

SUPERVISION OF PHYSICIAN, DENTAL, OPTOMETRY, CHIROPRACTIC, AND PODIATRY RESIDENTS

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) directive provides the procedural requirements to ensure proper supervision of residents in clinical care and its documentation thereof. This is fundamental for the provision of excellent patient care and education and training for future health care professionals.

2. SUMMARY OF MAJOR CHANGES: This directive includes the following major changes:

- a. Adds requirements pertaining to resident supervision standards in tele-medicine and tele-Intensive Care Unit (ICU) situations (see paragraph 8.c.(11)).
- b. Adds additional language clarifying requirements for the levels of surgical supervision during procedures (see paragraph 8.c.(5)).
- c. Clarifies language related to routine, bedside procedures (see paragraph 8.c.(6)).
- d. Clarifies requirements for discharge documentation (see paragraph 8.c.(1)(c)).

3. RELATED ISSUES: VHA Directive 1400.09(1), Education of Physicians and Dentists, dated September 9, 2016; VHA Directive 1052, Appropriate and Effective Use of Mandatory and Required Training, dated June 29, 2018;; VHA Handbook 1400.03, VHA Educational Relationships, dated February 16, 2016; VHA Handbook 1400.04, Supervision of Associated Health Trainees, dated March 19, 2015; VHA Handbook 1400.05, Disbursement Agreement Procedures for Physician and Dentist Residents, dated August 14, 2015; VHA Handbook 1400.07, Education of Advanced Fellows, dated February 26, 2016; VHA Handbook 1400.08, Education of Associated Health Professions, dated February 26, 2016; VHA Handbook 1400.10, Health Care Resources Contracting: Educational Costs of Physician and Dentist Resident Training Pursuant to Title 38 United States Code 8153, dated November 16, 2012; VHA Handbook 1400.11, Extended Educational Leave, dated April 1, 2016; and VHA Handbook 1907.01, Health Information Management and Health Records, dated March 19, 2015.

4. RESPONSIBLE OFFICE: The Chief Academic Affiliations Officer (10X1) is responsible for the content of this directive. Questions may be directed to 202-461-9490.

5. RESCISSIONS: VHA Handbook 1400.01, Resident Supervision, dated December 19, 2012, is rescinded.

6. RECERTIFICATION: This VHA directive is scheduled for recertification on or before

November 7, 2019

VHA DIRECTIVE 1400.01

the last working day of November 2024. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

**BY THE DIRECTOR OF THE OFFICE OF
THE UNDER SECRETARY FOR HEALTH:**

/s/ Carolyn Clancy, MD
Deputy Under Secretary for Health for
Discovery, Education, and Affiliate Networks

NOTE: *All references herein to VA and VHA documents incorporate by reference subsequent VA and VHA documents on the same or similar subject matter.*

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SUPERVISION OF PHYSICIAN, DENTAL, OPTOMETRY, CHIROPRACTIC, AND PODIATRY RESIDENTS

1. PURPOSE

This Veterans Health Administration (VHA) directive states policy for the supervision of physician, dentist, optometrist, chiropractic, and podiatry residents and focuses on resident supervision from the educational perspective. **NOTE:** See *VHA Directive 1401, Billing for Services Provided by Supervising Practitioners and Physician Residents, dated July 29, 2016, for guidance on billing related to services provided by supervising practitioners and residents.* **AUTHORITY:** Title 38 United States Code (U.S.C.) 7301(b).

2. BACKGROUND

a. A clear delineation of clinical responsibilities ensures that practitioners provide high-quality patient care, whether they are trainees or full-time staff. As resident trainees acquire the knowledge and judgment that accrues with experience, they are allowed the privilege of increased authority for patient care. To ensure safe patient care and effective teaching to allow this professional advancement, supervising clinicians must supervise resident activity.

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

c. VHA must comply with the requirements and accreditation standards of health care accrediting bodies, such as The Joint Commission, Commission on Accreditation of Rehabilitation Facilities and others as appropriate. Health care professionals with appropriate credentials and privileges provide care for Veterans and supervise residents in that care.

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

3. DEFINITIONS

a. **Additional Signer (or Identified Signer as this is referred to in Computerized Patient Record System)**. The additional signer (or Identified Signer as this is referred to in Computerized Patient Record System (CPRS)) 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 and cannot be used for resident supervision purposes. **NOTE:** For additional information, see VHA Handbook 1907.01, *Health Information Management and Health Records*, dated March 19, 2015.

b. **Chief Resident**. The chief resident is an individual who is considered senior in the training program and who may be a licensed independent practitioner (LIP). Chief residents are designated by the Program Director and may assume advanced administrative responsibilities necessary for the operation of the residency program. Chief residents fall into one of two categories:

(1) **Chief Resident – In Training**. In-training chief residents are currently enrolled in an accredited residency program, but have not completed the full academic program leading to board eligibility. These chief residents are not independent and cannot be privileged to work in the discipline for which they are being trained. This model is common in surgery programs. **NOTE:** *In-training chief residents may function as LIPs outside of their training programs if licensed, credentialed and privileged and meet staff appointment qualifications.*

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

c. **Co-Signer**. A co-signer is the supervising practitioner. A co-signer may also be a service chief, or designee, as defined by the organization's by-laws or policies. A co-signer may edit and authenticate a document if the author has not already signed the document. **NOTE:** See VHA Handbook 1907.01 for additional information.

d. **Designated Education Officer**. The Designated Education Officer (DEO) is the single designated Department of Veterans Affairs (VA) employee who oversees all clinical training at each VA medical facility that either sponsors or participates in accredited training programs. The DEO (whose preferred organizational title is ACOS/E) is a designated education leader with expertise in graduate medical education (GME) and health professions education. The DEO describes a functional assignment and not an organizational title.

e. **Designated Institutional Official.** The Designated Institutional Official (DIO) is an individual employed by the entity sponsoring the residency program who has the institutional authority for the oversight and administration of training in discipline-specific programs. Accreditation Council for Graduate Medical Education (ACGME) requires that each institution sponsoring ACGME-accredited programs have an individual appointed as the DIO. A VA medical facility that sponsors ACGME-accredited programs independently must have a DIO, although the responsibilities and functions overlap with those described for the DEO.

f. **Documentation.** For purposes of this directive, documentation is the written or electronic health record evidence of the interaction between a supervising practitioner and a resident concerning a patient encounter and the care provided.

g. **Entrustable Professional Activity.** An EPA is a unit of professional practice, defined as a task or responsibility to be entrusted to a trainee for unsupervised execution once the trainee has attained sufficient specific competence. EPAs are independently executable, observable, and measurable in their process and outcome, and suitable for entrustment decisions.

