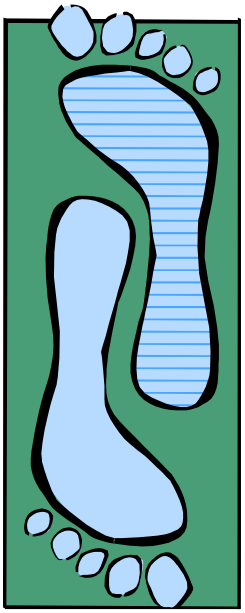
Podiatry Resident's Manual
Charlie Norwood VAMC



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Mission

The Charlie Norwood Veterans Affairs Medical Center (CNVAMC) pursues the development of compassionate, highly effective podiatric physicians through a structured learning experience in patient management, with training in the diagnosis and care of podiatric pathology.

Hippocratic Oath: Modern Version

Dr. Louis Lasagna, Academic Dean of the School of Medicine at Tufts University, revised the traditional Hippocratic Oath in 1964, and his modern version is used in many medical schools today:

> I swear to fulfill, to the best of my ability and judgment, this covenant:
>
> I will respect the hard-won scientific gains of those physicians in whose steps I walk, and gladly share such knowledge as is mine with those who are to follow.
>
> I will apply, for the benefit of the sick, all measures [that] are required, avoiding those twin traps of overtreatment and therapeutic nihilism.
>
> I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug.
>
> I will not be ashamed to say, "I know not," nor will I fail to call in my colleagues when the skills of another are needed for a patient's recovery.
>
> I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know. Most especially must I tread with care in matters of life and death. If it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty. Above all, I must not play at God.
>
> I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick.
>
> I will prevent disease whenever I can, for prevention is preferable to cure.
>
> I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm.
>
> If I do not violate this oath, may I enjoy life and art, respected while I live and remembered with affection thereafter. May I always act so as to preserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help.

The Podiatry Resident's Manual

A hard copy of the Podiatry Resident's Manual is kept in the Residents Room (4C153) in C Wing of the Fourth Floor of Building 801, the main building of the CNVAMC Downtown Division, 950 15th Street, Augusta, GA, 30904.

A soft copy of the Podiatry Resident's Manual is kept in the Podiatry S: drive,[1] accessible once you have completed your onboarding and received your Personal Identity Verification (PIV) card.

The folder in the S: drive also includes the following materials:

- Augusta University Paperwork
- Evans Surgery Center Paperwork
- Residency Rotation Assessments

} Folders

- CPME 320, "Standards and Requirements for Approval of Podiatric Medicine and Surgery Residencies" (October 2022, eff. July 2023)
- CPME 320, "Standards and Requirements for Approval of Podiatric Medicine and Surgery Residencies" (Updated to reflect new logging definitions as approved by CPME in April 2022)
- CPME 330, "Procedures for Approval of Podiatric Medicine and Surgery Residencies" (October 2022, eff. July 2023)
- CPME Proper Logging Guide (July 2023)
- CPME Proper Logging of Wound Care Cases (June 2024)
- CPME/ABFAS/ABPM Proper Logging of Podiatric Medical/Surgical Residency Experiences (July 2023) [Webinar slides]

- Secretary of Veterans Affairs Memo, "Equal Employment Opportunity; Inclusion, Diversity, Equity and Access; No FEAR; and Whistleblower Rights and Protection Policy Statement" (July 28, 2023)
- VHA Directive 1122, "Podiatric Medicine and Surgical Services" (February 2018)
- VHA Directive 1400.01, "Supervision of Physician, Dental, Optometry, Chiropractic, and Podiatry Residents" (November 2019)
- VHA Directive 1410, "Prevention of Amputation in Veterans Everywhere Program" (June 2022)
- VHA Handbook 1400.04(1), "Supervision of Associated Health Trainees" (June 2024)
- VHA Handbook 1400.08(1), "Education of Associated Health Professions" (June 2024)
- OCHCO Worklife and Benefits Service (058) Flyer – Update to Retirement and Benefit Eligibility Table for Students and Trainees, including the VHA Office of Academic Affiliation (OAA) Health Professions Trainees" (August 2023)

[1] S:\VHAAUGPODIATRY\Resident Manual\RESIDENT MANUAL AND ASSESSMENTS

- VA Handbook 5021/15, “Employees/Management Relations,” Part I, Appendix A. Title 5 – Table of Examples of Offenses and Penalties. §2. Range of Penalties for Stated Offenses.
- National Podiatry Program Office Guidance on the use of Podiatry tools Re: Rotary tools and Burrs (May 2024)
- DM 1100.509, “Supervision of Physician, Dental, Optometry, Chiropractic, and Podiatry Residents” (December 2021)
- MCP Memorandum No. 112-18-07, “Documentation and Completion of Health Records” (October 2018)
- Podiatry Medical and Surgical Service - Graduate and Post-Graduate Education and Training (August 2022)
- Anesthesiology Section Standard Operating Procedure – Pre-anesthesia Patient Evaluation (March 2023)
- CPRS Training – View Alert/Notification Options Update

The Charlie Norwood VA Podiatry Clinic

The CNVAMC Podiatry Clinic is part of the Surgery Service Line, and provides podiatric medicine and surgery services to Veterans throughout the Central Savannah River Area (CSRA) and beyond. Residents will complete a three-year program consisting of podiatric medicine and surgery practice at the CNVAMC's Downtown Division, as well as rotations with other clinics in the Surgery Service and with other podiatric practices in the area. Residents will be overseen by Attending Podiatrists and Attending Physicians at all times; many of these practitioners hold concurrent academic appointments with Augusta University.

Surgery Service Position	Staff Member
Acting Chief	James Frizzi, MD, FACS
Administrative Officer (AO)	Andria Robinson
Automatic Data Processing Application Coordinator (ADPAC)	Georgia Bryant
Program Support Assistant (PSA)	Bryant Murray
	Tonya Rollins
	Julius Sykes

Podiatry Section Position	Staff Member
Chief	Charles Kean, DPM, D. ABFAS
Residency Director	George Sich III, DPM, FACFAS
Attending	Terria Madison, DPM, ABPM
	Francis Castillo, DPM, ABPM
Program Coordinator	
Charge Nurse	

Resident Benefits

Podiatry residents are Healthcare Professional Trainees (HPTs) appointed to full-time employment with the VA (not to exceed 1-year, requiring Tier 1 investigation) under Title 38 of the United States Code, and are eligible for Federal Employee Health Benefits (FEHB). This is the only additional benefit full-time HPTs are authorized; there is no allowance for meals, housing, or uniforms. This period of employment does not count toward retirement benefits if the resident subsequently accepts a permanent federal position.

Residents accrue leave based on their Service Computation Date (SCD), and initially accrue 13 days of Annual Leave per year. Guidance on the use of leave is found in the Rules and Regulations for the Conduct of the Resident section of this manual, addressing Sick Leave, Annual Leave, and Holiday Leave.

Residents are protected from personal liability while participating in training at a VA healthcare facility under the Federal Employees Liability Reform and Tort Compensation At (28 U.S.C. 2679 (b)-(d)).

Federal Insurance Contribution Act (FICA) payroll taxes are automatically withheld. Residents are not eligible to contribute to the Federal Employee Retirement System (FERS), Civil Service Retirement System (CSRS), or Thrift Savings Plan (TSP), per 5. U.S.C. chapters 83 and 84 and 5 U.S.C. 5351.

