Contents
Welcome .................................................................................................................................................. 3
Mission .................................................................................................................................................. 4
Program Overview .................................................................................................................................. 4
Curricular Competencies ...................................................................................................................... 5
Location ................................................................................................................................................ 8
Faculty .................................................................................................................................................. 9
Duty Hours ............................................................................................................................................ 10
Compensation and Benefits .................................................................................................................. 10
Resident Appointments ...................................................................................................................... 12
Clinic Policies ..................................................................................................................................... 13
Professional Conduct .......................................................................................................................... 15
Evaluation ............................................................................................................................................ 16
Requirements for Residency Completion ............................................................................................ 18
Remediation and Due Process .............................................................................................................. 23
Previous and Current Residents .......................................................................................................... 30
Welcome

Welcome to the VA Greater Los Angeles Healthcare System/Southern California University of Health Sciences-Affiliated Chiropractic Integrated Clinical Practice Residency Program

The field of Chiropractic Care is constantly evolving and we are proud to be a part of the exciting progress. Since 2014, our program has trained chiropractic residents in integrated clinical practice in a hospital setting and has been dedicated to providing quality patient care. We are fully accredited by the Chiropractic Council on Education (CCE) and offer outstanding clinical experiences in hospital-based chiropractic care, including the full scope of diagnosis and treatment of patients with non-operative musculoskeletal and neuromuscular problems.

Our residency program benefits from the educational, clinical training, and research resources and faculty in the Physical Medicine and Rehabilitation (PM&R) and Pain Medicine Fellowship Program that hosts 25 PM&R Residents and supports 4 Pain Medicine Fellows and participates in many of their activities. The Pain Medicine Fellowship (founded and ACGME accredited since 2001) is co-staffed by Physiatrists, Anesthesiologists, Psychologists, Neurologists, and Psychiatrists, and offers a true multidisciplinary approach to comprehensive pain management. Thus, our chiropractic residents have the opportunity to learn from experts and gain exposure to various evaluation and treatment methods in pain management, including post-operative care and observe interventional pain procedures. Our full-time PM&R faculty members outnumber our trainees (a superb teaching faculty: resident ratio) and are passionately dedicated to educating our residents. In addition, our trainees work with numerous part-time and voluntary faculty clinicians based in the community and the private sector.

We are a multi-campus training program comprised of a family of affiliated hospitals in the Los Angeles areas (Greater Los Angeles VA Healthcare System – West Los Angeles and Sepulveda, Long Beach VA Healthcare System, and Southern California University of Health Sciences).

On behalf of the bright residents, fellows, and faculty across our family of facilities, I welcome you to learn more about us. We look forward to meeting you during your visit, elective rotation or interview here.

Best Regards,

Valerie Johnson, DC, DABCI
Chiropractic Residency Program Director
VAGLAHS Chiropractic Integrated Clinical Practice Residency Program
Mission
The Mission of the VA Greater Los Angeles Healthcare System Chiropractic Integrated Clinical Practice Residency program is to prepare chiropractic residents for clinical practice in hospitals, other medical settings, and/or academia by providing them with hospital-based clinical training, interprofessional education, and scholarly activities.

Program Overview
The program provides the resident with extensive clinical experience in hospital-based chiropractic care, including the full scope of diagnosis and treatment of patients with non-operative musculoskeletal and neuromuscular problems. The curriculum is organized into three main categories:

1. Patient care: The resident gains experience in managing complex conditions under the mentorship of senior VA chiropractors. Patient cases include traumatic brain injury, post-operative spine, inflammatory arthritis, radiculopathy, peripheral neuropathy, chronic pain syndrome, neuromuscular degenerative pathology, deformity, and complicated medical and psychosocial co-morbidity. Approximately 65% of the overall residency time (approximately 1,250 hours) is allotted to patient care in the chiropractic clinic.

2. Interprofessional education: The resident rotates through other services to gain exposure to a wider variety of cases, learn about the roles and approaches of other disciplines, and foster interdisciplinary teamwork and collaboration. Learning objectives focus on providing residents a better understanding of clinical practice in various specialties, and facilitating future communication and collaboration in team care settings. Approximately 17% of the overall residency time (approximately 316 hours) is spent in clinical rotations across the following services:
   a. Primary care: Internal Medicine and Geriatrics
   b. Medical/Specialties
      i. Physical Medicine & Rehabilitation Services (Acupuncture, Amputee clinic, Cardiac Rehab, General clinic, Inpatient, NCV/EMG clinic, Pain clinic, Prosthetics, Urgent Care, Wheelchair clinic, Physical Therapy, Occupational Therapy and Kinesiotherapy)
      ii. Radiology
      iii. Surgery (Interventional and Spine)
      iv. Elective

3. Scholarship: The resident teaches and assesses chiropractic students, attends ongoing scholarly presentations, gives lectures/presentations to other departments, obtains and appraises literature relevant to clinical care, presents critically appraised topics and/or case reports, and assists or participates in ongoing faculty research projects. Approximately 18% of the overall residency time (approximately 340 hours) consists of scholarly activities at VAGLAHS and the academic affiliate, the Southern California University of Health Sciences (SCU).
a. The resident will present a minimum of 2 formal critically appraised topics and/or case reports at various VA and/or SCU settings including in-person or online meetings, Journal Club sessions, or other relevant venues.

b. The resident will give at least 2 in-service presentations to staff and trainees at other clinical services in VAGLAHS, and/or to SCU audiences.

c. The resident will attend a minimum of 6 research/scholarly presentations.

d. The resident will attend and/or participate in a minimum of 1 clinical/scholarly presentations at the Pain Management Clinic and/or PM&RS M&M/Patient Safety