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

i. **Milestone.** Milestones are stages in the development of specific competencies during a trainee's training. Milestones may be linked to EPAs in determining the degree of supervision for particular activities.

j. **Network Academic Affiliations Officer.** The Network Academic Affiliations Officer is the designated education leader at the Veterans Integrated Service Network (VISN) level with expertise in health professions education, who coordinates regional education activities. The assignment may be collateral, part-time or full-time, depending on the size and complexity of the VISN education programs.

k. **Night Float and Over Cap Residents.**

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

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

l. **Observation Patient.** An observation patient is a patient who presents with an unstable medical, surgical, or mental health condition, and laboratory, radiologic, or other testing is necessary in order to assess the patient's need for hospitalization versus discharge. Alternatively, a patient for whom the treatment plan is not established; however, based on the patient's condition, completion of a treatment plan is anticipated within a period not to exceed 48 hours.

m. **Program.** For purposes of this policy, a program is a structured, accredited educational experience in graduate medical, dental, podiatry, chiropractic, or optometry education designed to conform to the program requirements of a particular specialty or subspecialty, the satisfactory completion of which may result in eligibility for board certification.

n. **Residency/Fellowship Program Director.** The Program Director is the person designated with authority and accountability for the operation of the accredited residency or fellowship program.

o. **Resident.** A resident is an individual who is engaged in an accredited graduate training program for physicians, dentists, optometrists, chiropractors, or podiatrists, and who participates in patient care under the direction of supervising practitioners. Although a trainee may be considered a resident within a training program, that person may also have completed training requirements for board eligibility in another specialty. If so, that resident may be considered an independent licensed practitioner only in accordance with paragraph 11.b., in the specialty for which he or she has met the board eligibility requirements. Within a training program, a resident is never considered a Licensed Independent Practitioner. ***NOTE: For the purpose of this directive, the term resident includes individuals in their first year of training, who are sometimes referred to as interns, and individuals in approved subspecialty graduate medical education programs, who are also referred to as fellows.***

(1) **Post-Graduate Year-1 Resident.** Post-Graduate Year (PGY)-1 residents are in their first PGY of training. ***NOTE: Sometimes referred to as interns.***

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

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

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

p. **Signer.** A signer is the author of the document. Once a document is signed, it cannot be edited. Additional documentation can be added to the original document by addenda. **NOTE:** See *VHA Handbook 1907.01 for additional information.*

q. **Supervising Practitioner.** Supervising practitioner (sometimes referred to as attending or faculty) refers to licensed independent physicians, dentists, optometrists, chiropractors, and podiatrists, regardless of the type of VA appointment, who have been credentialed and privileged at a VA medical facility and by the associated training program, in accordance with applicable requirements. In some training settings and according to the requirements of the accrediting body, other health care professionals with documented qualifications and appropriate academic appointments (i.e., nurse practitioners, psychologists, audiologists), may function as supervising practitioners for selected training experiences. **NOTE:** *A supervising practitioner must be approved by the program of the residency program in order to supervise residents.*

NOTE: *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 approves the assignment to teach and supervise residents. Assignment of supervising practitioners must be coordinated with the Program Director, the VA Site Director, the applicable VA Service Chief, and the affiliated Department Chair as appropriate. The specific VA staff approved to supervise residents should be delineated in the Program Letter of Agreement.*

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

(1) **Direct Supervision.** Direct supervision means the supervising practitioner is physically present with the resident and the patient. In direct supervision, the supervising practitioner is a party to the patient encounter between the patient and a resident even if the “encounter” with the patient is non-face-to-face. The resident and supervising practitioner must be co-located if the patient is remote (see paragraph 8.c.(11) on telemedicine). **NOTE:** *Text messaging, voice messaging, emails, or written*

letters, are not considered supervision. Direct supervision can be further characterized by the level of attending involvement according to whether the supervising practitioner:

- (a) Provides care with the resident observing or assisting.
- (b) Participates in care which is provided by the resident.
- (c) Observes while the resident provides care.

(2) **Indirect Supervision.** Indirect supervision is supervision exercised by a supervising practitioner who is not physically present with the resident and the patient during the patient encounter, procedure, or episode of care. In all such instances, the supervising practitioner is either located in the same site of patient care or is on-call by means of telephonic, video-conferencing, or other electronic modalities for consultation. In such instances, the supervising practitioner must be available in a manner that ensures patient safety to participate in patient care or direct supervision, as needed. The supervising practitioner may be:

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

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

NOTE: *The definitions of levels and intensity of supervision are from ACGME's Common Program Requirements (see <https://www.acgme.org/What-We-Do/Accreditation/Common-Program-Requirements>). **NOTE:** This linked document is outside of VA control and may not be conformant with Section 508 of the Rehabilitation Act of 1973.*

s. **Unstable Condition.** Unstable condition is defined as a variance from generally accepted normal laboratory values, and clinical signs and symptoms are present that are above or below those of normal range (for the patient) and are such that further monitoring and evaluation is needed; or changes in the patient's status or condition are anticipated and immediate medical intervention may be required.

t. **VA Advanced Fellow.** VA Advanced Fellow refers to a VA-based clinical trainee who has enrolled in a VA Advanced Fellowship Program for additional training, primarily in research. Advanced fellowships are non-accredited training programs that are funded directly from the Office of Academic Affiliations in a separate allocation process from accredited residency positions. VA Advanced Fellows are physicians in VA Advanced Fellowships who 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 Advanced Fellowships have completed a Commission on Dental Accreditation (CODA)-accredited residency and are licensed independent practitioners. Similar requirements apply to any optometrist, podiatrist or chiropractor VA Advanced Fellows. All VA Advanced Fellows must be credentialed and privileged in the discipline(s) of their completed programs. VA Advanced Fellows may function as supervising practitioners for other trainees.

u. **VA Program Site Director.** In accordance with accrediting and certifying body requirements, appropriately credentialed local VA clinicians are appointed as VA residency training program site directors for each residency training program. In affiliated programs, these designations must be made with the concurrence of the program director of the residency program.

4. POLICY

It is VHA policy that VA-appointed physician, dental, optometry, chiropractic, and podiatry trainees must serve under the supervision of a VHA licensed independent practitioner who is locally credentialed and appropriately privileged. Further, it is VHA policy that residents must be enrolled in accredited or Office of Academic Affiliations-approved training programs, and are not considered licensed independent practitioners regardless of licensure status while performing activities in the training program. Trainees assume graduated and incremental responsibilities (EPAs) for the clinical care of Veterans under supervision.

5. RESPONSIBILITIES

a. **Under Secretary for Health.** The Under Secretary for Health is responsible for ensuring overall VHA compliance with this directive.

b. **Deputy Under Secretary for Health for Operations and Management.** The Deputy Under Secretary for Health for Operations and Management is responsible for:

(1) Communicating the contents of this directive to each of the VISN.