As of Academic Year 2024-2025, the allocation per detail per trainee is as follows:

PGY 1	$26.58 hourly
Basic Pay per Assigned Hours	$55,974 (2024-2025 data)
Employer Share FICA	$4,229 (2023-2024 data)
Employer Share Benefits	$4,661 (2023-2024 data)
Total	$64,166
PGY 2	$27.71 hourly
Basic Pay per Assigned Hours	$58,369 (2024-2025 data)
Employer Share FICA	$4,410 (2023-2024 data)
Employer Share Benefits	$4,665 (2023-2024 data)
Total	$66,717
PGY 3	$28.94 hourly
Basic Pay per Assigned Hours	$60,959 (2024-2025 data)
Employer Share FICA	$4,605 (2023-2024 data)
Employer Share Benefits	$4,670 (2023-2024 data)
Total	$69,475

The employee dashboard [2] contains links to VATAS, TMS, myPay, eOPF, and other useful systems.

[2] https://hris.va.gov/portal/

Resident Wellbeing

Resident wellbeing is a priority for the CNVAMC.

Employees may take time to attend medical, mental health, and dental appointments, even if the only time available is during work hours. If scheduling appointments during the work day is unavoidable, we ask that the appointments be scheduled (if possible) at the beginning or the end of the work day to minimize disruption to clinical care and training. In any case, residents will notify the Program Director and Chief of Podiatry of upcoming appointments in writing (preferably email) and will post the appointment date and time in a note on the Podiatry community calendar in Conference Room 4C145. The location and type of appointment do not need to be shared on the calendar note.

CNVAMC offers employees health insurance plans that provide access to confidential and affordable mental health care, including both ongoing and acute mental health issues. If urgent care is required, employees may report to Employee Health (2B) or the Emergency Department to be treated as needed.

To support physical and mental wellbeing—especially while on call—residents have 24-hour access to a resident room (1D257A) in the Surgery Clinic on the First Floor. This room is available for breaks at any time and any day, and is stocked daily with food and snacks.

The VA provides education and resources that support residents in identifying in themselves or others the risk factors for developing or demonstrating symptoms of fatigue, burnout, depression, or substance abuse, or displaying signs of self-harm, suicidal ideation, or potential for violence. The National Podiatry Program website[3] includes links providing information on VHA Priorities like Whistleblower Protection, High Reliability Organization, Whole Health Resources, and Reducing Employee Burnout: REBOOT.

Part of the VA's annual training requirements is VHA Mandatory Training for Trainees, a course that discusses working and managing work in the VA system, including identification of general signs and symptoms of abuse and management of potentially violent or disruptive behavior. The more you learn and know, the better your experience of working in the VA system will be.

Employee Assistance Plan (EAP)

The EAP is a voluntary, work-based program that provides cost-free and confidential assessment, short-term counseling, referral, and follow-up services to employees who have personal or work-related problems that may affect attendance, or work performance, conduct such as substance abuse, biopsychosocial problems, or life stresses. Residents interested in EAP resources may call (800) 222-0364 or consult the Federal Occupational Health (FOH) website[4] for more details. The local point of contact is Brenda Byrd-Pelaez (brenda.byrd-pelaez@va.gov), at (706) 733-0188, ext. 33550.

[3] https://vaww.specialtycare.va.gov/programs/podiatry.asp
[4] https://www.foh4you.com

Faculty

Podiatric Faculty

Charlie Norwood VA Medical Center

Chief of Podiatry
Charles Kean, DPM, D. ABFAS

Residency Director
George Sich III, DPM, FACFAS

Attending
Terria Madison, DPM, ABPM
Francis Castillo, DPM, ABPM

Upperline Health Augusta (prev. Augusta Foot & Ankle)

Podiatrist/Foot and Ankle Specialist
Mickey D. Stapp, DPM, FACFAS Faculty Member, The Podiatry Institute

Podiatrist/Foot and Ankle Specialist
Christopher D. Anna, DPM, ABPM, ACFAOM

Podiatrist/Foot and Ankle Specialist
Brian N. Bennett, DPM, FACFAS, ACWS

Podiatrist/Foot and Ankle Specialist
Trevor S. Payne, DPM, FACFAS

Podiatrist/Foot and Ankle Specialist
Lisa Thatcher, DPM

Podiatrist/Foot and Ankle Specialist
Daniel Henry, DPM

26 Foot and Ankle

Physician
Christopher Menke, DPM, FACFAS Faculty Member, The Podiatry Institute Mentor, Emory Podiatric Medicine and Surgery Residency

Podiatrist/Foot and Ankle Specialist
Ruchi Ram, DPM, ABFAS and ABPM Qualified

Non-Podiatric Faculty

There are no non-Podiatric faculty affiliated with the Residency Program, but residents complete non-podiatric rotations with other sections. The responsible staff in those sections are listed in the Rotations and Contacts section of this manual.

Rotations and Contacts

Charlie Norwood VA Medical Center (Downtown Division)

950 15th Street, Augusta, GA 30904, (706) 733-0188

Anesthesiology	
Chief	Dr. Andrew Forgay (andrew.forgay@va.gov)
Location	3D143, ext. 32733
Point of Contact	Dr. James Heyman (henry.heyman@va.gov)
Staff	Drs. Drinkwater, Eichel, Heyman, Knight, Leahy, Sayre, Smith
	CRNAs Brown, Dr. Budinich, Delaney, Dominici, Fedele, Dr. Fortner, Plair, Dr. Philippe, Dr. Ray (Chief), Sprague, Starr, Stouder

Dermatology	
Chief	Dr. Adeline Johnson (adeline.johnson@va.gov)
Location	4C113, ext. 33746
Staff	Dr. Greenwood

Emergency Department	
Chief	Dr. Abhijit Singh (abhijit.singh6@va.gov)
Location	1D, ext. 33275

Imaging	
Chief	Dr. Timothy Mattison (timothy.mattison@va.gov)
Location	2D, ext. 32912
Point of Contact	Dr. Ajo John (ajo.john@va.gov)
Staff	Drs. James, John, Keshavamurthy

Infectious Diseases	
Chief	Dr. Peter Skidmore (peter.skidmore@va.gov)
Location	4D153, ext. 32197
Point of Contact	Dr. Stephanie Baer (stephanie.baer@va.gov)
Staff	Dr. Morris

Medicine	
Chief	Dr. Lauren Post (lauren.post@va.gov)
Inpatient Chief	Dr. Sonia Camphor (sonia.camphor@va.gov)
AU IM Site Director	Dr. Joseph Morris (joseph.morris2@va.gov)
Location	2D, ext. 32135
Gold Team	Dr. Tyson, Dr. Ujjin
Blue Team	Dr. Lall, Dr. Tabi
Yellow Team	Chief Residents Dr. Gotshall, Dr. Prasatik
Other Staff	Drs. Collier, Desai, Saleem

Orthopedics	
Chief	Dr. Terry Mueller (terry.mueller1@va.gov)
Location	1D, 4A106 (office), ext. 32810
Staff	Dr. Bozorgnia, PA Brown, PA Lane

Pain Medicine	
Chief	Dr. Marshall Bedder (marshall.bedder@va.gov)
Location	1D287, ext. 33162
Staff	Drs. Shell (Addiction), Xu (Pain), Higdon (Pharmacology), Trakowski (Psychology), NP Parker, NP Tuttle

Plastic Surgery	
Chief	Dr. Robert Dinsmore (robert.dinsmore@va.gov)
Location	4A112 (office), ext. 32588
Staff	Dr. Collins, Dr. Helling, PA Doster, PA Mayo

Rheumatology	
Chief	Dr. Hossam El Zawawy (hossam.elzawawy@va.gov)
Location	4D153, ext. 33555
Point of Contact	Dr. Brian Le (brian.le@va.gov)
Staff	Drs. Le, Oliver, Schiopu