Curricular Competencies

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

1. Patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.
   a. Demonstrate caring and respectful behaviors (verbal and non-verbal) with patients and families
   b. Elicit information using effective questioning and listening skills
   c. Perform comprehensive patient evaluations including history, review of medical records, physical examination, psychosocial assessment, and functional assessment
   d. Integrate and apply knowledge to diagnose and manage complex patient conditions
   e. Formulate a patient-centered, evidence-based treatment plan, including interdisciplinary management strategies as appropriate
   f. Demonstrate the ability to evaluate a patient’s decision-making capacity
   g. Integrate facts and data to make clinical decisions
   h. Assess patient outcomes and change treatment plans as indicated
   i. Identify barriers for return to work, incorporating vocational assessments
   j. Consult with other specialty providers as indicated
   k. Counsel patients, families and caregivers about the potential risks, benefits, and alternatives to the plan of care

2. Medical knowledge about established and evolving biomedical, clinical, and cognate (eg, epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.
   a. Generate a differential diagnosis for musculoskeletal and/or neuromuscular problems
   b. Integrate and apply knowledge to manage complex patient presentations
   c. Demonstrate knowledge of the relevant basic science of the pathophysiology of musculoskeletal and neuromuscular conditions
   d. Incorporate the relevant clinical science in establishing treatment plans
   e. Identify barriers to successful outcomes
   f. Understand biopsychosocial principles in the management of complex patients
   g. Demonstrate knowledge of special emphasis populations such as polytrauma, women’s health, PTSD, rural health, and geriatrics
   h. Develop rehabilitation plans to include complex musculoskeletal trauma
i. Differentiate pain types and generators and describe treatment approach to each
j. Understand medications commonly used to treat specific pain patterns (i.e., acute, chronic, neuropathic, phantom limb etc.), their common side effects and possible adverse reactions
k. Know the signs of narcotic abuse
l. Demonstrate knowledge of musculoskeletal and neuromuscular examination principles
m. Understand appropriate prescription of therapeutic modalities and orthoses
n. Recognize possible effects of physical and psychological impairment on activities of daily living, work capacity and social functioning

3. Practice-based learning and improvement that involves appraisal, assimilation and improvement of scientific evidence and investigation in patient care.
   a. Evaluate one’s knowledge and incorporate feedback from others
   b. Modify self-directed learning appropriately
   c. Use information technology to access and manage patient information
   d. Use information technology and other resources to support one’s own education
   e. Contribute to discussions of patient care with other health care professionals
   f. Attend and participate in teaching conferences and rounds

4. Interpersonal and communication skills that result in effective information exchange and collaboration with patients, their families, and other health professionals.
   a. Establish trust and maintain rapport with patients and families
   b. Complete chart notes in a timely manner
   c. Present material clearly and accurately to patients
   d. Synthesize information and present clearly to colleagues
   e. Utilize effective listening skills
   f. Communicate and interact with staff/team in respectful, responsive manner
   g. Promote teamwork

5. Professionalism, manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to diverse patient populations.
   a. Exemplify respect and compassion toward patients
   b. Exemplify altruism and responsiveness to patient needs that supersedes self-interest
   c. Demonstrate reliability, punctuality, integrity and honesty
   d. Accept responsibility for own actions and decisions
   e. Apply sound ethical principles in practice, including patient confidentiality, informed consent, provision or withholding of care, and interactions with insurance or disability agencies
   f. Consider effects of personal, social and cultural factors in patient management
   g. Demonstrate sensitivity and responsiveness to age, culture, disability, and gender of patients

6. Systems-based practice as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.
   a. Collaborate with and maintain appropriate professional attitudes and behaviors toward other medical professionals and allied health personnel
   b. Coordinate patient care within the given healthcare system
c. Use diagnostic and therapeutic procedures judiciously
d. Evaluate risks, benefits, limitations, and costs of patient care
e. Advocate for patients in dealing with system complexities
f. Advocate for quality patient care
g. Work effectively with other services, health care agencies, and case managers
h. Participate in identifying opportunities for system quality improvement

7. Evidence-based practice
   a. Demonstrate competence in the application of knowledge of accepted standards in chiropractic practice
   b. Appraise and assimilate evidence from scientific studies to enhance patient care
   c. Attend and participate in critical appraisal and journal club presentations
   d. Demonstrate commitment to life-long learning

Sample Outpatient Week at VA West Los Angeles/SACC

<table>
<thead>
<tr>
<th>Day</th>
<th>8AM-9AM</th>
<th>9AM-NOON</th>
<th>1PM-4:30</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td>Lecture</td>
<td>Rotation</td>
<td>Rotation</td>
</tr>
<tr>
<td>Tuesday</td>
<td>Lecture</td>
<td>WLA Chiropractic Clinic</td>
<td>Didactics</td>
</tr>
<tr>
<td>Wednesday</td>
<td>Pain Lecture</td>
<td>Rotation: PM&amp;R or Pain Clinic</td>
<td>Rotation: PM&amp;R or Pain Clinic</td>
</tr>
<tr>
<td>Thursday</td>
<td>Lecture</td>
<td>Chiropractic Clinic Weekly chiropractic residency call 11-12</td>
<td>Chiropractic Clinic</td>
</tr>
<tr>
<td>Friday</td>
<td>Outpatient Clinic</td>
<td>SACC Chiropractic Clinic</td>
<td>SACC Chiropractic Clinic</td>
</tr>
</tbody>
</table>

COMPONENTS OF THE PM&R/PAIN CURRICULUM
The chiropractic resident participates in many of the Physical Medical and Rehabilitation (PM&R) and Pain Medicine curriculum that include:
1) Basic Science and Clinical Didactics
2) Clinical Practice
3) Research

1. BASIC SCIENCE AND CLINICAL DIDACTICS
Basic Science: (ANNUAL LECTURE SERIES)
Presented on an annual basis, this series of modules consisting of six to twelve lectures each are given by specialists in their respective fields, as follows:
• Introduction to Physical Medicine and Rehabilitation
• Gait Analysis/Kinesiology
• Neuromuscular Physiology and Neurorehabilitation
• Functional Musculoskeletal and Neurological Anatomy
• Musculoskeletal Examination Skills
• Anatomy Lab (MSK Ultrasound)
• Electro-diagnosis I
• Electro-diagnosis II
• Research Methods
• PM&R Administration/Medical-Legal Practice Issues
• Prosthetics/Orthotics/Amputee Rehabilitation

