration. She teaches at the Pacific College of Health Sciences and is Adjunct Faculty at Palmer College of Chiropractic. Dr. Olson also serves on the National Certification Commission for Acupuncture and Oriental Medicine's Biomedicine Committee.





## Heather Meeks, DC

### Residency Attending

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Dr. Meeks received her B.S. degree from the University of St. Thomas in St. Paul, Minnesota, and her doctorate from Palmer College of Chiropractic in Davenport, Iowa. Dr. Meeks recently transitioned from leading our Rural Health Chiropractic Outreach program into full time clinical care at Des Moines VAMC. She is the program director for the student program and in addition to chiropractic care, Dr. Meeks has completed 300 hours of acupuncture training. She is currently pursuing her MS in Neuroscience through Parker University.



## Jeff Remsburg, DC, MS, Cert MDT

### Residency Attending

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Dr. Remsburg received his B.S. degree from Eastern Kentucky University and his M.S. degree from University of Texas at Arlington. He completed his D.C. degree from Palmer College of Chiropractic. He has earned Diplomate Status through the American Chiropractic Rehabilitation Board and is also certified in dry needling and Mechanical Diagnosis & Therapy (McKenzie Institute). He was in private practice for 10 years before joining VA Central Iowa Healthcare System where he splits his time between Mason City and Fort Dodge community-based outpatient clinics (CBOCs).



## Mandy Wong, DC

### Residency Attending

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Dr. Wong received her B.S. degree from Creighton University and her doctorate from Palmer College of Chiropractic, West Campus. She recently graduated from the VA Central Iowa Health Care System Chiropractic Integrated Clinical Practice Residency program in Des Moines, IA. Currently, Dr. Wong travels to two of the five community-based outpatient clinics (CBOCs) in Knoxville and Marshalltown, IA to better serve our rural veterans.



## Robert Percuoco, B.S., D.C.

### Academic Affiliate, Palmer College of Chiropractic

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Dr. Percuoco serves Palmer College of Chiropractic as the Vice Chancellor for Institutional Effectiveness. He received a Bachelor of Science degree in Biology in 1978 from Stonehill College in North Easton, MA and a doctorate in chiropractic in 1983 from Palmer College of Chiropractic. Previously held positions include, Vice Chancellor for Academics, Senior Director for Assessment, Assistant VPAA for Assessment, Dean of Academic Programs and Assistant Academic Dean. Dr. Percuoco has maintained a faculty position at Palmer for 1985. He served as a Councilor to the Council on Chiropractic Education (CCE) for ten years, and as a member of the CCE Academy of Site Team Visitors for 16 years.

## Ad-Hoc Members

Ad-hoc professionals support the Chiropractic Residency program in a consulting role related to program design and have expertise or leadership other professional onsite training programs and residencies.

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### Mary Rasmussen Pharm D. (ad-hoc)

#### Associate Chief of Pharmacy

**Dr. Mary Rasmussen** graduated from Drake University in 2007 and has been employed by the VA for over 10 years. She has worked in multiple areas of pharmacy, including the pain clinic, non-formulary review team, CBOCs, and outpatient pharmacy. Dr. Rasmussen has been a supervisor since 2014 and works to coordinate all the advance practice scopes for the pharmacy department. She is or has been a member of several national committees and workgroups and is certified as an Agent in Place for the Field Accreditation Services through the VA Employee Education System.

## Resident Selection Process

Resident selection is a competitive process that considers as the applicant's academic background, relevant experience, personal statement, letters of recommendation, and interview(s). The call for applications is issued yearly on the second Monday of January. Applications are only accepted during the open call.

#### Eligibility requirements:

- Applicants must hold or be scheduled to receive a DC degree from a CCE-accredited school prior to the start of the residency program.
- Applicants must be eligible for, or hold a current, full, active, and unrestricted chiropractic license in a State, Territory or Commonwealth of the US, or in the District of Columbia.
- Applicants must hold a DC degree from a CCE-accredited school or be scheduled to receive one prior to the July 1 start of the residency program. DC licensure is not required to apply or to be accepted into the program. Accepted residents, prior to program completion, must



obtain a full, active, and unrestricted chiropractic license in a State, Territory or Commonwealth of the US, or in the District of Columbia.