Vascular Surgery	
Chief	Dr. Manuel Ramírez (manuel.ramirez3@va.gov)
Location	4C133A (office), ext. 32041
Staff	NP Canty, NP Casella

Augusta University (Health Sciences Campus)

1120 15th Street, Augusta GA 30912

Orthopaedic Surgery	
Chief	Dr. Monte Hunter (Sports) (mohunter@augusta.edu)
Location	BA-3300, (706) 721-1633
Point of Contact	Shannon Williford (swillifo@augusta.edu)
Staff	Drs. Bryan (Pediatrics), Cearley (Pediatrics), Homlar (Orthopaedic Oncology), Johnson (Orthopaedic Trauma), Sich (Podiatry), Szabo (Podiatry), Willson (Sports)

Rheumatology	
Chief	Dr. Laura Carbone (lcarbone@augusta.edu)
Location	(706) 721-2981
Point of Contact	Piper Zdrodowski, Admin Assistant (pzdrodowski@augusta.edu)
Staff	Drs. Javaid, Rolle, Shi

Private Practice

Upperline Health Augusta Foot & Ankle	
Principal	Dr. Mickey Stapp
Location	1416 Wainbrook Drive, Augusta, GA 30909, (706) 312-3668
Staff	Drs. Anna, Bennett, Payne, Thatcher, Henry

Wellstar / MCG	
Principal	Dr. George Sich
Location	1) 901 Magnolia Drive, Aiken, SC 29803, (803) 648-6977 2) Wellstar/MCG Medical Office Building Orthopedic Clinic, 1447 Harper Street, Augusta, GA, 30913
Staff	Drs.

Bako Diagnostics	
Principal	Dr. Brad Bakotic
Location, Extension	6240 Shiloh Road, Alpharetta, GA 30005, (855) 422-5628
Point of Contact	Teri Bruce, Senior Supply Chain Manager (tbruce@bakodx.com)

Training Schedule

Over the course of their 36-month residency, Podiatry residents complete a series of rotations with various medical subspecialties, according to a structured plan. In the following tables, rotations are four-week blocks unless specifically labeled otherwise. Rotations with a private practice affiliate are colored grey, and rotations with Augusta University are colored blue.

Month	Rotation	Resident Year
July	Orientation/Podiatry	1
August	Podiatry	1
September	Orthopedics	1
October	Podiatry	1
November	Internal Medicine	1
December	Emergency Department	1
January	Podiatry	1
February	Podiatry	1
March	Anesthesiology	1
	Pain Medicine (2 weeks)	
April	Imaging (2 weeks)	1
	Podiatry (2 weeks)	
May	Podiatry	1
June	Podiatry	1

July	Augusta Foot & Ankle	2
August	Orthopaedics (Pediatric)	2
September	Podiatry	2
October	Infectious Diseases	2
November	Podiatry	2
December	Podiatry	2
January	Podiatry	2
February	Orthopaedics (Trauma)	2
March	Podiatry	2
April	General Surgery (2 weeks)	2
	Vascular Surgery (2 weeks)	
May	Podiatry	2
June	Podiatry	2

July	Podiatry	3
August	Podiatry	3
September	Rheumatology	3
October	Podiatry	3
November	Podiatry	3
December	Podiatry	3
January	Behavioral Science (2 weeks) Elective (2 weeks)	3
February	Podiatry	3
March	Podiatry	3
April	Podiatry (2 weeks)	3
April	Podiatry (2 weeks)	3
May	Plastic Surgery (2 weeks)	3
May	Dermatology (2 weeks)	3
June	Elective (2 weeks) Podiatry/Outprocess (2 weeks)	3

PGY-2 and PGY-3 Residents alternate Friday surgeries with Dr. Stapp's Upperline Health (prev. Augusta Foot & Ankle) practice according to their availability.

Rotation Schedules

MONTHS	PGY-1	PGY-2	PGY-3
JULY	Podiatric Medicine & Surgery	Private practice - Stapp (4)	Podiatric Medicine & Surgery
AUGUST	Podiatric Medicine & Surgery	AU Orthopedics - Pediatrics (4)	Podiatric Medicine & Surgery
SEPTEMBER	VA Orthopedics (4)	Podiatric Medicine & Surgery	Rheumatology (4)
OCTOBER	Podiatric Medicine & Surgery	Infectious Diseases (4)	Podiatric Medicine & Surgery
NOVEMBER	Internal Medicine (4)	Podiatric Medicine & Surgery	Podiatric Medicine & Surgery
DECEMBER	ER (4)	Podiatric Medicine & Surgery	Podiatric Medicine & Surgery
JANUARY	Podiatric Medicine & Surgery	Podiatric Medicine & Surgery	Behavioral Science (2) / Elective (2)
FEBRUARY	Podiatric Medicine & Surgery	AU Orthopedics - Trauma (4)	Podiatric Medicine & Surgery
MARCH	Anesthesiology (2) / Pain Management (2)	Podiatric Medicine & Surgery	Podiatric Medicine & Surgery
APRIL	Medical Imaging (2) / PM&S (2)	General Surgery (2) / Vascular (2)	PM&S (2) / AU Pod - Szabo/Sich (2)
MAY	Podiatric Medicine & Surgery	Podiatric Medicine & Surgery	Plastics (2) / Dermatology (2)
JUNE	Podiatric Medicine & Surgery	Podiatric Medicine & Surgery	Free Elective / PM&S / Out Process
	PM&S = Podiatric Medicine & Surgery		

This rotation schedule's future alignment with CPME 320/330:

FUTURE ALIGNMENT WITH CPME 320/330					* Required by CPME	Weeks required	Weeks scheduled
				X	* Anesthesiology	2	2
MONTHS	PGY-1	PGY-2	PGY-3	X	* Behavioral Sciences	2	2
JULY	Podiatric Medicine & Surgery	Private practice - Stapp (4)	Podiatric Medicine & Surgery	X	* Emergency Medicine	4	4
AUGUST	Podiatric Medicine & Surgery	AU Orthopedics - Pediatrics (4)	Podiatric Medicine & Surgery	X	* Medical Imaging	2	2
SEPTEMBER	VA Orthopedics (4)	Podiatric Medicine & Surgery	Rheumatology (4)		*** Medical Subspecialities**	**12**	**18**
OCTOBER	Podiatric Medicine & Surgery	Infectious Diseases (4)	Podiatric Medicine & Surgery	X	* Internal Medicine / FP	4	4
NOVEMBER	Internal Medicine (4)	Podiatric Medicine & Surgery	Podiatric Medicine & Surgery	X	* Infectious Diseases	2	4
DECEMBER	ER (4)	Podiatric Medicine & Surgery	Podiatric Medicine & Surgery		Burn Unit	2	
JANUARY	Podiatric Medicine & Surgery	Podiatric Medicine & Surgery	Behavioral Science (2) / Elective (2)	X	Dermatology	2	2
FEBRUARY	Podiatric Medicine & Surgery	AU Orthopedics - Trauma (4)	Podiatric Medicine & Surgery		Endocrinology	2	
MARCH	Anesthesiology (2) / Pain Management (2)	Podiatric Medicine & Surgery	Podiatric Medicine & Surgery		Geriatrics	2	
APRIL	Medical Imaging (2) / PM&S (2)	General Surgery (2) / Vascular (2)	PM&S (2) / AU Pod - Szabo/Sich (2)		Intensive / Critical Care	2	
MAY	Podiatric Medicine & Surgery	Podiatric Medicine & Surgery	Plastics (2) / Dermatology (2)		Neurology	2	
JUNE	Podiatric Medicine & Surgery	Podiatric Medicine & Surgery	Free Elective / PM&S / Out Process	X	Pain Management	2	2
				X	(AU) Pediatrics	2	4
	PM&S = Podiatric Medicine & Surgery				Physical Medicine & Rehab	2	
				X	Rheumatology	2	4
					Wound Care	2	
					Vascular Medicine	2	
					*** Surgical Subspecialities**	**8**	**14**
				X	* Vascular / Endo	2	2
					Cardiothoracic surgery	2	
				X	General surgery	2	2
					Hand surgery	2	
				X	Orthopedic surgery	2	4
				X	Plastic surgery	2	2
	Stapp surgery every Fri (PGY 2 and PGY 3 alternate based upon schedule)				Surgical intensive care unit (SICU)	2	
				X	(AU) Trauma team/surgery	2	4

Assessments

Annual

The Council on Podiatric Medical Education (CPME) Annual Assessment Fee of $5000 is invoiced in April/May of each year, and is due no later than September 1 each year, along with the CPME Annual Report and resident certificate submission.