Clinical Didactics: (CORE LECTURE SERIES)
A second component is the Core Lecture Series, which is presented over a three-year period by Staff and Residents as follows:
• Stroke Rehabilitation (2013-14; 2010-11)
• Geriatric Rehabilitation (2013-14; 2010-11)
• Neuromuscular Disorders (2013-14; 2010-11)
• Rheumatologic and Connective Tissue Diseases (2013-14; 2010-11)
• Modalities and Therapeutic Exercises (2013-14; 2010-11)
• Spinal Cord Injury (2014-15; 2011-12)
• Degenerative Spine Disorders (2014-15; 2011-12)
• Musculoskeletal/Sports (2014-15; 2011-12)
• Pediatric Rehabilitation (2014-15; 2011-12)
• Cardiopulmonary, Cancer Rehab (2014-15; 2011-12)
• Traumatic Brain Injury (2015-16; 2012-13)
• Central Nervous System Disorders (2015-16; 2012-13)
• Industrial Rehabilitation (2015-16; 2012-13)
• Pain Management (2015-16; 2012-13)
• Additional Topics (burns, skin, movement disorders, polytrauma) (variable)
• Pain Lecture Series held every Wednesday morning 8-9am

Location
Training takes place at the VA West Los Angeles Healthcare Center (11301 Wilshire Blvd, Los Angeles, CA 90073) and VA Sepulveda Ambulatory Care Center (16111 Plummer Street North Hills, CA 91343). VAGLAHS The chiropractic program at VA Greater Los Angeles Healthcare System (VAGLAHS) is among the first within the VA program nationally with on-station services offered since January 2005. The VA Greater Los Angeles Healthcare System is the largest, most complex healthcare system within the Department of Veterans Affairs. It is one component of the VA Desert Pacific Healthcare Network (VISN22) offering services to Veterans residing in Southern California and Southern Nevada. VAGLAHS consists of three ambulatory care centers, a tertiary care facility and 10 community based outpatient clinics. VAGLAHS serves Veterans residing throughout five counties: Los Angeles, Ventura, Kern, Santa Barbara, and San Luis Obispo. There are 1.4 million Veterans in the VAGLAHS service area. VAGLAHS is affiliated with both UCLA School of Medicine and USC School of Medicine, as well as more than 45 colleges, universities and vocational schools in 17 different medical, nursing, paramedical and administrative programs including SCUHS.
The chiropractic clinic is aligned administratively within Physical Medicine and Rehabilitative Services and located on two campuses. In West Los Angeles it is physically situated in the Physical Medicine and Rehabilitative Service Polytrauma Center in close proximity to the main hospital.

Faculty
The resident is mentored by an accomplished core faculty who are national leaders in integrated chiropractic practice. These clinicians share their expertise in patient care, academics and research to provide a robust educational experience.

Valerie Johnson, DC, DABCI is the residency director of training (DOT) for VAGLAHS. Dr. Johnson received a BS from and her DC degree from Los Angeles College of Chiropractic. Prior to coming on board with the VA she worked in an integrative setting with a primary care provider and orthopedic group in the City of Beverly Hills for over fifteen years. In 2005 she became the first chiropractor appointed to the medical staff of the VA-Greater Los Angles Healthcare System, where she developed processes for integrating hospital-based clinical services and inter-professional clinical education. In 2006 she established an academic affiliation with VAGLAHS and Southern California University of Health Sciences and is an Associated Faculty member. She earned her Diplomate in Diagnosis and Internal Disorders (DABCI) in 2012.

Charles Fernandez, DC, MS was Associate Professor and Coordinator of Community Outreach Services, and was with SCU since 1985. In 1988 he was named Director of the university's Glendale, CA health center and went on to serve as Chief of Staff for SCU's University Health Center system. Dr. Fernandez received his Masters of Science from SCU and Doctor of Chiropractic from Logan College of Chiropractic. He came on board at VAGLAHS in 2006 and is presently a part time fee basis consultant at the Sepulveda campus.

Paul Barkmeier, DC earned a BA from California State University Long Beach in 2002 and a Doctor of Chiropractic degree in 2008 from Southern California University of Health Sciences. He is a Veteran, serving from 1992 to 1998 in the United States Marine
Corps as a Squad Leader. He has worked at VAGLAHS in the capacity as a fee basis chiropractor since 2011.

**Robb Russell, DC** earned a bachelor’s degree from San Diego State University in 1978 and a Doctor of Chiropractic degree from Los Angeles College of Chiropractic, in 1982. He has held several leadership positions including Chairman of the Chiropractic Section of Pacific Hospital of Long Beach (1990-91) and various posts with the California Chiropractic Association, serving on the Board of Directors and Executive Committee. He has been an Exam Commissioner and Expert Witness for the California Board of Chiropractic Examiners. He was an Examiner for the National Board of Chiropractic Examiners for almost 15 years. He has published articles in chiropractic magazines and journals and made presentations before chiropractic and medical conferences. In 2012, after 30 years in practice, he made a transition to an academic and administrative position at Southern California University of Health Sciences (SCU). He serves as Director of SCU’s Spine Care, overseeing the SCU Spine Care residency program. He is also Executive Director of SCU’s Centers of Excellence, which includes Diagnostic Imaging, Sports Medicine, Human Performance and the aforementioned Spine Care. SCU is the academic affiliate of the VAGLAHS chiropractic residency program.

**Benjamin Liang, DC** earned a bachelor’s degree from UCLA in psychology in 1999. He earned a Doctor of Chiropractic degree from Cleveland Chiropractic College in 2012 after completing his remaining chiropractic education at Southern California University of Health Sciences. He attended a clinical student internship at VA WLA and Sepulveda between 2011 and 2012. He owns a private practice and was the first VAGLAHS chiropractic resident from 2014-2015. He is a fee basis consultant as of July 2015.