- Applicants must have documentation of at least 3 months of direct patient care activity within the last year. Clinical rotations while pursuing a chiropractic degree meet this criteria for recent graduates. Observer experiences and non-clinical graduate work do not meet this requirement.
- Applicants must submit 3 reference letters from US chiropractic and/or medical physicians who have personal knowledge of the applicant's clinical abilities and personal attributes.
- Applicants must meet all VA employment requirements, including US citizenship and Selective Service registration when applicable.
- Applicants must have sufficient written and spoken English language skills to make patient care safe and effective.
- Additional eligibility requirements are specified in the annual call for applications.

# Policies

## Infection Control

All healthcare workers in direct patient contact areas must:

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

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

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

If sharps are used during an encounter, contaminated sharps will be placed in rigid puncture-resistant containers designed for sharp disposal. Other contaminated instruments will be placed immediately in a puncture resistant, leak-proof container labeled with a biohazard warning

## Facility Safety

1. Accidents/Injuries: If an injury occurs at work, the resident is required to immediately notify the residency program director.
2. Electrical safety: Inspect all electrically powered equipment before use. Do not use equipment with frayed cords or broken plugs. Report defective equipment to the residency program director.

3. Equipment safety: Know how to use equipment properly and inspect for defects prior to use. Remove any defective/inoperative equipment from use and report it to the area supervisor.
4. Fire: Upon discovering or suspecting a fire in the area:
  - a. Rescue anyone in danger from the fire
  - b. Activate the nearest fire alarm pull station and have someone call the fire department
  - c. Confine fire spread by closing all doors
  - d. Extinguish if the fire is small and you are properly trained.
5. Hazardous materials: Become familiar with the hazards associated with the chemicals you use before you use them. Ensure all containers are properly labeled with the name of the product, manufacturer's name and address, and appropriate hazard warnings. Know the location of your chemical inventory and material safety data sheets (MSDS).

## Compensation and Benefits

The residency is a 1-year program (2,080 hours) running from July 1 through June 30 of the following year and is full-time (40 hours/week). Due to opportunities around the facility including at distant Community Based Outpatient Clinics, the schedule is subject to change. Any hours over the normal 8-hour tour will be provided back to the Resident from another day. On some days, the resident will attend a scheduled scholarly presentation during the lunch break period. On instances when these events do not allow for lunch, the resident will be given a lunch break either before or after the event. The resident stipend is established based on geographic location by the VA Office of Academic Affiliations. This stipend is not contingent upon resident productivity. Residents are paid every two weeks.



### Health Insurance

Residents are entitled to participate in a VA sponsored health insurance plan of their choosing. Health insurance plans are paid for by a combination of VA and employee (resident) contributions. The portion of plan premiums which are the responsibility of the employee (resident) will be deducted from the resident's paycheck.