The Centralized Application Service for Podiatric Residencies (CASPR) participation fee of $1,500 and Council of Teaching Hospitals (COTH) membership fee of $1000 are paid through the American Association of Colleges of Podiatric Medicine (AACPM) website as part of the CASPR registration process in July of each year. This registration and invoice process opens in the beginning of June.

Podiatry Residency Resource (PRR), American Board of Foot and Ankle Surgery (ABFAS), and the American Board of Podiatric Medicine In-training Exam (ITE) fees include:

PRR Access	$195 per resident
ABFAS ITE	$240 per resident
ABFAS FINAL	$300
ABPM ITE	$250 per resident

Residents are encouraged to sign up for ITE as soon as possible when the scheduling window opens to take full advantage of the opportunity. Because testing space is severely limited in Augusta, late registration may require travel to Atlanta or elsewhere to take the exams.

Graduating PGY-3 residents' evaluation of the program are due by June 30 each year.

Annual self-assessments per CPME 320 are due by June 30.

Fees are paid by the Academic Affiliations Office (for more information, contact Latonya Johnson, ext. 26852, latonya.johnson3@va.gov.

Quarterly

Resident evaluations

Monthly

Resident off-service rotation assessment evaluations.

Clinic and Surgical Schedule

Clinic Schedule

The Podiatry Clinic is open from 08:00 through 16:30, Monday through Friday. Each morning before clinic or surgery, residents will present call patients to the attendings, hear announcements, discuss problems/improvements, and pass or receive updates on all inpatients being followed by Podiatry.

Inpatient rounds will be coordinated with Attending either between the morning and afternoon outpatient clinics, or in the afternoon after the last outpatient clinic.

If time remains after completion of all clinic duties, residents will remain on site for educational time (e.g., reading, research, studying, hands-on skill practice).

Monday (AM/PM)

Resident can present to any available Attending

Tuesday (AM/PM)

Pre-op in AM (resident present to Attending on case)
Post-op in PM (resident present to Attending on case)
Resident can present to any available Attending

Cadaver Lab (based on availability), after clinic until 18:30

Wednesday (AM)

McGlamry Book Club (every other Wednesday)

Wednesday (PM)

Resident can present to any available Attending

Wednesday Meeting, 16:00 – 18:00

Thursday (AM/PM)

Resident can present to any available Attending.
Clubfoot Clinic at Wellstar/MCG begins at 2:00PM. One resident must attend weekly.

Friday (AM/PM)

Resident can present to any available Attending
Dr. Stapp, Augusta Foot & Ankle (PGY-2 and PGY-3 alternate)

Attendance at the McGlamry Book Club every other Wednesday morning is mandatory except for residents on off-service rotation **AND** when the off-service rotation schedule will not allow attendance. Otherwise, attendance is expected. The lead resident will prepare a Word document outline of important points to remember for all residents and the Attending chairing the meeting.

Each month residents on Podiatry Rotation will be given specific clinic and surgery assignments.

The Podiatry Elective Surgery calendar in located on the Augusta VA Intranet page and under Augusta SharePoint.

Surgical Schedule

Operating Room availability at CNVAMC changes from month to month, and the Chief of Surgery announces each service's availability for elective surgery a few months in advance. Once the time has been made available, there is a 10-day window to post cases, after which any unused blocks can be taken by other surgical services. It is therefore vital that elective cases be posted in Perioperative Planner or Veterans Health Information Systems Technology and Architecture (VistA) as soon as the patients confirm that they want to proceed with surgery.

Emergent cases or inpatient surgeries are posted into VistA immediately, and must be coordinated with the OR Scheduler (ext. 33461) to arrange time for the case to proceed.

Residents are responsible for monitoring ALL scheduled VA foot, rearfoot, ankle, and lower extremity surgeries (including BKAs), regardless of whether they are scheduled to assist and regardless of whether the resident is on Podiatry service or on an outside rotation.

Residents will regularly follow and monitor the VA Orthopedic Surgery calendar for foot and ankle cases. Residents shall be acutely familiar with the patient history, exam and imaging findings with VA Orthopedic foot and ankle surgery patients. The residents shall communicate with and discuss these patients with the VA Orthopedic attendings (Dr. Mueller and Dr. Bozorgnia) before surgery. This broadens the residents' exposure to Orthopedic and Podiatric cases, and justifies the CNVAMC program's status as a Podiatric Medicine and Surgery Residency/Rearfoot and Ankle Surgery (PMSR/RRA) program.

When assigned to assist in the Operating Room (OR), residents will report no later than 07:15 (preferably earlier) to prepare notes and orders in the VistA Computerized Patient Record System (CPRS), to review patient medical histories and x-rays, to prepare x-rays for the OR if needed, to visit with the patient in the OR holding area, to assist the Attending in marking the surgical site according to the Universal Protocol, and to prepare the OR for surgery **(Please see the Final OR Set-up Checklist in the Appendix)**. At a minimum, residents should plan to set aside 45 minutes after surgery for charting (notes, orders, and reports, etc.)

Note that more than one resident may scrub in to assist in a case if schedules permit. One resident will be primary (1) and the other secondary (2). Residents should pay careful attention to what cases are scheduled and when, to take full advantage of opportunities to assist or observe in unusually complex cases, and to ensure that they have achieved the quantity and variety of cases required for completion of the residency program.

Residents may also scrub in to participate in surgical cases at Augusta University (AU) if the schedule at CNVAMC permits. The Residency Program Director, Dr. Sich, will arrange for PGY-1 residents to obtain badges and computer access at AU for the duration of the three-year residency. As Dr. Sich holds appointment as Assistant Professor of Podiatry at Augusta University, he is the liaison between CNVAMC and AU, and each week he will notify residents what podiatric and orthopedic cases are scheduled at AU.

PRINCIPLES OF SURGERY

Understanding the primary goal of the surgery.
Planning / prepare in advance.
Precision.
Hemostasis.
Perfection.

Rule 1: Verify everything and do not rely on the information provided by others.
Rule 2: Once you agree to accept the patient, take total control of the patient's care.
Rule 3: Never make promises you can't keep.

Podiatry Wednesday Meeting Outline

The Podiatry Wednesday Meeting is scheduled for 1600 so that the Nursing staff can attend the first part before their tour of duty ends at 1630. Attendance is mandatory except for residents on off-service rotations **AND** when the off-service rotation schedule makes attendance inconvenient (examples – rotation is off of the VA/Wellstar MCG campus, rotation has night schedule, or if the podiatry meeting time is in the middle of off-service learning and patient activity). If the resident misses a meeting for this reason, he or she should confer with the other residents to ensure that any important information is shared. If it is discovered that a resident, who is done for the day before 4:30pm on an off-service rotation (not meeting the criteria above), purposely misses the Wednesday Podiatry meeting, the resident will be counseled and this could lead to dismissal from the program.