### Duty Hours

The residency is a 1-year program running from July 1 through June 30 of the following year. The tour of duty is full-time (40 hours/week) from 8:00am to 4:30pm Monday through Friday with a 30 minute lunch break each day. The resident’s time is allocated in 2-week periods of 80 hours each approximately as follows:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Hours per 2-week period</th>
<th>% time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical care at VAGLAHS chiropractic clinic</td>
<td>52</td>
<td>65%</td>
</tr>
<tr>
<td>Clinical rotations in other services</td>
<td>14</td>
<td>17%</td>
</tr>
<tr>
<td>Scholarly activities at VAGLAHS</td>
<td>10</td>
<td>13%</td>
</tr>
<tr>
<td>Scholarly activities SCU</td>
<td>4</td>
<td>5%</td>
</tr>
</tbody>
</table>

The resident does not have call responsibility outside of duty hours, however some additional weekly time may be needed for scholarly or other training activities.

### Compensation and Benefits

**Compensation**
The resident stipend is established based on geographic location by the VA Office of Academic Affiliations. The compensation for the 2017-2018 academic-years is $40,848. This stipend is not contingent upon resident productivity. Residents are paid on a two week salary period. http://vaww.oaa.med.va.gov/DBReports/LocBasedStipends.aspx.

Health insurance
Residents are entitled to participate in a VA sponsored health insurance plan of their choosing. Any plan premiums will be deducted from the resident’s paycheck. Health insurance information can be found in the 5000 series of VA policies (particularly VA Directive 5005, Staffing; VA Handbook 5007, Pay Administration; VA Handbook 5011, Hours of Duty and Leave; and VA Handbook 5021, Employee/Management Relations). The information in paragraph 8 of this Handbook is intended to summarize key aspects of recruitment and compensation, but employees should rely on guidance from VA’s Office of Human Resources and Administration for comprehensive, accurate, and up-to-date information.

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

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

1. All AL must be approved in advance by the DOT. AL may be taken only at those times which will not be disruptive to the program’s training schedule. The resident must notify the DOT of his/her request for AL at least 4 weeks in advance of the desired time off. AL during the first or last week of the rotation will not be granted, unless for urgent purposes. At the end of the residency any unused AL days will not be converted to, or compensated by payment. 
2. SL is reserved for physical and mental illness only. The resident must notify their attending supervisor or the DOT before 8:00 AM of any unexpected leave due to illness. You must interact with a live person to ensure notification. In the event you are unable to reach a live person, leave a message and continue to call until you are able to contact someone directly. It is not acceptable to send a text, email, or leave a message on an answering machine without speaking to someone directly. Failure to comply will be documented in the resident’s main file as AWOL (absent without official leave) and will be recorded as vacation usage. An absence of 3 days or more due to illness (self or family member) requires the resident to submit a written statement from the treating physician stating the physician has examined and treated resident or ill family member. If sick leave is reported following vacation time or after an out of town trip, the resident must provide documentation of his/her previous intention to return to work upon conclusion of their scheduled vacation dates, in the form of an original trip itinerary (airline ticket, cruise ticket, etc.) Failure to provide the required documentation or any abuse of SL for any other purpose will result in deduction from future vacation time and/or AWOL status.
3. Authorized Absence (AA) may be granted to residents when they are involved in professional development activities consistent with the residency program mission at an off-site location. This can include attending professional conferences or other training opportunities related to the resident’s area of interest. AA may be granted for attending a job interview only if at another VA site. The days approved for AA do not deduct from either AL or SL. All AA must be approved by the DOT.

Frequent and/or prolonged absence of any type (AL and/or SL, including maternity/paternity leave) may result in an extension of the period of time the resident must participate in the program in order to meet the training requirements. If this becomes necessary and the resident has been paid during the period of absence, the extended dates of training may be on a without-compensation basis (that is without salary and benefits.)

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

**Resident Appointments**

**Selection**
Resident selection is through a competitive process considering factors such as academic background, relevant experience, personal statement, letters of recommendation, and telephone and/or in-person interviews. A call for applications is issued each year on the second Monday of January. Applications are only accepted during the open call. Decisions are made by a selection committee of the facility DOE or designee, residency DOT, residency faculty, and SCU faculty.

**Eligibility requirements**
- Applicants must hold or be scheduled to receive a DC degree from a CCE-accredited school prior to the start of the residency program.
- Applicants must be eligible for, or hold a current, full, active, and unrestricted chiropractic license in a State, Territory or Commonwealth of the US, or in the District of Columbia.
- Applicants must have documentation of at least 3 months of direct patient care activity within the last year. Clinical rotations during chiropractic school will suffice for recent graduates. Observer experiences and non-clinical graduate work do not meet this requirement.
- Applicants must submit 3 reference letters from US chiropractic and/or medical physicians who have personal knowledge of their clinical and personal abilities.
- Applicants must meet all VA employment requirements including US citizenship, and Selective Service registration when applicable.
- Applicants must have sufficient written and spoken English language skills as to make patient care safe and effective.

Additional eligibility requirements are specified in the annual call for applications.
Clinic Policies

Resident supervision

The Department of Veterans Affairs mandates appropriate supervision for trainees of all disciplines. All clinical care provided by the chiropractic resident is under the supervision of staff attending DCs in accordance with VHA Handbooks 1400.01 and 1400.04.


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

Attendings follow a graduated responsibility approach to supervision. The resident is gradually granted more autonomy during the course of the residency year as the resident demonstrates competence, and staff doctors become more familiar with and confident in the resident's clinical and case management skills. There are four levels of resident supervision:

<table>
<thead>
<tr>
<th>Resident Supervision Levels</th>
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<tbody>
<tr>
<td><strong>Level</strong></td>
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<tr>
<td>1</td>
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<tr>
<td>2</td>
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<tr>
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</tbody>
</table>
Residents can implement plans for cases in which they have demonstrated acceptable competence
  - Attending: Room, area, or available

All aspects of case management for instances in which competence has not yet been demonstrated are discussed with attending before a plan is implemented
  - Attending: Room or area

| 3 | Weeks 14-30 | Typically, residents have demonstrated acceptable competence in all straightforward and some complex cases, while competence in some rarer areas may still be emerging and/or unassessed. |

Resident responsibility
- Residents can implement plans for cases in which they have demonstrated acceptable competence
  - Attending: Room, area, or available
- All aspects of case management for instances in which competence has not yet been demonstrated are discussed with attending before a plan is implemented
  - Attending: Room or area

| 4 | Weeks 26-52 | With the approval of the DOT, residents are permitted to supervise 4th year chiropractic students. Such cases must be reviewed with a staff attending and the patient record must be co-signed by the staff attending per VA supervision guidelines. |

Resident responsibility
Supervision of the resident’s own cases continues on at Level 3 above

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

Contaminated sharps will be placed in rigid puncture-resistant containers designed for sharp disposal. Other contaminated instruments will be placed immediately in a puncture-resistant,
A leak-proof container labeled with a biohazard warning, and then transported to Supply, Processing, and Distribution Section (SPD).