(2) Ensuring that each VISN Director has sufficient resources to fulfill the terms of this directive in all VA medical facilities within that VISN.

(3) Providing oversight of VISNs to assure compliance with this directive, relevant standards, and applicable regulations.

c. **Deputy Under Secretary for Health for Discovery, Education and Affiliate Networks.** The Deputy Under Secretary for Health for Discovery, Education and Affiliated Networks is responsible for:

- (1) Overseeing and advancing the health professions education mission for VA.
- (2) Enhancing knowledge of VA's education mission through communication with internal and external stakeholders.
- (3) Ensuring that the Office of Academic Affiliations (OAA) has sufficient resources to carry out the statutory mission and the responsibilities in this directive.
- (4) Providing senior executive leadership guidance to OAA.

d. **Chief Academic Affiliations Officer.** The Chief Academic Affiliations Officer is responsible for:

- (1) Defining national policies pertinent to residents in VA medical facilities, and overseeing implementation of the OAA policies through multiple oversight mechanisms.
- (2) Completing an annual review of resident supervision through the Annual Report of Resident Training Programs (ARRTP) (RCN 10-0906).
- (3) Sharing results from the annual review with appropriate VHA leadership to ensure that VA continuously improves its ability to provide safe and effective patient care; ensuring applicable feedback is provided to VISNs and their respective facilities.
- (4) Presenting pertinent decision-making information to VHA's leadership.
- (5) Allocating specific resources for residents' stipends and benefits.

e. **Veterans Integrated Service Network Director.** The VISN Director is responsible for:

- (1) Addressing residency program needs and obligations in VISN planning and decision-making, and making necessary resources available to the respective affiliated VA medical facilities to ensure resident supervision is provided as outlined in this directive.
- (2) Appointing a Network Academic Affiliations Officer for coordination of regional education activities.
- (3) Ensuring that each affiliated VA medical facility has a monitoring process in place as detailed in paragraphs below.
- (4) Reviewing the annual reports of all affiliated facilities in the VISN to identify opportunities for improvement or areas that need further review.

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

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

(1) Completing an annual VISN-level AR RTP assessment of VA medical facility residency training and resident supervision activities and identifying opportunities for improvement or areas that need further review after a review of each VA medical facility's AR RTP (RCN 10-0906).

(2) Presenting educational needs and obligations to the VISN Director for consideration in VISN planning and decision-making.

(3) Assisting VA medical facilities in implementing policies relating to health professions training.

(4) Ensuring that all VA medical facilities comply with the contents of this directive and have a robust local monitoring program.

g. **VA Medical Facility Director.** The VA medical facility Director is responsible for:

(1) Appointing and assigning the duties of the Designated Education Officer (DEO) to the appropriate local education leader and ensuring that appropriate staff is available for monitoring resident supervision at the VA medical facility-level.

(2) Appointing and assigning the duties of the Designated Institutional Officer (DIO) for the facility if the VA facility has sponsorship residency programs.

(3) Ensuring through the Chief of Staff, and/or the Associate Chief of Staff for Education, that a local monitoring process exists for resident supervision.

(4) Reporting to the VISN Director or designee the status of resident training programs in that VA medical facility. This reporting must take place through the AR RTP (RCN 10-0906) process.

(5) Confirming that the VA medical facility adheres to current accreditation requirements as set forth by the ACGME, CODA, the Executive Committee of the Council on Postdoctoral Training (ECCOPT), the Council on Podiatric Medical Education (CPME), the American Osteopathic Association (AOA), the Council on Chiropractic Education and Accreditation Council on Optometric Education (ACOE) for all matters pertaining to the resident training program, including the level of supervision provided.

(6) Confirming that 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), CODA, American Board of Podiatric Orthopedics and Primary Podiatric Medicine (ABPOPPM),

and ACOE are incorporated into VA training programs and fulfilled through local medical facility guidelines and procedures to ensure that each successful program graduate is eligible to sit for the certifying examination in the graduate's specialty.

h. **VA Medical Facility Chief of Staff.** The VA medical facility COS or designee is responsible for:

(1) Assessing the quality of residency training programs at the VA medical facility, and the quality of care provided by supervising practitioners and residents.

(2) Ensuring the presence of a work environment that is consistent with quality patient care and the educational needs of residents that meet all applicable program requirements. **NOTE:** *An ACOS/E (DEO) may assist the CoS in fulfilling these requirements.*

i. **Associate Chief of Staff for Education or the Designated Education Officer.** The ACOS/E or the DEO is responsible for ensuring that:

(1) The contents of this directive are followed.

(2) Graduated levels of responsibility are established in each specialty or subspecialty and the information regarding these levels is accessible to ward and clinic staff.

(3) The VA medical facility completes the AR RTP including monitoring resident supervision on a quarterly basis.

(4) The VA medical facility establishes a process for identifying and remediating areas with insufficient resident supervision.

(5) Assists the Chief of Staff (COS) in assessing the quality of residency training programs and the quality of care provided by supervising practitioners and residents. All VA medical facilities with more than a single residency program must have one designated responsible individual for these functions.

j. **Residency/Fellowship Program Director.** The Residency/Fellowship Program Director (who may be based at the VA or the affiliate institution) is responsible for:

(1) Providing residents with direct experience in progressive responsibility for patient management.

(2) Monitoring the quality of the overall education and training program in a given discipline (i.e., medicine, dentistry, optometry, chiropractic, or podiatry).

(3) Ensuring that the program is in compliance with the policies of the respective accrediting or certifying bodies.

(4) Defining the levels of responsibilities for each year of training by preparing a description of the types of clinical activities residents may perform. Each training program must be constructed to encourage and permit residents to assume increasing levels of responsibility relative to their individual progress in experience, skill, knowledge, and judgment. Annually, at the time of promotion or more frequently as appropriate, this document, along with a list of residents assigned to each year or level of training, is provided to the relevant VA Site Director, Service Chief, COS, and DEO.

(5) Giving residents permission to engage in any clinical activity outside the scope of their current training program.

k. **VA Program Site Director.** The VA Site Director is responsible for:

(1) 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.

(2) Ensuring that residents function within their assigned graduated level of responsibility.

(3) Structuring and monitoring training programs, in collaboration with the Program Director, consistent with the requirements of the accrediting and certifying bodies identified in paragraph 5.g.(5) and the affiliated participating entity.

(4) 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.

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

(6) Ensuring that for services that provide 24 hours a day, 7 days per week (24/7) resident coverage, call schedules are provided to the VA medical facility administration. Call schedules must delineate both resident and attending coverage for acute and extended care wards, intensive care units, and consultative services.

(7) Ensuring provision of a duty hour schedule that is consistent with proper patient care, the educational needs of residents, and all applicable program requirements.

l. **Designated Institutional Official.** The Designated Institutional Official (DIO) (who is usually not based at VA) is responsible for:

(1) The oversight and administration of training in discipline-specific programs.