16:00	Podiatry Nursing
	Future clinic schedules (especially, Attending and Resident days off)
	Clinic management issues
	LEAF requests for future schedules
	Weekly attending comments about residents
16:30	Vendor versus Faculty lecture (30 min. maximum)[5]
17:00	Chief's Remarks, by Dr. Kean
	Attending's Remarks, by Dr. Madison and/or Dr. Castillo
	Residency Director's Remarks, by Dr. Sich
	Interesting cases, M&M, and billing
	Review of inpatients at CNVAMC
	Preop (VA Podiatry) conference/surgical case review
	Review of this week's VA surgical cases
	Review of next week's VA surgical cases
	Preview of surgery schedules for this week and next week – who is where?
	CNVAMC Podiatry and Orthopedics
	AU Orthopaedic, Pediatric, Trauma Surgery
	Surgery Center Columbia County (SCCC)
	Evans Surgery Center (ESC)
	Skills workshop/Resident's lecture
	PRR Review
	Journal Club (last Wednesday of the month)
	Student presentation (last Wednesday of the month)

The first Podiatry Wednesday Meeting in August will include annual training in CAC/CPRS presented by Joshua Walton from Clinical Informatics. This training is mandatory for all residents.

[5] No more than one Vendor may present per month. Dr. Sich may approve exceptions to this rule in months with five weeks on a case-by-case basis.

Schedule of Didactics and Journal Review Schedule (Under Revision)

Annual Didactic Schedule

Month	Subject
July	Orientation: review of handbook; H&P, medical documentation
August	Surgical skills & workshop: instruments, suturing, osteotomies, fixation
September	Perioperative patient: DVT prophylaxis, complications
October	Foot conditions and deformities: hammertoes, HAV, hallux rigidus, bunionette
November	Foot conditions and deformities: plantar fasciitis, neuroma, equinus
December	Research methodology
January	Basic pathophysiology: wound healing, bone healing, nerve healing
February	Diabetes mellitus: neuropathy, ulcers, infections, Charcot foot
March	Complex deformities: pes planus, pes cavus
April	Foot and ankle trauma; emergencies
May	Pediatrics and congenital deformities
June	Biomechanics; bracing and prosthetics

The specific topics within each general field are rotated every two to three years. Residents are encouraged to request specific topics they would like to review.

Specific topics in each general field and lecturers will be assigned and scheduled two months prior, and the schedule will be posted on the calendar in the conference room (4C145). The first three weeks of each month will consist of formal lectures, and the fourth week will consist of Journal Club, a review of research in the specific area being covered.

Formal lectures will be 20- to 30-minute Power Point presentations incorporating multiple sources, and will include history, bibliography, and a reading list. Each lecture will be followed by discussion time.

Case presentations will be 10- to 15-minute Power Point presentations incorporating more than one information source. Each presentation will include diagrams, pictures, X-rays, and other visual aids.

Journal Club presentations will focus on a journal article selected and distributed the first week of the month. Each presentation will include a brief summary, interesting points, and opinions, and will be followed by discussion time.

Additional Education Resources

Residents have PRESENT access and are encouraged to view this regularly in addition to the lectures and practicum presented as part of the structured course.

Residents also have access to the Augusta VA Online Medical Library,[6] which contains a number of paid subscriptions to databases (including UpToDate, EBSCO Discovery Service, PubMed, BrowZine, and LibKey.io), continuing education, literature and journals, as well as other resources.

In addition to the weekly Wednesday podiatry meeting, residents are responsible for attending the following:

Scheduled occurrence	Event
Tuesdays	Weekly AU Vascular conference (Zoom Conference 7AM)
Wednesday AM – no surgery	McGlamery Book Club – one chapter per session
1st Wednesday of the month	Online PRESENT/VA CME lectures
2nd Wednesday of the month	Morbidity and Mortality Conference
Last Wednesday of the month	Journal Club (see above)
Daily	AU/WMCG Orthopaedic conference (see monthly schedule)

The Residency Director may excuse residents from attending these meetings as appropriate.

Residents shall attend all Podiatry-related morning didactive AU/Wellstar/MCG Orthopedic lectures. This can be in person or via Zoom. These lectures commence at 06:30, and may be attended via ZOOM (https://us04web.us/j/166224207), using the password "mcg".

Podiatry-related means anything musculoskeletal related lumbar spine and leg related, including hips, knees, lower leg, ankle, and foot. This also includes imaging, oncology, neuromuscular related topics. This includes adult and pediatric related topics. All these structures influence the foot in one way or another.

DVAMC Lectures from National – Louis Stokes Cleveland VAMC Podiatry may be attended via Microsoft Teams (Conference ID 3249872758, or call in at (872) 701-0185). Residents will receive these announcements via email from the Podiatry Chief and/or Residency Director.

[6] https://liblynxgateway.com/va/at/aug

"6.7" Complementary and Supplementary Didactics

Pursuant to CPME requirements,[7] the following didactic activities complementary and supplementary to the curriculum must be completed annually:

Topic	Presenter
Falls prevention	Jason Pattillo, DPT, Chief of Physical Therapy
Resident well-being	Terri Lockhart, MD, FACP, Director of Health Equity
Pain management and opioid addiction	Marshall Bedder, MD, FRCP, Chief of Pain Medicine and Addiction Medicine Fellowship Program Director
Cultural humility	Terri Lockhart, MD, FACP, Director of Health Equity; Mandatory completion of TMS Course VA4309852 with certificate filed with Residency Director within 24 hours of completion
Workplace harassment and discrimination	Mandatory completion of TMS Course VA45224 with certificate filed with Residency Director within 24 hours of completion
Coding and medical documenation	George Sich III, DPM, Podiatry Residency Program Director

[7] CPME 320, *Standards and Requirements for Approval of Residencies in Podiatric Medicine and Surgery* (July 2023), §6.7.

Rules and Regulations for the Conduct of the Resident

Podiatry Residents are supervised by Podiatry Attendings according to the terms of Medical Center Policy Memorandum #33/11, Supervision of Residents.

Resident Responsibilities

Attendance

All residents must report to the Podiatry Clinic by 07:30. Residents must clock in and clock out each day in the Podiatry Residency Resource (PRR). Failure to report at the required time or failure to report for morning meeting with result in disciplinary action determined by the Chief of Podiatry.

If a resident will be late or absent for any reason, it is the resident's responsibility to ensure that Chief of Podiatry and Residency Director are made aware via email for tracking purposes.

VA Time and Attendance System (VATAS)

Podiatry residents are time-limited Title 38 Excepted Service Appointment employees of the Federal Government, and are treated as staff podiatrists for leave and attendance purposes. They are not eligible to receive overtime or other premium pays, and must submit leave requests via the VA Time and Attendance System (VATAS). Residents should log into this system regularly (even if they do not intend to request leave) to prevent their accounts from being disabled.

The Surgery Service Program Support Assistant (PSA) assigned to support Podiatry is the Primary Timekeeper. At the time of writing, this position is provisionally held by Julius Sykes. He is the primary point of contact for questions about VATAS or leave, and can enter leave on the resident's behalf in the event of an emergency. In the event he is not available, other Surgery Service PSAs are Backup Timekeepers and can assist. Residents are responsible for communicating with the Timekeeper to ensure that leave is correctly documented in VATAS.

Dr. Kean is the Primary Supervisor and TL Approver in VATAS for all Podiatry staff. In the event he is not available, the chiefs of other sections in the Surgery Service are Backup Supervisors and Backup TL Approvers and can assist.

Communication is essential to the success of the Residency Program. Residents must ensure that both the Chief of Podiatry and the Residency Director are aware of any issues that may affect attendance. Email should be used to ensure continuity and awareness, and absences should be scheduled as far in advance as possible to avoid disruption, confusion, and delay.