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

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

Facility safety
- Accidents/Injuries: If you are injured, immediately notify your supervisor.
- Electrical safety: Inspect all electrically powered equipment before use. Do not use equipment with frayed cords or broken plugs. Report defective equipment to your supervisor.
- Equipment safety: Know how to use equipment properly and inspect for defects prior to use. Remove any defective/inoperative equipment from use and report it to your supervisor.
- Fire: Upon discovering or suspecting a fire in the area: 1) Rescue anyone in danger from the fire, 2) Activate the nearest fire alarm pull station and have someone call the fire department 3) Confine fire spread by closing all doors, and 4) Extinguish if the fire is small and you are properly trained.
- Hazardous materials: Become familiar with the hazards associated with the chemicals you use before you use them. Ensure all containers are properly labeled with the name of the product, manufacturer’s name and address, and appropriate hazard warnings. Know the location of your chemical inventory and material safety data sheets (MSDS).

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

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

Residents should not eat or drink in exam rooms or in front of patients. During working hours, residents will be mentally and physically capable of executing job functions, with no appearance to the contrary. This implies freedom from over-fatigue, illness or intoxicants such as alcohol.
All patients, staff members, and guests shall be treated with dignity and courtesy. Patients should generally be referred to as “Mr. _______” or “Ms. __________”, or by the title “Sir” or “Ma’am”, when appropriate. However, you may wish to discuss particular cases with your supervisors.

Chiropractic clinic faculty, and other VAGLAHS doctors, should be addressed as “Dr.______” when in the clinic or around patients or in other encounters on station.

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

Residents are expected to be punctual. The tour of duty begins at 7:30 am and concludes at 4:00pm. It is your responsibility in the morning to prepare your room/equipment and review necessary records so as to be prepared to start your first scheduled patient. It is the resident’s responsibility to arrive as early as necessary to accomplish this.

All work performed by chiropractic residents must be supervised by a staff chiropractor. No clinical work is to be done after hours and/or when there is no covering chiropractor available (this includes phone calls to patients). Residents need to always be aware of who the assigned supervisor is for the particular clinical work that is being accomplished. Generally, this will be consistent throughout the year.

**Evaluation**

The resident is evaluated via formative and summative processes. Residents will submit time logs every two weeks to the residency director, who will monitor and provide administrative oversight. Assessment input is obtained from multiple stakeholders including chiropractic attendings, program director, other service attendings, support staff, patients, and the resident’s own self-assessment. Assessment instruments and schedule are summarized in the tables below.

<table>
<thead>
<tr>
<th>Assessment Instrument</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation of live clinical performance</td>
<td>A questionnaire evaluating aspects of clinical care using general descriptors (superior/satisfactory/ unsatisfactory) and a numerical 1-9 scale.</td>
</tr>
<tr>
<td>Chart-stimulated recall</td>
<td>A standardized oral assessment on clinical case management that covers reasons behind the work-up, diagnosis, interpretation, and/or treatment plan.</td>
</tr>
<tr>
<td>Chart review, faculty</td>
<td>Medical records are pulled, reviewed and rated according to a specific protocol and coding form. Interpretation of this exercise is complicated by the fact that the final patient record has already been checked and possibly corrected by an attending.</td>
</tr>
<tr>
<td>Chart review, peer</td>
<td>Each residency director sends 3 de-identified files to the chiropractic program director each quarter. These are assigned in sequential fashion to off-site residents, with</td>
</tr>
</tbody>
</table>

VAGLAHS Chiropractic Residency Handbook Updated 12/5/2017

Page 16
reviews returned to the program director, which then sends reviews to each residency director.

<table>
<thead>
<tr>
<th>Other service attending's perception of resident</th>
<th>5 item numeric scales rating resident’s conduct, professionalism, performance.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff perception of resident</td>
<td>5 item numeric scales rating resident’s conduct, professionalism, performance.</td>
</tr>
<tr>
<td>Patient perception of resident</td>
<td>These assessments allow patients to evaluate their satisfaction with care, their impression of resident competency, etc.</td>
</tr>
<tr>
<td>Resident self-assessment</td>
<td>Five-item Likert scales assessing overall competencies, and open ended questions to identify learning goals and professional development targets.</td>
</tr>
<tr>
<td>Case log</td>
<td>Documentation of the types and numbers of cases seen by the resident, either in delivering care or observation.</td>
</tr>
<tr>
<td>Portfolio</td>
<td>A collection of documents, slide presentations, abstracts or other materials prepared by the resident that gives evidence of learning and achievement. This includes a log of scholarly activities (date of activity, location, type of activity, whether the resident presented or attended) and general comments and reflections by the resident. The portfolio is reviewed by the attending.</td>
</tr>
<tr>
<td>Milestones assessment</td>
<td>Performance scales and open ended comments assessing competence in domains of patient care, medical knowledge, practice-based learning, interpersonal and communication skills, professionalism, system-based learning, and evidence-based practice.</td>
</tr>
<tr>
<td>Resident assessment of rotation</td>
<td>Six-item Likert scales and open ended questions assessing educational experiences in clinical rotations.</td>
</tr>
<tr>
<td>Resident assessment of faculty</td>
<td>Six-item Likert scales and open ended questions assessing resident perception of faculty performance.</td>
</tr>
<tr>
<td>Resident assessment of program</td>
<td>Six-item Likert scales and open ended questions assessing resident perception of overall program.</td>
</tr>
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### Assessment Instrument Frequency and Scheduling