(2) The oversight and administration of the sponsoring institution's ACGME accredited programs.

(3) Ensuring compliance with ACGME institutional requirements.

m. **Supervising Practitioner.** The supervising practitioner is responsible for:

(1) Being personally involved in the care of their patients in all clinical settings. Whenever a resident is involved in the care of a patient, the supervising practitioner must continue to maintain a personal involvement in the care of the patient.

(2) Providing the appropriate level and intensity of supervision based on the patient's condition, including the complexity and acuity of such condition, and the experience and capability of the trainee being supervised. All patient care services must be rendered under the supervision of the responsible practitioner or must be personally furnished by the supervising practitioner. Supervising practitioners can provide care and supervision only for those activities and in settings for which they have clinical privileges, and for residents in programs for which they have clearly documented relationships. The supervising practitioner's name must be identifiable in the record of each patient being treated.

(a) For example, while a rheumatologist could supervise a podiatry resident on a rheumatology clinic elective or on an inpatient internal medicine rotation, a rheumatologist could not be the supervising practitioner for a podiatry resident in podiatry clinic or in the operating room (OR).

(b) Likewise, an oral surgery resident rotating on an internal medicine service could not provide oral surgery services when under the supervision of a general internist.

(c) Also, a hospitalist, emergency department (ED) physician, or anesthesiologist may directly supervise a PGY-1 surgery resident for non-surgical patient management when there are appropriately documented relationships in place.

(3) Delegating responsibility for the care of the patient and the supervision of the residents involved to an alternate supervising practitioner, if necessary. Ensuring 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.

(4) Ensuring patient safety and high-quality care while maximizing the educational experience of the resident in the clinical setting. In the ambulatory setting, it is expected that an appropriately privileged supervising practitioner will be physically present and available for supervision during clinic hours.

(5) Ensuring that all trainee supervision is properly documented in the health record by the supervising practitioner or reflected within the trainee progress note. The health record must reflect the involvement of the supervising practitioner. (For detailed information, see paragraph 8.)

(6) Authorizing the performance of non-routine, non-bedside procedures and being physically present in the procedural area for such procedures.

(7) Obtaining access to the electronic health record to properly supervise trainees.

6. RESIDENT FUNCTIONS GENERALLY

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

b. **Chief Resident - Post Training.** Post-training chief residents may function either as a trainee, as a staff physician and supervising practitioner, or as a hybrid trainee and supervising practitioner, depending on the type of personnel appointment, salary level and source, and privileges according to the following three options. **NOTE:** *The requirements for billing are outside the scope of this resident supervision handbook. Refer to VHA Directive 1401 on guidance for services provided by supervising practitioners and physician residents.*

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

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

- (a) Co-sign other resident and student notes.
- (b) Supervise other trainees; and in general.
- (c) Function as independent practitioners.

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

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

(a) In order to function as licensed independent practitioners, they must:

- 1. Go through the credentialing process.
- 2. Have full medical licensure.

3. Be granted privileges by VA to function independently within their specialty.

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

1. Co-sign other resident and student notes.

2. Supervise other trainees.

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

c. **Resident.** Within the scope of the accredited training program, all residents must function under the supervision of supervising practitioners at all times. Residents must:

(1) Be aware of their limitations and not attempt to provide clinical services or perform procedures for which they have not achieved the appropriate level of experience or capability.

(2) Know the graduated level of responsibility described for their level of training and not practice beyond that level or outside their scope of practice.

(3) Be responsible for communicating significant patient data to the supervising practitioner. Circumstances warranting immediate resident communication with the supervising practitioner include, but are not limited to: significant changes in patient status (e.g., acute decline in physiologic condition); end of life decisions; use of restraints; and “near misses” or adverse events that may occasion a patient safety incident report. Such communication must be documented in the record. Residents must introduce themselves to patients or to the patient’s surrogate, in the event that the patient is unable to communicate with the resident, and explain their role in providing supervised patient care to the patient. **NOTE:** *In some cases, residents, including chief residents, have completed one residency program and required training for board eligibility or board-certification while enrolled in an additional residency training program. These individuals (i.e., fellows or post-training chief residents) may be credentialed and privileged for independent practice only in the discipline in which they have attained board certification or have completed the training for board eligibility.*

7. GRADUATED LEVELS OF RESPONSIBILITY

a. As part of their training programs, residents earn progressive levels of responsibility (attainment of milestones/EPAs) for the care of the patient. The determination of a resident's ability to provide care to patients without a supervising practitioner present (EPA), or to act in a teaching capacity, is based on documented evaluation of the resident's clinical experience, judgment, knowledge, and technical skill. Ultimately, it is the decision of the supervising practitioner as to which activities the resident will be allowed to perform within the context of the assigned levels of responsibility. In general, residents may order laboratory studies, radiology studies, pharmaceuticals, and therapeutic procedures as part of their assigned levels of

responsibility. In addition, residents are allowed to certify and re-certify certain treatment plans (e.g., physical therapy, speech therapy) as part of their assigned levels of responsibility. These activities are considered part of the normal course of patient care and require no additional documentation on the part of the supervising practitioner over and above standard setting-specific documentation requirements. See VHA Directive 1400.09(1), Education of Physicians and Dentists, dated September 9, 2016, regarding medical and dental student participation in care and documentation. The overriding consideration in determining assigned levels of responsibility must be the safe and effective care of the patient. In order to write prescriptions for patients, residents must have a National Provider Identifier (NPI). **NOTE:** See VHA Directive 1066, Requirement for NPI and Taxonomy Codes, dated November 7, 2013.

b. VA staff such as nursing, respiratory therapy, and supervising attendings, must have 24/7 access to a listing or description of graduated levels of responsibility. Provision of these lists or access to online resources that allow determination of what each resident may perform is the responsibility of the Program Director (see paragraph 5.j.(4)).

c. Annually, at the time of promotion or more frequently as appropriate, this documentation of the graduated levels of responsibility, along with a list of residents assigned to each year or level of training, is provided to the relevant VA Program Site Director, Service Chief, COS, and DEO.

8. DOCUMENTATION OF SUPERVISION OF RESIDENTS

a. **Supervising Practitioner Involvement.** The health record must clearly demonstrate the involvement of the supervising practitioner in each type of resident-patient encounter as described below. **NOTE:** *Documentation requirements are outlined in paragraph 8.c.*

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

(1) Types of allowable documentation include, depending on the clinical situation, (see below):

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

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

(c) Co-signature of the progress note or other health record entry by the supervising practitioner. **NOTE:** *The supervising practitioner's co-signature signifies that the supervising practitioner has reviewed the resident note, and absent an addendum to the contrary, concurs with the content of the resident note or entry.*

(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, diagnosis and the plan for evaluation and treatment. Statements such as the following are acceptable to demonstrate the supervising practitioner's level of supervision or oversight responsibility:

1. "I have seen and discussed the patient with my supervising practitioner, Dr. 'X' and Dr. 'X' agrees with my assessment and plan."