Sick Leave

Sick Leave (LS) must be reported to Chief of Podiatry and Residency Director before the start of clinic hours at 07:30, or to the Attending supervisor for non-Podiatry rotations. LS more than 2 days' duration will require a medical excuse to be provided upon return to duty.

Annual Leave

Annual Leave (LA) must be requested for any day off that is not a weekend or a federal holiday, and must be requested 45 days in advance by email and must be approved in writing by the Chief of Podiatry before it is requested in VATAS; text messages are not acceptable in lieu of email correspondence. Leave during non-Podiatry rotations must be discussed with the Attending supervisor for that rotation prior to the rotation starting, and will be documented as days missed on the resident's rotation evaluation. Residents may not take more than 5 consecutive work days of leave.

Leave time shall also be written upon the community calendar in the Podiatry Conference Room 4C145 and manually entered into the Podiatry SharePoint Surgery Calendar.

Holiday Leave

Residents have federal holidays off on the observed date, with exceptions for being on call; it is not necessary to enter Holiday Leave (LH) into VATAS.

Call Schedule

Dr. Madison designates the call schedule each month, and the current day is posted on line at Amion ("Am I on?"), accessible via username "augustava". All Attendings and residents have their cell phone numbers on the call sheet; cell phones are preferred to pagers because cell phones have been found to have better coverage in the Augusta area than pagers. The on-call resident will contact the on-call Attending immediately, if a patient is admitted to the hospital after-hours or if the resident has questions or doubts about how to proceed. Less urgent calls will be discussed with the Attending the following morning.

Residents on non-Podiatry rotations will be the on-call resident for that service while on rotation. The Podiatry call schedule will reflect this.

The PGY-3 Resident will not take call on Thanksgiving, Christmas, or New Year's Day. These holidays will be split between the PGY 1 and 2 residents. The PGY-2 Resident will have first choice of which one of these holidays to cover. The PGY-1 Resident will take call on the two remaining holidays.

Moonlighting

Moonlighting is prohibited.

Clinical Documentation

Clinical documentation is entered into the CPRS. Operation reports will be completed the same day the surgery is performed; discharge summaries will be completed within 24 hours of discharge. Patient charting **will be completed on the same day the patient is seen**, even though

the CNVAMC Policy is that charting notes can be completed within 72 hours. See MCP Memo 112-18-07 - Documentation and Completion of Health Records (10-2018). The appropriate Attending must be listed as cosigner on all charting.

Academic tasks assigned by any of the Attendings will be completed according to the time table designated by the Attending when the assignment is made.

Inpatient Consults

Inpatient consults will be completed within 24 hours of receipt. Inpatient consults for nail care will be forwarded to PAVE Health Technicians upon approval by Attending.

Logging Policy

To meet the requirements of the Podiatric Medicine and Surgical Residency (PMSR), residents must complete prescribed levels of clinical and surgical experience. To ensure that they receive proper credit for the time and work that residents complete toward the PMSR requirements, it is imperative that residents keep accurate logs supported by documentation. The CPME website, CPME.org, has information about how to log activities, including a Proper Logging Guide[8] and Webinar slides.[9]

Residents shall log all patient surgical experiences in the Podiatry Residency Resource (PRR) by Monday, whether on Podiatry rotation or non-Podiatry rotation, at the CNVAMC or at an affiliated site. (Procedures performed at affiliated sites will be verified by the Attending.) All logging must be completed within two weeks of the date of visit, and logs will be verified every two weeks. Procedures unsupported by documentation should not be logged.

Residents may log as many patient clinical experiences as they like, in addition to ALL surgical experiences (done in the Podiatry Clinic, ER, and in the OR), provided that the total number of entries (surgical and clinical) is at least three per day. If there are fewer than three surgeries on a given work day, the resident shall log as many clinical experiences as are necessary to complete three entries for that day. Please note that this does NOT mean that residents only have to see three patients a day.

If there are fewer than three experiences (both surgical and clinical) on a given work day, the resident will log however many clinical experiences he or she had, and will notify the Program Director by email that there were fewer than the required three experiences that day.

Failure to comply with this logging policy (all surgical experiences and as many clinical experiences as are needed to complete at least three entries per work day) will be grounds for dismissal from the Residency Program.

Questions about how to log a case should be presented at the Wednesday meeting only after the resident has checked the CPME website CPME 320, the Logging Guide, and Webinar slides. Care must be taken to avoid duplication or fragmentation.[10] Residents can use PRR's Clinical Log Audit Detail (CLAD) Report to review their logging to identify possible duplication or fragmentation, and to determine if a better procedure code is available to describe the procedure being logged. The Minimum Activity Volume (MAV) diversity option can be used to keep up with case requirements in real time.

How a resident is classified on a specific case affects how the case is counted toward meeting MAV. Cases in which a resident is classed as 1 or 2 count toward overall case numbers, but cases staffed as 2 will not count toward a specific category unless they are trauma-related. Residents must be mindful of this when assessing their case requirements.

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[8] https://apma.cms-plus.com/files/2023-5_Proper_Logging_Guide.pdf
[9] https://apma.cms-plus.com/files/2023-5_Proper_Logging_Webinar_Slides_May_2023.pdf
[10] See CPME Logging Profile Memorandum, October 23, 2007.

To respect patient privacy, patients' full Social Security Numbers (SSN) should not be used. VA patients will be logged with the first letter of their last name, then with the first letter of their first name, and, finally, the last four digits of their SSN. Patients seen at affiliated sites will be logged with Medical Record Numbers (MRN).

When logging biomechanical exams, the diagnosis, record of the exam with gait analysis, and treatment decision based on the exam must be recorded.[11] Not every biomechanical exam needs to result in prostheses or orthotic devices. Biomechanical exams can be entered for surgical workups if the notes show the biomechanical exam and it substantiates the need for a certain procedure.

CPME has an ABPM Suggested Biomechanical Examination Form available online,[12] and the American Board of Podiatric Medicine (ABPM) has Pathology Specific Biomechanical Examination Templates as downloadable documents on its website.[13]

CPME has also released information for proper logging of wound care cases. CPME Proper Logging of Wound Care Cases (06-2024). Please refer to this reference first before discussing question with the Residency Director.

[11] See CPME Biomechanical Exam Memorandum, June 23, 2009.
[12] https://apma.cms-plus.com/files/ABPM%20Suggested%20Biomechanical%20Evaluation%20Form.pdf
[13] https://my.podiatryboard.org/pages/biomechanical.

Competencies Specific to Each Rotation

Podiatry Medicine Competencies

- Proficiency in palliative foot care and basic podiatric office procedures, including digital, nail, and soft tissue procedures.
- Proficiency in giving local anesthetic blocks and/or therapeutic injections.
- Ability to evaluate, diagnoses, and treat various ulcers of foot and/or leg.
- Ability to recognize foot conditions associated with systemic or chronic diseases.
- Ability to perform biomechanical examination and identify the proper interventional devices needed to treat conditions identified.
- Ability to communicate effectively with patient, family, and health care professionals in planning proper total patient care.
- Ability to effectively order laboratory workup and properly interpret results.
- Ability to properly order imaging studies and properly interpret and evaluate results.
- Ability to appropriately consult other health care professionals when needed.
- Proficiency in charting and dictation.