<table>
<thead>
<tr>
<th>Residency Month</th>
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<td>Calendar Month</td>
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<tr>
<td>Evaluation of live clinical performance</td>
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<tr>
<td>Chart-stimulated recall</td>
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<tr>
<td>Chart review, faculty</td>
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<td>Chart review, peer</td>
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<td>Staff perception of resident</td>
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<td>Patient perception of resident</td>
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VAGLAHS Chiropractic Residency Handbook Updated 12/5/2017
Milestones assessment
Resident self-assessment* 1 1 1 1
Resident assessment of faculty* 1 1 1 1
Resident assessment of program* 1 1 1 1
Resident assessment of rotation* At the completion of each rotation
Other attending's perception of resident At the completion of each rotation
Case log* Weekly
Portfolio* Weekly

* Indicates instruments completed by the resident

Requirements for Residency Completion
In order to successfully complete the residency program and receive a residency certificate, the resident will:

- Follow all VA policies and procedures as described in the TMS Mandatory Training for Trainees
- Attend and complete all chiropractic clinic sessions with expected competence
- Attend and complete all interdisciplinary rotations in a professional collaborative manner
- Achieve satisfactory performance evaluations
- Appropriately maintain the Resident Case Log documenting clinical encounters
- Appropriately maintain the Resident Portfolio documenting learning activities including
  - Presentation of at least 2 formal critically appraised topics and/or case reports at various VA and/or SCU settings including in-person or online meetings, Journal Club sessions, or other relevant venues.
  - Presentation of at least 2 in-service presentations to staff and trainees at other clinical services in VAGLAHS, and/or to SCU audiences
  - Attendance of PM&RS and Pain didactic classes
  - Attendance and/or participation in a minimum of 2 clinical/scholarly presentations
- Attend and document all other assigned activities, including external rotations, didactic, and scholarly activities
- Complete all assigned evaluations of the residency program and faculty

Scholarly activities encompass approximately 340 hours to be completed prior to completion of the residency program. The number and percentage of hours listed below provides a representative example.

1. **Group Online Courses- 2 Credit hour courses in Geriatrics and Biostatistics**
   - **Biostatistics Course Description:** An on-line didactic course designed to introduce the graduate student to typical methods in analyzing biomedical data using descriptive and inferential statistics. Curriculum included in Resident National Common Project.
   - **60 Hours 17%**
• **Geriatrics Course Description**: This course was established to fill a growing need in chiropractic care. Within the coming years the geriatric population will continue to grow, and is estimated to represent 20% or more of our population within the next 10-20 years. The number of older veterans is also growing. Given the increased demands on primary care physicians to deal with the co-morbidities in the older adult, chiropractors have a tremendous opportunity to fill the need for well-trained musculoskeletal specialists. Curriculum included in Resident National Common Project.

2. **Daily PM&R Didactic, weekly Pain Lecture, and monthly Morbidity and Mortality/Patient Safety Class**  
75 Hours 22%

• Daily PM&R didactic courses and weekly Pain Lecture, and monthly Morbidity and Mortality/Patient Safety Class to advance clinical knowledge, improved robust knowledge of relevant medical specialties and associated health disciplines and patient safety and quality improvement to be able to be fully competent in team-based case management

• Evidence is 75% attendance validated w/ sign in sheets. Once resident has reached maximum of didactic hours for residency program, to discuss future attendance w/ residency director.

3. **Weekly Resident Calls**  
40 Hours 12%

• Participate in weekly conference calls with other resident class members discussing national projects, interesting cases, clinical rotations, career placement, and various other VA topics. To improve clinical training and development of advanced clinical skill sets those results in the resident's attainment of an advanced level of clinical knowledge in integrated practice.

• Upon completion of this rotation the resident will evidence of attendance of weekly calls w/ 75% of attendance.

4. **Resident Projects**  
15 Hours 5%

• An evidence-based approach to choosing examination procedures for manual interventions. (That is, how does a prudent chiropractor decide what examination process/procedures to use?)

• The learning objectives for this specific rotation are:
  o Development of a template for interdisciplinary rotation learning objectives: Residents will review and critique existing examples for background. The aim is to identify material that will provide residents with greater knowledge on the key diagnostic/treatment methods of a given medical specialty, and particular items for preparation in advance of the given rotation.

• Will meet the following Standards learning objective(s):
Clinical training and development of advanced clinical skill sets that results in the resident's attainment of an advanced level of clinical knowledge in integrated practice

Specific to the area of training, the residency program expands and builds on the entry-level competencies

Clinical training to increase capacity to handle all straightforward and most complex cases

Performance is conducive to safe and effective care of very high quality

Upon completion of this rotation the resident will evidence with presentation of product.

5. PM&R Resident Orientation Days

- Orientation with PM&R residents and pain fellows including curriculum, badge processing, computer orientation, and employee benefits.

- The learning objectives for this specific rotation are: Orientation into VA, VAGLAHS, PM&R, chiropractic clinic, and chiropractic residency program

- Upon completion of Orientation Day the resident will evidence competence in understanding policies and procedures of VA system, VAGLAHS, CPRS, HR, VA Chiropractic Residency Handbook, and integration in VA staff, other PM&R residents, chiropractic service/support service/residency program and complete initial assessment tools in chiropractic residency program.
  - Specific to the area of training, the residency program expands and builds on the entry-level competencies

- Will meet the following Standards learning objective(s):
  - Improved robust knowledge of relevant medical specialties and associated health disciplines to be able to be fully competent in team-based case management
  - Performance is conducive to safe and effective care of very high quality

- Upon completion of Orientation Day the resident will sign evidence of attendance of sessions and handbook. Must attend 100% of program.