### Malpractice

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

## Leave

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

1. **Planned Annual Leave:** All AL must be approved in advance by the RPD. AL may be taken only at times which will not disrupt the program's training schedule. The resident must notify the RPD of his/her request for AL at least 4 weeks in advance of the desired time off. AL during the first or last week of the rotation will not be granted, unless for urgent purposes. At the end of the residency any unused AL days will not be converted to or compensated by payment.
2. **SL is reserved for physical and mental illness only.** It also includes medical, dental, and other health related preventive or ongoing appointments and care of immediate family. The resident must notify their attending supervisor or the RPD before 8:00 AM of any unexpected leave due to illness. The resident must interact with a live person to ensure notification. In the event the resident is unable to reach a live person, leave a message and continue to call until able to contact someone directly. It is not acceptable to send a text, email, or leave a message on an answering machine without speaking to someone directly. Failure to comply will be documented in the resident's main file as absent without official leave (AWOL) and will be recorded as vacation usage. An absence of 3 days or more due to illness (self or family member) requires the resident to submit appropriate documentation from a medical professional. If sick leave is reported following vacation time or after an out of town trip, the resident must provide documentation of his/her previous intention to return to work upon conclusion of their scheduled vacation dates, in the form of an original trip itinerary (airline ticket, cruise ticket, etc.) Failure to provide the required documentation or any abuse of SL for any other purpose will result in deduction from future vacation time and/or AWOL status.
3. **Authorized Absence (AA)** may be granted to residents when they are involved in professional development activities consistent with the residency program mission at an off-site location. This can include attending professional conferences or other training opportunities related to the resident's area of interest. AA may be granted for attending a job interview if at another VA site. The days approved for AA do not deduct from either AL or SL. All AA must be approved by the RPD.
4. **Unplanned Absence (UA)** includes unforeseen events such as loss of childcare, weather issues, burst pipes, funeral, etc. and are absences that do not require 4 weeks of advanced notice.

Frequent and/or prolonged absence of any type (AL and/or SL) may result in an extension of the time the resident must participate in the program in order to meet the training requirements. If this

becomes necessary and the resident has been paid during the period of absence, the extended dates of training may be on a without-compensation basis (without salary and benefits).

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

## **Moonlighting**

Residents are not required to moonlight; however, second trimester or higher residents may apply for external moonlighting privileges. Internal moonlighting is not allowed in VA.

To apply for moonlighting privileges the resident must meet the following criteria:

1. Good standing in the second quarter of the residency and beyond
2. Hold a valid unrestricted Iowa chiropractic license
3. No marginal or low satisfactory evaluations (number 1-4) during the previous trimester
4. No evaluation comments stating or implying the concern for inadequate knowledge base, poor ethical conducts, work habits, patient care, etc.
5. No incomplete notes
6. No issues of tardiness within the last trimester
7. No delinquencies, delayed, or incomplete scholarly assignments
8. Passing score on academic course work

Interested residents must complete a written request to VACIHCS Chiropractic Residency Program Director (RPD) with the following information:

1. Description of the employment
2. A statement regarding who is responsible for malpractice insurance (VACIHCS liability protection for residency activities does not cover any moonlighting)
3. A statement concerning the resident accepting the responsibility of documenting monthly the number of hours worked at the moonlighting location.
4. This documentation must be turned into the program director.

The VACIHCS RPD reviews and approves the request before the resident is allowed to moonlight. Approval is reviewed each trimester and may be renewed or revoked. Renewal of moonlighting privileges is contingent upon the following:

1. Time spent moonlighting must not interfere with residency program requirements and academic performance.
2. Moonlighting should enhance education, not compromise it. Under no circumstances should patient care at VACIHCS be jeopardized because of resident moonlighting activities.

3. Moonlighting must not adversely affect the interests, objectives or policies of the residency program or VACIHCS
4. Resident scheduled activities should not be manipulated in order to accommodate moonlighting activities
5. The resident must record and report monthly the hours spent moonlighting to the RPD and track so as not to exceed 20 hours per week. This will be reviewed monthly by the Program Director. Documentation from the external employer (either a pay stub with wages, etc. redacted, or a letter verifying the number of hours worked) may be required.

Moonlighting privileges may be revoked at any time under any of the following conditions

1. The resident fails to meet the criteria in #2 above. The resident receives any disciplinary action.
2. The resident was noted to be excessively fatigued (regardless of reason) with repeated incidence of falling asleep or inability to focus during the regular hours such as didactics, rounds, and clinics. Monitoring for excessive tiredness or fatigue will be done by attending evaluations, direct observation during rounds, clinic, didactics, and evaluations by colleagues, patient, nursing, administrative and therapy staff.