2. "I have discussed the patient with my supervising practitioner, Dr. 'X' and Dr. 'X' agrees with my assessment and plan."

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

c. Supervision and Documentation Across Patient Settings.

(1) Inpatient Care.

(a) Inpatient Admission. For patients admitted to an inpatient service of the VA, the supervising practitioner must physically meet, examine, and evaluate the patient within the timeframe specified in the VA medical facility bylaws, not to exceed the end of the next calendar day after admission, including weekends and holidays. Documentation of the supervising practitioner's personal involvement, findings and recommendations regarding the treatment plan must be in the form of an independent progress note or an addendum to the resident note. This may take the form of "I have personally assessed the patient, reviewed the medical record and diagnostic studies, and agree with the resident's assessment and plan." This documentation must be entered within the timeframe specified in the VA medical facility bylaws, not to exceed the end of the next calendar day following admission. If the specific requirements of the pre-operative notes are included, the admission note (or addendum) may serve as the pre-operative note. PGY-1 residents must have on-site supervision at all times by either a supervising practitioner or a more advanced resident, with the supervising practitioner being available on-call (on-site or off-site).

(b) Night Float and Over Cap Admissions. For patients admitted to an inpatient service of the VA medical facility during evenings or nights, a night float or over cap resident may provide care before the care of the patient is transferred to an inpatient

ward team. In these cases, the supervising practitioner of the inpatient ward team receiving the patient must physically meet and examine the patient within the timeframe specified in the VA medical facility bylaws, not to exceed the end of the next calendar day after admission by the night float to the inpatient service, irrespective of the time the ward team assumes responsibility for the patient. In addition, appropriate handoff procedures and the designation of a supervising practitioner for night float admissions must follow VA medical facility guidelines. On-site supervision of the night float or over cap resident must be in place, if that resident is a PGY-1 resident. **NOTE:** *Documentation requirements are the same as in preceding paragraph 8.c.(1)(a).*

(c) 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 VA medical facility is appropriate and based on the specific circumstances of the patient's diagnoses and therapeutic regimen; discharge instructions and orders may include physical activity, medications, diet, functional status, and follow-up plans, including coordination with the patient's primary care team. Evidence of this supervisory involvement must be documented by the supervising practitioner's co-signature on the discharge note (last progress note of the patient's stay), of the discharge instruction note, resident documentation of the supervisor's agreement with discharge, or an addendum or independent discharge note, in a timeframe that ensures patient safety. Any of these methods will suffice to ensure supervisor agreement with the discharge plan. The discharge summary must also be co-signed by the supervising practitioner. All timeliness standards should be defined in medical staff bylaws.

(d) 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 and this assessment is documented in the health record using any of the four types of documentation referenced in paragraph 8.b. When a patient requires a different level of care within the same ward or unit, the supervising practitioner must be involved in the decision to change the level of care and documentation of the appraisal must be entered into the health record using any of the four types of documentation referenced in paragraph 8.b.(1)(a)-(d). 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. **NOTE:** *This provision covers transfers into and out of intensive care units or transfers to extended care. However, if the same supervising practitioner is responsible for the patient across different levels of care, transfer documentation is not required.*

(e) Inpatient Consultations. A consultant supervising practitioner on a specialty service is responsible for clinical consultations for their specialty service. When residents are involved in consultation services as consultants, the consultant supervising practitioner is responsible for the supervision of these residents. **NOTE:** *Any of the four types of documentation referenced in paragraph 8.b.(1)(a)-(d) is acceptable.*

(f) Intensive Care Units, including Medical, Cardiac, and Surgical Intensive Care Units. For patients admitted to, or transferred into, an Intensive Care Unit (ICU) of the VA medical facility, the supervising practitioner must meet, personally evaluate the patient, review the history, perform a physical examination, review diagnostic data, as soon as practicable, 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 indicating the personal involvement and independent assessment (see 8(c)(1)(a)) is required in the timeframe specified in the VA medical facility bylaws, not to exceed the end of the next calendar day after admission. Due to the unstable nature of patients in ICUs, based on the patient's condition, an appropriate level of involvement, including independent personal assessments, by the supervising practitioner, with documentation of such involvement, is required. PGY-1 residents must have on-site supervision at all times by either a supervising practitioner or a more advanced resident, with the supervising practitioner being available on-call. Supervising practitioner involvement is expected on a daily or more frequent basis and must be documented using any of the four types of documentation referenced in paragraph 8.b.(1)(a)-(d).

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

(2) **Outpatient Clinic.**

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

(b) New Outpatient Encounters. New patients to a VA medical facility (including Vet Centers) require a higher level of supervising practitioner documentation than established outpatients. Each new patient needs to be seen by or discussed with the supervising practitioner. Documentation of supervising practitioner involvement must be entered in the patient health record per paragraph 8.b.(1)(a)-(d). **NOTE:** *Supervising practitioner's co-signature of the resident's note is not sufficient documentation of resident supervision.*

(c) Outpatient Consultations. A supervising practitioner is responsible for the decision to initiate clinical consultations from an outpatient clinic to a consultation service. When residents are involved in delivering consultation services, the consulting

supervising practitioner is responsible for supervision of these residents. The consulting attending must be contacted by the resident on the consultation service while the patient is still in the clinic. **NOTE:** *Any of the four types of documentation referenced in paragraph 8.b.(1)(a)-(d) 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.

(e) Discharge from Outpatient Clinic. The supervising practitioner, in consultation with the resident, ensures that the discharge of the patient from the clinic is appropriate.

(3) **Extended Care or Community Living Centers.**

(a) New Extended Care Admissions. Each new patient admitted to an extended care or Community Living Center (CLC) facility must be seen by the responsible supervising practitioner within 72 hours of admission.

(b) Continuing Care in the Extended Care or CLC Setting. The identity of the supervising practitioner must be communicated to the resident 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. Any of the four types of documentation referenced in paragraph 8.b.(1)(a)-(d) is acceptable.

(4) **Emergency Department.**

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

(b) ED Visits. Each patient to the ED must be seen by or discussed with the supervising practitioner.

(c) Discharge from the ED. The supervising ED practitioner, in consultation with the ED resident, ensures that the discharge of the patient from the ED is appropriate.