6. Talent Management Systems Training

- The VA Learning University (VALU) is VA's corporate university that supports the agency’s mission and business objectives through high quality, cost-effective continuous learning and development that enhances leadership, occupational proficiencies, and personal growth.
  - The learning objectives for this specific rotation are: complete mandatory training for all residents Clinical training and development of advanced clinical skill sets that results in the resident's attainment of an advanced level of clinical knowledge in integrated practice (to be further developed)

- Will meet the following Standards learning objective(s):
  - Specific to the area of training, the residency program expands and builds on the entry-level competencies
  - Improved robust knowledge to be able to be fully competent in team-based case management
7. **Journal Club**

- Monthly Tele-Conference amongst VA chiropractic providers presenting relevant research and literature to the chiropractic and medical field. Each resident selected a topic and presented to the group one time throughout the residency program as well as attended other presentations throughout the year.
- The learning objectives for this specific rotation are: Improve knowledge of relevant research and literature to the chiropractic and medical field (to be further developed)
- Will meet the following Standards learning objective(s):
  - Clinical training and development of advanced clinical skill sets that results in the resident's attainment of an advanced level of clinical knowledge in integrated practice
  - Specific to the area of training, the residency program expands and builds on the entry-level competencies
  - Clinical training to increase capacity to handle all straightforward and most complex cases
  - Improved robust knowledge of relevant medical specialties and associated health disciplines to be able to be fully competent in team-based case management
  - Performance is conducive to safe and effective care of very high quality
- Upon completion of this rotation the resident will evidence competence by attending 75% of Journal Club and make one presentation.

8. **UCLA PM&R Research Day**

- Attendance of PM&R annual resident Research Day at UCLA viewing research posters and attending guest lectures. The learning objectives are: (to be further developed)
- Will meet the following Standards learning objective(s):
  - Clinical training and development of advanced clinical skill sets that results in the resident's attainment of an advanced level of clinical knowledge in integrated practice
  - Specific to the area of training, the residency program expands and builds on the entry-level competencies
  - Clinical training to increase capacity to handle all straightforward and most complex cases
  - Improved robust knowledge of relevant medical specialties and associated health disciplines to be able to be fully competent in team-based case management
  - Performance is conducive to safe and effective care of very high quality
- Upon completion of this rotation the resident will evidence by attendance.

- Performance is conducive to safe and effective care of very high quality
- Upon completion of this rotation the resident will evidence competence in assigned courses
9. Elective Hours

- Hours spread amongst continuing education seminars, peer-review of charts, ACC-RAC attendance, future resident interview process, and all other scholarly activities.
- The learning objectives for this specific rotation are: (to be further developed)
- Will meet the following Standards learning objective(s):
  - Clinical training and development of advanced clinical skill sets that results in the resident's attainment of an advanced level of clinical knowledge in integrated practice
  - Specific to the area of training, the residency program expands and builds on the entry-level competencies
  - Clinical training to increase capacity to handle all straightforward and most complex cases
  - Improved robust knowledge of relevant medical specialties and associated health disciplines to be able to be fully competent in team-based case management
  - Performance is conducive to safe and effective care of very high quality
- Upon completion of this rotation the resident will evidence competence in performing/understanding.

IN WITNESS WHEREOF, the parties here to have signed this syllabus on the _________. By signing below, I acknowledge that I have received and copy, read and accept the responsibilities outline above. I understand that I have made a professional commitment to the VA Greater Los Angeles Healthcare System Chiropractic Residency Program to compete these scholarly activities prior to the completion of the chiropractic residency program.

Director of the Chiropractic Residency Program __________________________________________
Resident ______________________________________

Remediation and Due Process

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

I. Definition of problematic behavior or impairment

For the purposes of this policy, problematic behavior/impairment is defined broadly as an interference in professional functioning that is reflected in one or more of the following ways: (1) an inability and/or unwillingness to acquire and integrate professional behaviors and ethical standards, (2) an inability to acquire the level of professional skills necessary to reach an acceptable level of competency, (3) an inability to control personal stress, psychological problems, and/or excessive emotional reactions that interfere with professional functioning.
Ultimately, it becomes a matter of professional judgment as to when a resident's behavior is seriously impaired. However, problems typically become identified as impairments when they include one or more of the following characteristics:

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

II. Remediation Alternatives

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

1. **Verbal Warning** to the resident emphasizes the need to discontinue the inappropriate behavior under discussion. No record of this action is kept.

2. **Written Acknowledgment** to the resident formally acknowledges:
   a. that the Director of Training (DOT) is aware of and concerned with the performance rating,
   b. that the concern has been brought to the attention of the resident,
   c. that the DOT will work with the resident and/or supervisors to rectify the problem or skill deficits, and
   d. that the behaviors associated with the rating are not significant enough to warrant more serious action.

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

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

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

4. **Schedule Modification** is a time-limited, remediation-oriented closely supervised period of training designed to return the resident to a more fully functioning state. Modifying a resident’s schedule is an accommodation made to assist the resident in responding to personal reactions to environmental stress, with the full expectation that the resident will complete the residency. This period will include more closely scrutinized supervision conducted by the regular supervisor in consultation with the DOT. 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 DOT in consultation with the relevant supervisor(s). The termination of the schedule modification period will be determined, after discussions with the resident, by the DOT in consultation with the relevant supervisor(s). Remediation alternatives numbered 4 thru 8 will be documented in the resident’s file.

5. **Probation** is also a time limited, remediation-oriented, more closely supervised training period. Its purpose is to assess the ability of the resident to complete the residency and to return the resident to a more fully functioning state. Probation defines a relationship in which the DOT systematically monitors for a specific length of time the degree to which the resident addresses, changes and/or otherwise improves the behavior associated with the inadequate rating. The resident is informed of the probation in a written statement that includes:
   a. the specific behaviors associated with the unacceptable rating;
   b. the recommendations for rectifying the problem;
   c. the time frame for the probation during which the problem is expected to be ameliorated, and
   d. the procedures to ascertain whether the problem has been appropriately rectified.

   e. If the DOT determines that there has not been sufficient improvement in the resident's behavior to remove the Probation or modified schedule, then the DOT will discuss with the relevant supervisor(s) and the Service Chief possible courses of action to be taken. The DOT 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 DOT 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 DOT will communicate to the Service Chief that if the resident's behavior does not change, the resident will not successfully complete the residency.
6. Suspension of Direct Service Activities requires a determination that the welfare of the resident's patients has been jeopardized. Therefore, direct service activities will be suspended for a specified period as determined by the DOT 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 DOT 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 DOT 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, after a reasonable time period, do not rectify the impairment and the resident seems unable or unwilling to alter her/his behavior, the DOT will discuss with the Service Chief the possibility of termination from the training program or dismissal from the agency. Either administrative leave or dismissal would be invoked in cases of severe violations of the ACA Code of Ethics, or when imminent physical or psychological harm to a patient is a major factor, or the resident is unable to complete the residency due to physical, mental or emotional illness.