Repeated unexcused tardiness to didactics, clinics or other residency duties. Any incident of failure to attend assigned didactics, clinics or other residency duties. Examples:

1. The resident was unprepared to present during scheduled scholarly activities.
2. Any incident of leaving the clinic prior to completion of all needed work and prior to all patients being seen.
3. Any incident of leaving early prior to the completion of didactic sessions without prior permission.
4. Difficulty with regular duties or workload expected for the level of training.
5. Major medical illness or more than 5 individual days of sick leave per Trimester

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

## **Professional Conduct**

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

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

Residents should not eat or drink in exam rooms or in front of patients. During working hours, residents will be mentally and physically capable of executing job functions. This implies freedom from over-fatigue, illness or intoxicants such as alcohol.

All patients, staff members, and guests shall be treated with dignity, courtesy and respect for their culture and values. Patients should generally be referred to by their preferred name. Patients will be called to their visit by Veteran “last name”. Upon beginning the visit, patients will be asked how they preferred to be addressed and this will be documented in the chart.

Chiropractic clinic faculty, and other VACIHCS healthcare providers who hold doctoral degrees, should be addressed as “Dr.” when in the clinic or around patients or in other encounters on station.

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

Residents are expected to be punctual. The tour of duty begins at 0630 and concludes at 1530. It is your responsibility in the morning to prepare your room/equipment and review necessary records to be prepared to start your first scheduled patient. It is the resident’s responsibility to arrive as early as necessary to accomplish this.

All clinical work performed by chiropractic residents must be supervised by a faculty chiropractor. Residents will be supervised during rotations by the rotation attending. No treatments are to be provided during any of the rotations. Evaluations can be performed when rotation clinician has the scope to evaluate and diagnose. No clinical work is to be done after hours and/or when there is no covering faculty chiropractor available (this includes phone calls to patients). Residents need to always be aware of who the assigned faculty is for the particular clinical work that is being accomplished. Generally, this will be consistent throughout the year.

## **Due Process**

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

### **I. Definition of Problematic Behavior or Impairment**

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For the purposes of this policy, problematic behavior/impairment is defined broadly as an interference in professional functioning that is reflected in one or more of the following ways:

1. An inability and/or unwillingness to acquire and integrate professional behaviors and ethical standards,
2. An inability to acquire the level of professional skills necessary to reach an acceptable level of competency,
3. An inability to control personal stress, psychological problems, and/or excessive emotional reactions that interfere with professional functioning.

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

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



## II. Remediation Alternatives

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

1. Verbal Warning to the resident emphasizes the need to discontinue the inappropriate behavior under discussion. No record of this action is kept.
2. Written Acknowledgment to the resident formally acknowledges that:
  - a. the RPD is aware of and concerned with the performance rating,
  - b. the concern has been brought to the attention of the resident,
  - c. the RPD will work with the resident and/or faculty to rectify the problem or skill deficits, and
  - d. the behaviors associated with the rating are not significant enough to warrant more serious action.

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

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

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

4. Schedule Modification is a time-limited, remediation-oriented closely supervised period of training designed to return the resident to a more fully functioning state. Modifying a resident's schedule is an accommodation made to assist the resident in responding to personal reactions to environmental stress, with the full expectation that the resident will complete the residency. This period will include more closely scrutinized supervision

conducted by the faculty in consultation with the RPD. Several possible and perhaps concurrent courses of action may be included in modifying a schedule. These include:

- a. increasing the amount of supervision, either with the same or other supervisors;
- b. change in the format, emphasis, and/or focus of supervision;
- c. recommending personal therapy;
- d. reducing the resident's clinical or other workload;
- e. requiring specific academic coursework.