Podiatry Surgery Competencies

- Ability to perform a surgical workup/history and physical (H&P) evaluation, with ability to recognize warning signs for “high risk” patients.
- Ability to present preoperative patients with indications for surgery, risks, benefits, complications, and post-operative plan.
- Proficiency in sterile technique, including ability to assist and maintain the Mayo stand and instrumentation.
- Familiarity with surgical instrumentation used in podiatric surgery.
- Familiarity with surgical procedures and techniques common to podiatric surgery.
- Proficiency in surgical skills, including ability to open and close surgical sites and maintenance of sterility.
- Proficiency in post-operative care for surgical patients.
- Ability to complete timely and detailed operative note dictations.

Internal Medicine Rotation Competencies

- Proficiency in preparing comprehensive histories, showing attentiveness and good interviewing skills.
- Proficiency in performing comprehensive physical examinations.
- Ability to obtain and interpret pertinent lab data.
- Ability to diagnose and manage diabetic disease, including dietary and pharmacological management.
- Familiarity with common coagulation disorders and the indications for anticoagulation.
- Ability to interpret electrocardiogram (EKG) findings and familiarity with normal vs abnormal heart rhythms.
- Understanding of fluid and electrolyte imbalance

- Understanding of appropriate antibiotic coverage for various infections, e.g., cellulitis, pneumonia, urinary tract infection.
- Ability to order appropriate consultation to specialty and ancillary services.
- Ability to effectively communicate with other health care providers, and the patient.
- Proficiency in team approach to development and implementation of preventative treatment plans.
- Ability to derive treatment plan from thorough history, physical exam, and appropriate diagnostic tests and imaging.

General Surgery Rotation Competencies

- Ability to perform complete surgical H&P.
- Ability to manage patient's general medical status in perioperative period.
- Ability to order and evaluate diagnostic studies, labs, and imaging.
- Ability to formulate a comprehensive treatment plan, including appropriate consults and referrals.
- Proficiency in diagnosis and care of patients with disease and disorders affecting the abdomen, digestive tract, skin, and blood vessels, and generalized disease processes (including conservative and surgical management).
- Understanding of perioperative fluid requirements and electrolyte balance.
- Proficiency in evaluation, diagnosis, and treatment of postoperative complications, e.g., pulmonary embolism, deep vein thrombosis, congestive heart failure, atrial fibrillation, bleeding, cellulitis, wound infection, atelectasis, pneumonia.

Medical Imaging Rotation Competencies

- Familiarity with appropriate indications for various diagnostic techniques, i.e., musculoskeletal (MSK) magnetic resonance imaging (MRI), MSK computer tomography (CT), nuclear medicine bone scan (lower extremity focus), and plain film.
- Ability to recognize benign and malignant bone tumors, especially in lower extremities.
- Ability to recognize different arthritides, e.g., rheumatoid, osteoarthritis, gouty.
- Familiarity with normal osseous anatomy.
- Familiarity with signs of osteomyelitis and Charcot foot.
- Understanding of correlation between multiple modalities and recognition of their role in imaging in the podiatric setting.
- Familiarity with resources, including books, articles, and online materials.

Behavioral Science Rotation Competencies

- Familiarity with comprehensive psychiatric history/mental status exam.
- Familiarity with multi-axial classification criteria described by the Diagnostic and Statistical Manual of Disorders (DSM-IV).
- Ability to recognize various mental conditions, e.g., post-traumatic stress disorder (PTSD), schizophrenia, depression, substance abuse, other psychotic disorders.
- Knowledge of indications for dosing, side effects, and drug interactions of mood stabilizers, antipsychotics, antidepressants, anxiolytics, etc.

- Awareness of psychological impact amputations may have on Veterans.
- Knowledge of substances being abused and management of toxicity and withdrawal.

Dermatology Rotation Competencies

- Knowledge of diagnosis and treatment of general dermatologic conditions.
- Proficiency in diagnosis of skin conditions of the lower extremity and dermatologic conditions associated with diabetes, rheumatologic conditions, endocrine disorders, and infectious diseases.
- Familiarity with topical and oral medications routinely prescribed in dermatology.
- Experience (observation or participation) with skin procedures, e.g., biopsy, curettage.
- Ability to identify fungal potassium hydroxide (KOH) slides.

Orthopedic Rotation Competencies

- Familiarity with anatomy of musculoskeletal system, physiology of tissue, and bone-healing mechanism.
- Ability to take a history covering all areas pertinent to the presenting lower extremity orthopedic problem.
- Ability to conduct a physical examination leading to a correct diagnosis of the presenting lower extremity orthopedic problem.
- Ability to diagnose and treat arthropathies such as gout and arthritis.
- Ability to diagnose and treat common lower extremity athletic injuries.
- Ability to describe X-ray findings accurately and knowledge of appropriate classification systems.
- Familiarity via observation of minor orthopedic procedures, e.g., cast application, arthrocentesis, insertion of traction pins.
- Familiarity via observation of various aspects of surgical management of orthopedic patients including total joint replacement, arthroscopy, operative reduction of fractures, and reconstructive surgery in the adult patient.

Orthopedic Pediatric Rotation Competencies

- Ability to obtain a comprehensive pediatric history and physical exam.
- Understanding of the etiology, diagnosis, and treatment of neuromuscular disease (cerebral palsy, muscular dystrophy, spina bifida, Charcot-Marie-Tooth disorder, and Friedrich's ataxia); infectious bone and joint diseases in children; and congenital digital deformities (clinodactyly, polydactyly, syndactyly).
- Ability to evaluate the etiology, and diagnose and treat metatarsus adductus; juvenile hallux abductovalgus; talipes calcaneovalgus; vertical talus; talipes equinovalgus (club foot); internal and external tibial torsion; tibia varum and tibia valgum; genu varum and genu valgum; antetorsion and retrotorsion; dislocatable, dislocated, and subluxed hip, including Ortolani, Barlow, and Allis tests; and coxa vara and coxa valga.
- Ability to diagnose and treat epiphyseal and bony fractures, including knowledge of the Salter classification.

Emergency Department Rotation Competencies

- Knowledge of the principles of general emergency medicine and protocol.
- Knowledge of and experience in the assessment, resuscitation, and stabilization of an emergency or trauma patient.
- Ability to complete a H&P and present a plan of care to the emergency or trauma team.
- Ability to interpret chest/abdominal X-rays, EKGs, and pulmonary function tests (PFTs).
- Ability to interpret standard laboratory tests, e.g., blood counts, coagulation studies, blood chemistry, urinalysis, blood fluid analyses, microbiology tests.
- Awareness of the classification of fractures and dislocations of lower leg and foot.
- Knowledge of the complexities of emergent/trauma care, including family support, financial constraints, and complex discharge planning (including rehab).

Pathology Rotation Competencies

- Knowledge of proper techniques for procuring pathology specimens.
- Ability to recognize normal and abnormal gross features.
- Experience via observation of automated process of laboratory testing in hematology, immunology, toxicology, and microbiology.
- Ability to interpret results of blood chemistries, drug screens, coagulation studies, blood gases, synovial fluid analysis, urinalysis, and tissue cultures.
- Ability to critically select test proper to specific diagnostic problem based on knowledge of limitations of various studies.
- Knowledge of the principles considered in test selection for screening, diagnosis, treatment, and monitoring of disease.

Infectious Diseases Rotation Competencies

- Ability to perform thorough, problem-focused H&P exam evaluating for infectious diseases.
- Ability to order and interpret appropriate laboratory studies.
- Ability to order and interpret appropriate diagnostic modalities.
- Ability to properly collect culture specimens (soft tissue, fluid, bone).
- Ability to interpret culture and sensitivity results and place patient on appropriate antibiotic.
- Knowledge of various laboratory testing/cultures for various infectious organisms.
- Understanding of antibiotic therapy (oral and parental) in both normal and compromised patients, including drug pharmacology, potential interactions, side effects, and cost factors.