(d) ED Consultations. A consulting supervising practitioner is responsible for clinical consultations requested for their specialty service. When residents are involved in consultation services, the consulting service supervising practitioner is responsible for supervision of these residents. Residents from a consulting service must contact their supervising practitioners while the patient is still in the ED in order to discuss the case and to develop a recommended plan of management. The ED practitioner is responsible for the disposition of the patient. **NOTE:** *The ED practitioner is not the supervisor of the consulting resident, but is the responsible practitioner for the patient.*

(5) **Operating Room Procedures.** Supervising practitioners must provide appropriate supervision for the patient's evaluation, including management decisions

involving the patient's medical condition, and procedures performed on the patient. The level of supervision is a function of the level of responsibility assigned to the individual resident involved, demonstrated competence, and the complexity of the patient's condition and procedure. PGY-1 residents providing care in the OR must be directly supervised at all times, except if the OR is used for convenience or space reasons, but the procedures are actually routine bedside or clinic procedures. In that case, supervision more appropriately follows routine or clinic procedure guidelines, where on-site supervision is allowed after demonstration and documentation of competence is attained. **NOTE:** *If independent performance of a routine bedside or clinic procedure is authorized in clinic or inpatient locations, it is also authorized in the OR.*

(a) Pre-procedure Note. For all elective or scheduled surgical procedures, a supervising practitioner must evaluate the patient and write a pre-procedural note or an addendum to the resident's pre-procedure note describing the findings, diagnosis, plan for treatment, and choice of specific procedure to be completed. The pre-procedure supervising practitioner note requirement applies to procedures performed in the OR or procedure rooms. 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. This pre-procedural evaluation and note may be done up to 30 days in advance of the surgical procedure. All applicable health care accrediting body standards concerning documentation must be met. A pre-procedure note may serve as the admission note if it is written within the timeframe specified in the VA medical facility bylaws, not to exceed the end of the next calendar day after 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. **NOTE:** *Use of appropriate note titles in the electronic medical record is encouraged.* Other services involved in the patient's operative care (e.g., Anesthesiology) must write their own pre-procedure notes (such as for the administration of anesthesia) as required by the pertinent health care accrediting body but such documentation does not replace the pre-operative documentation required by the surgery supervising practitioner.

(b) Informed Consent. Informed consent must be obtained as detailed in VHA Handbook 1004.01, Informed Consent for Clinical Treatments and Procedures, dated August 14, 2009.

(c) Time Out. Every procedure must have the attending present for the time out in accordance with the VHA Directive 1039, Ensuring Correct Surgery and Invasive Procedures In and Out of the Operating Room, dated November 28, 2018.

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

1. Level A: Attending Performing the Operation. The staff practitioner performs the case, and may or may not 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 resident performs the procedure under the observation and direction of the supervising practitioner. The supervising practitioner may not be engaged in a simultaneous procedure in or outside the OR.

4. Level D: Attending in OR Suite, Immediately Available. The supervising practitioner is physically present in the operative or procedural suite and able to provide direct supervision or consultation without delay as needed and may not be involved in a simultaneous procedure.

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

6. Level F: Non-OR Procedure. Routine bedside and clinic procedures done electively in the OR for patient safety or due to unavailability of non-OR space (as example, a cystoscopy that would have normally been performed in the clinic gets performed in the OR due to lack of equipment). The supervising practitioner is identified in the documentation by the resident.

(6) Non-Operating Room Procedures.

(a) Routine Bedside and Clinic Procedures. Routine bedside and clinic procedures include activities such as: skin biopsies, therapeutic bronchoscopy in an ICU setting, central and peripheral lines, lumbar punctures, centeses, and incision and drainage (list is not inclusive of all possible routine bedside procedures). The degree of supervision these procedures takes is dependent on the complexity and inherent risk of the procedure, the experience of the resident, and demonstrated competency via graduated levels of responsibility.

(b) Non-routine, Non-bedside Procedures. Non-routine, non-bedside procedures (e.g., endoscopy, cardiac catheterization, invasive radiology) are procedures that require a high level of expertise in their performance and interpretation. Although gaining experience in doing such procedures is an integral part of the education of the resident, such procedures may be done only by residents with the required knowledge, skill, and judgment and under an appropriate level of supervision by a supervising practitioner. The degree of supervision for these procedures is dependent on the complexity and inherent risk of the procedure, the experience of the resident, and demonstrated competency via graduated levels of responsibility. Supervising

practitioners are responsible for authorizing the performance of such procedures and must be physically present in the procedural area.

NOTE: *Documentation standards must follow the setting-specific guidelines (see paragraph 8.c.) Documentation of the degree (level and intensity) of supervising practitioner involvement is encouraged. Any of the four types of documentation referenced in paragraph 8.b.(1)(a)-(d) are acceptable.*

(7) **Chemotherapeutics.** The supervising practitioner must provide oversight over treatment planning (i.e., choice of modality and regimen), dosage or dosimetry determinations, and writing of chemotherapy. Neither the supervising practitioner nor the resident needs to be present during the administration of chemotherapy, since therapy delivery is a function of associated health personnel. Any of the four types of documentation referenced in paragraph 8.b.(1)(a)-(d) is acceptable.

(8) **Radiation Therapy.** For radiation therapy, irradiation may be off-site and neither the responsible radiation oncology attending nor resident presence is necessary during treatment delivery. An attending note or an addendum to, or co-signature of, the resident's note or consultation documenting the treatment plan is acceptable.

(9) **Restricted Medications.** Some medications require specific training or licensure.

(a) Attending only. Some medications (e.g., clozapine) require the attending physician write the orders. Local Pharmacy and Therapeutics committees will determine these guidelines.

(b) Special licensure or DEA registration (e.g., buprenorphine). Some medications require specialized training, licensure, or DEA registration. While residents may be able to write these orders, they must have completed the required competency and state licensure/DEA registration.

(10) **Home Visits.** Home visits generally occur as a part of VA's Home-Based Primary Care (HBPC) Program. Residents who participate in home visits must have received orientation and training related to handling of emergency situations and related HBPC policies and procedures, as provided by supervisors in HBPC. PGY-1 residents may participate in home visits only when accompanied by a supervising practitioner. Although the supervising practitioner need not accompany second post-graduate year or higher (PGY-2+) residents on the home visit (assuming an acceptable, documented level of graduated responsibility), the supervising practitioner must be readily available at an agreed-upon, identifiable phone number for the duration of the time the resident is making home visits. Following home visits, the supervising practitioner must discuss each case with the resident. **NOTE:** *Any of the four forms of documentation referenced in paragraph 8.b.(1)(a)-(d) may be used to record this interaction.*

(11) **Telemedicine and Telehealth.**

(a) Real-time Videoconferencing.

1. In situations where the supervising practitioner and resident are physically present at a VA medical facility delivering telehealth care to a remote patient, resident-provided care is acceptable in all circumstances where VA clinical standards permit the staff practitioner to deliver care remotely. The supervising practitioner must be in the general vicinity and available to the resident for direct supervision without delay, as if the patient were being seen in a clinic. At the current time, VA does not endorse or permit supervision configurations where the supervising practitioner and resident are not co-located. Documentation requirements must follow the setting for which the telehealth is being utilized – e.g., outpatient consultations should follow supervisory documentation guidance for outpatient visits.