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

1. Issues can be discussed with the DOT at any time, but they should first be addressed within the supervisory relationship. The DOT will encourage such direct resolution. (If the resident has a problem that directly involves the DOT, he or she is encouraged to address that problem first with the DOT. If an issue with the DOT 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 DOT will meet with the resident(s) and supervisor(s) to assist in problem resolution. At this point the Training Committee and Chief, Psychology Service will be apprised of the problem and the steps taken to attempt resolution.

3. If this process does not quickly resolve the problem or the problem promptly recurs, the Training Committee will become formally involved in discussions leading to a solution. The supervisor(s) and resident(s) may be asked to attend the Committee meeting 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 Training Committee believes that the nature of the resolution lies outside its scope of authority, the Chief of the Psychology 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 DVA has an active policy in the event of incapacitation.

5. Whenever a decision has been made by the DOT about a resident's training program or status in the agency, the DOT will inform the resident in writing and will meet with the resident to review the decision. This meeting may or may not include the resident's supervisor(s).

6. The resident may choose to accept the conditions or may choose to challenge the action. The procedures for challenging the action are presented below.

IV. Due Process

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

1. During the orientation period, presenting to the residents, in writing, the program's expectations related to professional functioning. Discussing these expectations in both group and individual settings.

2. Stipulating the procedures for evaluation, including when and how evaluations will be conducted. Such evaluations should occur at meaningful intervals.

3. Articulating the various procedures and actions involved in making decisions regarding impairment.

4. Instituting, when appropriate, a remediation plan for identified inadequacies, including a time frame for expected remediation and consequences of not rectifying the inadequacies.

5. Providing a written procedure to the resident that describes how the resident may appeal the program's action. Such procedures are included in the residency handbook. The Residency Handbook is provided to residents and reviewed during orientation.

6. Ensuring that residents have sufficient time to respond to any action taken by the program.

7. Using input from multiple professional sources when making decisions or recommendations regarding the resident's performance.

8. Documenting, in writing and to all relevant parties, the actions taken by the program and its rationale.

V. Grievance Procedure

This document provides guidelines to assist Residents who wish to file complaints against staff members. In general, there are two situations in which grievance procedures can be initiated:
1. In the event a resident encounters any difficulties or problems with staff members (e.g. poor supervision, unavailability of supervisor, evaluations perceived as unfair, workload issues, personality clashes, other staff conflict) during his/her training experiences, a resident can:
   a. Discuss the issue with the staff member(s) involved;
   b. If the issue cannot be resolved after this discussion, the resident should discuss the concern with the DOT;
   c. If the DOT cannot resolve the issue, the resident and DOT should discuss the problem with the Service Chief; Or, if the resident has a concern with the DOT that has not been resolved through discussion with the DOT, 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 DOT, the supervisor or any member of the training staff by following this procedure:
   e. In the event that the resident has a concern with the Service Chief, the resident can discuss the problem with the Associate Chief of Staff for Education prior to filing a formal complaint (as noted above).

   The resident should file a formal complaint, in writing and all supporting documents, with the DOT. 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 DOT 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 DOT.
   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 DOT for a review of the situation. When this occurs, the DOT will within five days of a formal complaint, the DOT 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 DOT and the resident involved in the dispute. The resident has the right to hear all facts with the opportunity to dispute or explain the behavior of concern.
   b. Within five (5) work days, a hearing will be conducted in which the challenge is heard and relevant material presented. Within three (3) work days of the completion of the review, the Review Panel submits a written report to the Service Chief, including any recommendations for further action. Recommendations made by the Review Panel will be made by majority vote.
   c. Within three (3) work days of receipt of the recommendation, the Service Chief will either accept or reject the Review Panel's recommendations. If the Service
Chief rejects the panel's recommendations, due to an incomplete or inadequate evaluation of the dispute, the Service Chief may refer the matter back to the Review Panel for further deliberation and revised recommendations or may make a final decision.

d. If referred back to the panel, they will report back to the Service Chief within five (5) work days of the receipt of the Service Chief's request of further deliberation. The Service Chief then makes a final decision regarding what action is to be taken.

e. The DOT 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.

The Due Process section is substantially based on policy of the VAGLAHS Clinical Health Psychology Intern Program. Elements of VA Associated Health Residency programs in optometry, podiatry and psychology were also used.
<table>
<thead>
<tr>
<th>Date:</th>
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<tbody>
<tr>
<td>Resident name:</td>
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I acknowledge that I have received and read the VA Greater Los Angeles Healthcare System Chiropractic Residency Program Handbook.

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

As a trainee of the VA Greater Los Angeles Healthcare System, I understand that I am responsible for complying with the rules and regulations as set forth in this handbook and other VA trainings.

<table>
<thead>
<tr>
<th>Resident signature:</th>
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<tbody>
<tr>
<td>Residency Director name:</td>
<td>Valerie Johnson, DC, DABCI</td>
</tr>
<tr>
<td>Residency Director signature:</td>
<td></td>
</tr>
</tbody>
</table>
Current and Previous Residents

Benjamin Liang, DC/ 2014-2015
Hometown: Los Angeles, CA
Chiropractic Educational: Cleveland College of Chiropractic

Justin Goehl, DC/ 2015-2016
Hometown: Kalamazoo, MI
Chiropractic Educational: Logan University

Shery Assal, DC/ 2016-2017
Hometown: Orange County, CA
Chiropractic Educational: Southern California University of Health Sciences
Rachel Clark, DC/ 2017-2018
Hometown: Dennisville, NJ
Chiropractic Educational: University of Bridgeport