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

5. Probation is also a time limited, remediation-oriented, more closely supervised training period. Its purpose is to assess the ability of the resident to complete the residency and to return the resident to a more fully functioning state. Probation defines a relationship in which the RPD systematically monitors for a specific length of time the degree to which the resident addresses, changes and/or otherwise improves the behavior associated with the inadequate rating. The resident is informed of the probation in a written statement that includes:
  - a. the specific behavior(s) associated with the unacceptable rating,
  - b. the recommendation(s) for rectifying the problem,
  - c. the time frame for the probation during which the problem is expected to be ameliorated, and
  - d. the procedures to ascertain whether the problem has been appropriately rectified.
  - e. If the RPD determines that there has not been sufficient improvement in the resident's behavior to remove the Probation or modified schedule, the RPD will discuss with the relevant faculty and the Service Chief possible courses of action to be taken. The RPD will communicate in writing to the resident that the conditions for revoking the probation or modified schedule have not been met. This notice will include the course of action the RPD and Service Chief have decided to implement. These may include continuation of the remediation efforts for a specified time period or implementation of another alternative. Additionally, the RPD will communicate to the Service Chief that if a resident's behavior does not change, the resident will not successfully complete the residency.
6. Suspension of direct service activities requires a determination that the welfare of the resident's patients has been jeopardized. Therefore, direct service activities will be

suspended for a specified period as determined by the RPD in consultation with the Service Chief, Hospital Administration, and Human Resources. At the end of the suspension period, the resident's supervisor in consultation with the RPD and Service Chief will assess the resident's capacity for effective functioning and determine when direct service can be resumed.

7. Administrative Leave involves the temporary withdrawal of all responsibilities and privileges in the agency. If the Probation Period, Suspension of direct service activities, or Administrative Leave interferes with the successful completion of the training hours needed for completion of the residency, this will be noted in the resident's file. The RPD in consultation with the Service Chief will inform the resident of the effects the administrative leave will have on the resident's stipend and accrual of benefits.
8. Dismissal from the Residency involves the permanent withdrawal of all agency responsibilities and privileges. When specific interventions do not, after a reasonable time period, rectify the impairment and the resident seems unable or unwilling to alter their behavior, the RPD will discuss with the Service Chief the possibility of termination from the training program or dismissal from the agency. Either administrative leave or dismissal would be invoked in cases of severe violations of the ACA Code of Ethics, or when imminent physical or psychological harm to a patient is a major factor, or the resident is unable to complete the residency due to physical, mental or emotional illness.

### III. Procedures for Responding to Inadequate Performance by a Resident

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

1. Issues can be discussed with the RPD at any time, but they should first be addressed within the supervisory relationship. The RPD will encourage such direct resolution. (If the resident has a problem that directly involves the RPD, he or she is encouraged to address that problem first with the RPD. If an issue with the RPD is not resolved in a satisfactory fashion, the resident is encouraged to discuss the issue with the Service Chief).
2. If the initial discussions are unsuccessful within a short time (e.g., 1-2 weeks), the RPD will meet with the resident(s) and faculty to assist in problem resolution. At this point the ACOS for Education and Chief and Service Chief of Rehabilitation and Extended Care Physical Medicine and Rehabilitation Service will be made aware of the problem and the steps taken to attempt resolution.
3. If this process does not quickly resolve the problem or the problem promptly recurs, the ACOS for Education and Chief and Service Chief of Rehabilitation and Extended Care Physical

Medicine and Rehabilitation Service will become formally involved in discussions leading to a solution. The faculty and resident(s) may be asked to discuss the problem and alternative solutions, especially if the problem involves either ethical issues related to patient care or possible changes in the student's program of training. A remediation alternative may be suggested, as described above.

4. If the problem cannot be resolved through these steps or if the ACOS for Education believes that the nature of the resolution lies outside its scope of authority, the Chief of the Rehabilitation and Extended Care Physical Medicine and Rehabilitation Service, Human Resources, and/or other hospital administrators may be consulted to assist in planning and adjustments. If the situation, for example, should involve the health or functioning of a resident, the VA has an active policy in the event of incapacitation.
5. Whenever a decision has been made by the RPD about a resident's training program or status in the agency, the RPD will inform the resident in writing and will meet with the resident to review the decision. This meeting may or may not include the resident's faculty.
6. The resident may choose to accept the conditions or may choose to challenge the action. The procedures for challenging the action are presented below.