2. Real-time videoconferencing must not be used to substitute for appropriate educational supervision, e.g., in situations where the resident is with the patient in a remote setting (e.g., at a Community-Based Outpatient Clinic (CBOC)) and the supervising practitioner is at a parent VA medical facility with videoconferencing connectivity. Resident-provided care in remote settings requires the onsite supervision by a supervising practitioner. However, consultation with specialists via remote connections may be handled as any outpatient consultation would be conducted.

(b) Store and Forward Telehealth. In store and forward telehealth, the resident and supervising practitioner would not see the patient, except through examination of images or specimens (e.g., teleradiology films, teleretinal scans, or telepathology specimens). The resident reviews the material with or without the supervising practitioner present, and the supervising practitioner reviews the same material. The interpretations and reports on all images and pathology specimens must be verified by the supervising practitioner. The supervisor, at the minimum, must co-sign validated resident reports.

(c) Home Telehealth. In home telehealth, the supervising practitioner and resident are delivering home care to a patient by videophone or in-home messaging devices. Such an arrangement is acceptable in all circumstances in which VA standards permit the supervising practitioner to deliver care remotely. Residents who are assigned responsibility for home telehealth patients must consult with the supervising practitioner regarding any changes in a patient's status or proposed changes in the treatment plan. Supervising practitioners are expected to exercise general oversight of the home telehealth care provided by residents. In these instances, the supervising practitioner does not have to be in the same location as the resident. The resident may document the home visit in the record; the supervisor must co-sign any home notes.

(d) Cross-Facility Health Care. Residents and supervising practitioners are often involved in delivering health care to distant locations such as CBOCs or more rural VA medical facilities through telehealth methodologies. CBOCs that are administratively aligned to a VA health care system would necessarily honor all appropriate privileges and trainee appointments from their main VA health care system. However, when delivering care at another VA medical facility or non-aligned CBOC via technology or otherwise, mechanisms through agreements between VA medical facilities must be created that ensure the following:

1. Supervising practitioners must have privileges to provide care in the “receiving” facility. This may be provided through “proxy privileges” or other reciprocal arrangements.

2. Trainees must have an appropriate appointment status in the “receiving” facility such as a Without Compensation appointment. Appointment paperwork may be copied and sent to the receiving facility to enable this appointment action. **NOTE:** *Duplicate onboarding need not be conducted.*

3. The trainee’s educational program must permit the trainee to function in this capacity via program director approval.

(e) Tele-ICU Coverage. In ICU settings, resident supervision will be provided by an assigned, local supervising practitioner. See paragraph 8.c.(1) regarding inpatient and ICU supervision. In VA teaching facilities where tele-ICU coverage is provided from a remote monitoring site and includes monitoring of patients in one or more ICUs, residents who provide concomitant, in-house, local ICU coverage will continue to have their assigned, local supervising practitioner who is ultimately responsible for the management of patients assigned to the resident and may not be supervised by the tele-ICU practitioner. Tele-ICU physicians who are remotely monitoring patients in the ICU may act as consultants in the same manner as any consultant assisting with ICU patient care. The tele-ICU practitioner may provide guidance and recommendations to the resident. The resident is expected to discuss significant changes in patient status and proposed changes in treatment plans with the responsible supervising attending.

9. EMERGENCY SITUATIONS

An emergency situation is where immediate (i.e., without delay) care is necessary to preserve the life of or to prevent serious harm to the health of a patient. In such situations, any resident, assisted by medical facility personnel (consistent with the informed consent provisions of VHA Handbook 1004.01) is permitted to do everything medically consistent with the resident’s training 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.

10. ACCREDITATION REQUIREMENTS

a. The procedures within this directive are applicable to supervision of physician, dental, optometric, chiropractic, and podiatric residents involved in patient care services including, but not limited to: Inpatient care, outpatient care, community and long-term care, emergency care, home health care, and the performance and interpretation of diagnostic and therapeutic procedures. Telehealth and telemedicine describe communication modalities that are allowed in the conduct of VA patient care and may be used in certain circumscribed circumstances with appropriate supervision as outlined in this document.

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

c. 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), Commission on Dental Accreditation (CODA), American Board of Podiatric Medicine (ABPM), American Board of Chiropractic Specialties (ABCS), and Accreditation Council on Optometric Education (ACOE) must be incorporated into VA training programs and fulfilled through local VA medical facility procedures to ensure that each successful program graduate is eligible to sit for the certifying examination in the graduate's specialty.

11. SUPERVISION OF PHYSICIAN RESIDENTS PROVIDING EMERGENCY CARE COVERAGE

a. **Emergency Department Physician.** Physicians providing independent Emergency Department (ED) coverage must be credentialed, privileged, and fully licensed. Residents who have not completed core training requirements for board-certification are still subject to the same supervisory requirements specified in this directive. However, in a critical staffing emergency, permission to use a third post-graduate year (PGY-3) and above, non-board-eligible resident for sole, unsupervised coverage may be requested from the VISN Director. When such an emergency exists, the VISN Director may approve the use of a PGY-3 and above, non-board-eligible resident on a short-term, time-limited basis, when truly exceptional circumstances exist and only for the duration of the emergency staffing issue. In these rare instances, the resident must be appropriately credentialed and privileged and be an approved provider of Advanced Cardiac Life Support (ACLS) (see VHA Handbook 1100.19, Credentialing and Privileging, dated October 15, 2012).

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

(1) Physician residents who are board-certified or who have completed the training requirements for board eligibility may be privileged as independent practitioners for purposes of ED coverage. Privileges sought and granted may only be those delineated within the general category for which the resident is board-certified or has completed training. **NOTE:** *Physician residents who are credentialed and privileged to work as attendings in the ED will maintain the person class of 'resident'. See VHA Directive 1095, Provider Person Class/Taxonomy File, dated July 18, 2018.*

(2) Subspecialty residents, fellows, or chief residents who are appointed to work independently in the ED, outside the scope of their training program (i.e., in areas for

which they are fully qualified by virtue of having completed core residency training in either internal medicine, emergency medicine, psychiatry, or general surgery), must be fully licensed, credentialed, and privileged for the duties they are expected to perform. In this capacity, they are not working under the auspices of a training program and must meet the requirements for staff appointment and are subject to the provisions contained in VHA Handbook 1100.19.

(3) The residents in subsections (1) and (2) of this paragraph must have the permission of their Program Director to engage in any clinical activity outside the scope of their current program. Specialty or subspecialty privileges which are solely within the scope of the resident's current training program may not be granted.

(4) In all instances, the resident must receive feedback on his or her interpretation of store-and-forward telehealth data for learning purposes.

12. 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; program directors determine the manner and timeframe of these evaluations.

(2) When a resident's performance or conduct is judged to be detrimental to patient care, evaluation of the resident, in mutual consultation with the faculty, must be completed. Residents may be dismissed from VA assignment in accordance with VA Handbook 5021, Employee/Management Relations, Part VI, Paragraph 18, Separation of Medical and Dental Residents, dated February 19, 2016, and appointed under 38 U.S.C. 7406, which includes a requirement to notify the 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 medical facility must be given the opportunity to complete confidential written evaluations of supervising practitioners and VA. Evaluations must be conducted in accordance with the standards of the appropriate accrediting or certifying bodies. Evaluations need to conform to program-specific requirements. Academic evaluations are the confidential property of the residency program and 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 Program Director. The evaluations are aggregated and analyzed in compliance with accrediting and certifying body standards. The evaluations must be communicated to the responsible VHA Service Chief or VA Site Director in a manner and timetable agreeable to both.

13. MONITORING PROCEDURES

a. Goals and Objectives.

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

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

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

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

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

b. VA Medical Facility Monitoring and Use of Results. Resident training occurs in the context of different disciplines and in a variety of structured clinical settings. The VA medical facility Director is responsible for ensuring that a local monitoring process exists for resident supervision. The monitoring process must occur at the institutional level and must include the following:

(1) A local standard operating procedure (SOP) for "Monitoring of Resident Supervision." This SOP must define the procedures that are to be followed for the monitoring of resident supervision and assignment of facility-level responsibility for monitoring, (i.e., services may not monitor the adequacy of supervision of their own attending staff members). The SOP must include procedures for monitoring all activities involving the following elements:

- (a) Inpatient care involving residents;

- (b) Outpatient care involving residents;
- (c) Procedural care (including OR care) involving residents;
- (d) Emergency care involving residents; and
- (e) Consultative care involving residents.

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

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

(a) Results of health record reviews and other locally-derived quality management data concerning patient care involving residents;

(b) Incident reports and tort claims involving residents;

(c) Risk events including adverse events and “near misses” involving residents;

(d) Patient complaints involving residents;

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

(f) Review of reports by accrediting and certifying bodies.

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

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

(5) Completing the AR RTP (RCN 10-0906).

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

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

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

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

c. **VISN-Level Oversight and Procedures.** VISN oversight of monitoring processes for resident supervision is designed to meet VISN and VHA strategic goals, identify VISN trends, practices and areas for improvement, and support formulation of appropriate action plans.

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

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

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

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

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

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

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

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

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

The Annual Report on Residency Training Programs (ARRTP) (RCN 10-0906) is a Web-based survey of residency education that is updated annually by each VA medical facility with residents and by each VISN. The information is requested from each affiliated VA medical facility for all resident training programs covered in this directive (i.e., medical (allopathic and osteopathic), dental, optometric, and podiatric programs). The ARRTP may include reviewing patient safety, risk management, and quality improvement data (protected by 38 U.S.C. 5705 and its revised implementing regulations and current VA policy) and information about the residency programs. Protected material cannot be disclosed to anyone without authorization as provided for by 38 U.S.C. 5705 and 38 CFR 17.500 *et seq.* Summary results may be shared with VHA leadership and other groups as appropriate.

15. TRAINING

There are no formal training requirements associated with this directive.

16. RECORDS MANAGEMENT

All records regardless of format (paper, electronic, electronic systems, created in this directive must be managed according to the National Archives and Records Administration (NARA) requirements and the NARA-approved rules found in VHA Records Control Schedule (RCS) 10-1. Questions regarding any aspect of records management may be referred to the facility Records Manager or Records Liaison.

17. REFERENCES

- a. 38 U.S.C. 5705.
- b. 38 U.S.C. 7301(b).
- c. 38 U.S.C. 7406.
- d. 38 CFR 17.500.
- e. VA Handbook 5021, Employee/Management Relations, Part VI, Paragraph 18, Separation of Medical and Dental Residents appointed under 38 U.S.C. 7406, dated February 19, 2016.
- f. VHA Directive 1039(1), Ensuring Correct Surgery and Invasive Procedures In and Out of the Operating Room, dated November 28, 2018.
- g. VHA Directive 1052, Appropriate and Effective Use of VHA Employee Mandatory and Required Training, June 29, 2018
- h. VHA Directive 1066, Requirement for National Provider Identifier (NPI) and Taxonomy Codes, dated November 7, 2013.
- i. VHA Directive 1095, Provider Person Class/Taxonomy File, dated July 18, 2018.
- j. VHA Directive 1400, Office of Academic Affiliations, dated November 9, 2018.
- k. VHA Directive 1400.09(1), Education of Physicians and Dentists, dated September 9, 2016.
- l. VHA Directive 1401, Billing for Services Provided by Supervising Practitioners and Physician Residents, dated July 29, 2016.
- m. VHA Handbook 1004.01(2), Informed Consent for Clinical Treatments and Procedures, dated August 14, 2009.
- n. VHA Handbook 1100.19, Credentialing and Privileging, dated October 15, 2012.

- o. VHA Handbook 1400.03, Veterans Health Administration Educational Relationships, dated February 16, 2016.
- p. VHA Handbook 1400.04, Supervision of Associated Health Trainees, dated March 19, 2015.
- q. VHA Handbook 1400.05, Disbursement Agreement Procedures for Physician and Dentist Residents, dated August 14, 2015.
- r. VHA Handbook 1400.07, Education of Advanced Fellows, dated February 26, 2016.
- s. VHA Handbook 1400.08, Education of Associated Health Professions, dated February 26, 2016.
- t. VHA Handbook 1400.10, Health Care Resources Contracting: Educational Cost of Physician and Dentist Resident Training Pursuant to Title 38 United States Code 8153, dated November 16, 2012.
- u. VHA Handbook 1400.11, Extended Educational Leave, dated April 1, 2016.
- v. VHA Handbook 1907.01, Health Information Management and Health Records, dated March 19, 2015.
- w. Accreditation Council of Graduate Medical Education's Common Program Requirements. <https://www.acgme.org/What-We-Do/Accreditation/Common-Program-Requirements>. **NOTE:** *This linked document is outside of VA control and may not be conformant with Section 508 of the Rehabilitation Act of 1973.*
- x. Bernard, J. M. and R. K. Goodyear. *Fundamentals of Clinical Supervision*. 2nd ed. Needham Heights, MA: Allyn & Bacon, 1998.
- y. Kashner, T. Michael et al. "Measuring Progressive Independence with the Resident Supervision Index: Empirical Approach." *Journal of Graduate Medical Education*, 2010.