#### IV. Due Process

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

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

6. Ensuring that residents have sufficient time to respond to any action taken by the program.
7. Using input from multiple professional sources when making decisions or recommendations regarding the resident's performance.
8. Documenting, in writing and to all relevant parties, the actions taken by the program and its rationale.

## V. Grievance Procedure

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

1. In the event a resident encounters any difficulties or problems with staff members (e.g. poor supervision, unavailability of supervisor, evaluations perceived as unfair, workload issues, personality clashes, other staff conflict) during their training experiences, a resident can:
  - a. Discuss the issue with the staff member(s) involved;
  - b. If the issue cannot be resolved after this discussion, the resident should discuss the concern with the RPD;
  - c. If the RPD cannot resolve the issue, the resident and RPD should discuss the problem with the Service Chief; or, if the resident has a concern with the RPD that has not been resolved through discussion with the RPD, the resident can discuss the problem with the Service Chief.
  - d. If the Service Chief cannot resolve the issue, the resident can formally challenge any action or decision taken by the RPD, the supervisor or any member of the training staff by following this procedure:
  - e. If the resident has a concern with the Service Chief, the resident can discuss the problem with the Associate Chief of Staff for Education prior to filing a formal complaint (as noted above). The resident should file a formal complaint, in writing and all supporting documents, with the RPD. If the resident is challenging a formal evaluation, the resident must do so within 5 days of receipt of the evaluation. Within five days of a formal complaint, the RPD must consult with the Service Chief and implement Review Panel procedures as described below.
2. If a training staff member has a specific concern about a resident (other than inadequate performance), the staff member should:
  - a. Discuss the issue with the resident(s) involved.
  - b. Consult with the RPD

- c. If the issue is not resolved informally, the staff member may seek resolution of the concern by written request, with all supporting documents, to the RPD for a review of the situation. When this occurs, the RPD will within five days of a formal complaint, the RPD must consult with the Service Chief and implement Review Panel procedures as described below.

### 3. Review Panel and Process

- a. When needed, a Review Panel will be convened by the Service Chief. The Panel will consist of three staff members selected by the Service Chief with recommendations from the RPD and the resident involved in the dispute. The resident has the right to hear all facts with the opportunity to dispute or explain the behavior of concern.
- b. Within five (5) workdays, a hearing will be conducted in which the challenge is heard and relevant material presented. Within three (3) workdays of the completion of the review, the Review Panel submits a written report to the Service Chief, including any recommendations for further action. Recommendations made by the Review Panel will be made by majority vote.
- c. Within three (3) workdays of receipt of the recommendation, the Service Chief will either accept or reject the Review Panel's recommendations. If the Service Chief rejects the panel's recommendations, due to an incomplete or inadequate evaluation of the dispute, the Service Chief may refer the matter back to the Review Panel for further deliberation and revised recommendations or may make a final decision.
- d. If referred back to the panel, they will report back to the Service Chief within five (5) workdays of the receipt of the Service Chief's request of further deliberation. The Service Chief then makes a final decision regarding what action is to be taken.
- e. The RPD informs the resident, staff members involved and if necessary members of the training staff of the decision and any action taken or to be taken.
- f. If the resident disputes the Service Chief's final decision, the resident has the right to contact the Associate Chief of Staff for Education to discuss this situation.
- g. If the resident disputes the Associate Chief of Education's decision, the resident has the right to contact the Department of Human Resources to discuss this situation.

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

# Resident Acknowledgement

I acknowledge that I have received and read the VA Central Iowa Health Care System Chiropractic Residency Program Handbook.

I have had an opportunity to discuss the contents with the Residency Director and have any questions answered.

As a trainee of the VA Central Iowa Health Care System, I understand that I am responsible for complying with the rules and regulations as set forth in this Handbook and other VA trainings.

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Resident Name

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Resident Signature

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Date

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Residency Director Name

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Residency Director Signature  
Nathan Hinkeldey, D.C.

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Date