Rheumatology Rotation Competencies

- Ability to perform a complete joint examination.
- Ability to diagnose rheumatoid arthritis, systemic eythematosus, scleroderma, polymyositis, spondyloarthropathies, vasculitis, crystal-induced synovitis, osteoarthritis, regional musculoskeletal pain syndrome, and fibromyalgia.

- Proficiency in diagnostic lab work, joint fluid analysis, and imaging processes used to aid diagnosis of arthropathies.
- Proficiency in therapeutic injection of diarthrodial joints, bursae, and tenosynovial structures.
- Proficiency in use of nonsteroidal anti-inflammatory drugs (NSAIDs), analgesics, glucocorticoids, and antihyperuricemic drugs.

Anesthesiology Rotation Competencies

- Understanding of components, techniques, and normals/abnormals of H&P exam pertinent to preanesthetic assessment.
- Understanding of laboratory tests pertinent to preanesthetic assessment and their normal/abnormal values.
- Understanding of the advantages/disadvantages of general, spinal, epidural, regional, and conscious sedation anesthesia versus other potentially applicable forms of anesthesia.
- Understanding of anesthetic complications and their management.
- Understanding of pertinent regional anatomy, including the airway.
- Understanding of the technical aspects of maintaining an airway, including intubation and introduction of a laryngeal mask airway (LMA).
- Understanding of the technical aspects of obtaining intravenous (IV) access.
- Understanding of the technical aspects of administration of spinal anesthesia.
- Understanding of the technical aspects of peri-anesthesia monitoring of a patient.

Plastic Surgery Rotation Competencies

- Ability to perform complete surgical H&P exam pertinent to plastic surgery.
- Ability to perform elective skin incision planning and execution.
- Knowledge of the types of closure (primary, secondary, delayed) and when each is appropriate.
- Knowledge of more advanced plastic surgical techniques, including atraumatic tissue handling, suture techniques, and instrumentation.
- Experience via participation in comprehensive team approach to medical and surgical management of diabetic ulcer.
- Knowledge in the various techniques of soft tissue coverage, i.e., skin graft, vascular flap, and skin plasty.
- Proficiency in management of basic and complex wounds and infections.

Private Practice Rotation Competencies

- Understanding of proper documentation for each patient visit and how this affects billing.
- Understanding of the use of radiology in office setting and associated regulations and billing.
- Knowledge of medications and products used in the office setting and expiration dates.
- Understanding of proper International Statistical Classification of Diseases and Related Health Problems (ICD-10) and Current Procedural Terminology (CPT) coding to optimize billing and collections.

- Knowledge of most common CPT modifiers for billing purposes.
- Understanding of proper Medicare guidelines for diabetic foot care, shoes, and durable medical equipment (DME).

Pain Medicine Rotation Competencies

- Understanding of the multidimensional nature of pain and complexities.
- Ability to differentiate between somatic, visceral, and neuropathic pain, and the relevant treatment pathways.
- Familiarity with various pain assessment and measurement tools.
- Understanding of various approaches to pain management, including both pharmaceutical and non-pharmaceutical routes.
- Understanding of medical practitioner's role in pain management.
- Knowldge of anatomy and pathophysiology of pain mechanisms.

Vascular Surgery Rotation Competencies

- Ability to perform complete surgical H&P and place appropriate preop and postop orders.
- Familiarity with surgical management of patients with arterial, venous, and lymphatic diseases, including preoperative, operative, and postoperative care.
- Familiarity with techniques and reading of vascular radiology.
- Familiarity with primary interventional procedures (e.g., carotid, peripheral, and visceral stenting; thoracic and abdominal aortic aneurysm stent grafts) and advanced open and endovascular surgical procedures.
- Experience with limb salvage and preservation, as well as amputation stump preparation, in the context of the VA's Prevention of Amputation in Veterans Everywhere (PAVE) multidisciplinary program (including coordination with rehabilitative services and the Amputee Clinic).

Orthopedic Trauma Rotation Competencies

- Knowledge of pathoanatomy of skeletal injuries to the foot and lower leg.
- Knowledge of classification of fractures and dislocations of the foot and lower leg.
- Understanding of the priorities of initial management, triage, and initial stabilization of skeletal injuries in a multi-inured patient.
- Knowledge of the indications or various methods of operative and not-operative treatment of trauma to the foot and lower leg.
- Knowledge of how to treat compartment syndromes of the foot and lower leg.
- Understanding of the postoperative care of trauma patients, including management of injury-specific rehabilitation and deep vein thrombosis (DVT) screening and prophylaxis.

Assessment Documents

The following documents are used to document each resident's performance and competencies during the rotations described in the preceding sections. A copy of the appropriate rotation assessment will be provided to the appropriate Attending supervising the resident's rotation for completion and return to the Residency Director.

Charlie Norwood VAMC
Podiatric Resident Rotation Assessment – Podiatric Surgery

Resident: _____ PGY: _____
Rotation month/year _____
Rotation: PODIATRY SURGERY

Rating Scale:
N/A – Not Applicable
1-3: Unsatisfactory – requires remediation to achieve expected competency
4-6: Satisfactory – meets expected competency for PGY level
7-8: Superior – what one would expect from a resident ready to graduate
9: Practitioner – what one would expect from an experienced licensed practitioner in Podiatry

Use Rating Scale Above to Grade Attainment of Competencies

Competencies Specific for Rotation:	Grade:
Demonstrates the ability to properly do a surgical work-up/history and physical examination and knows the warning signs for "high risk" patient	_____
Proper presentation of pre-operative patients with indications for surgery, risks, benefits, complications, post-operative plan	_____
Demonstrates proper sterile technique and ability to assist and maintain the mayo stand and the instrumentation	_____
Familiar with the surgical instrumentation used in podiatric surgery	_____
Familiar with the surgical procedures / techniques common to podiatric surgery	_____
Demonstrates proper surgical skills to open and close a surgical site and to maintain sterility	_____
Ability to manipulate instrumentation and power equipment	_____
Ability to reduce deformities and manipulate osteotomies	_____
Ability to place hardware, internal and/or external fixation	_____
Suturing skills – deep fascia / tendon	_____
Suturing skills – subcutaneous tissues	_____
Suturing skills – skin	_____
Ability to apply proper layered dressing	_____
Demonstrates proper post-operative care for the surgery patient	_____

Demonstrates timely and detailed operative note dictations _____

Accepts responsibility and demonstrates reliability and desire to learn _____

Is well organized, punctual, and efficient _____

Overall Evaluation/Expectations (please check one):
Exceeds: Has the skills to practice independently _____
Meets: Demonstrated required competencies _____
Fails: Fails to meet expectations or demonstrate required competencies _____

What skills require more practice / improvement?

What skills require formal remediation? If, none, please check here ☐

Attending / Faculty Comments:

Resident's Comments:

(Comments may be continued on back of form if necessary.)

	Printed Name:	Signature:	Date:
Attending:	_____	_____	
Resident:	_____	_____	
Program Director:	George Sich III, DPM	_____	

Charlie Norwood VAMC
Podiatric Resident Rotation Assessment – Podiatric Medicine/Clinic

Resident: _____ PGY: _____
Rotation month/year _____
Rotation: PODIATRY MEDICINE/CLINIC

Rating Scale:
N/A – Not Applicable
1-3: Unsatisfactory – requires remediation to achieve expected competency
4-6: Satisfactory – meets expected competency for PGY level
7-8: Superior – what one would expect from a resident ready to graduate
9: Practitioner – what one would expect from an experienced licensed practitioner in Podiatry

Use Rating Scale Above to Grade Attainment of Competencies

Competencies Specific for Rotation:	Grade:
Demonstrates proficiency in palliative foot care and basic podiatric office procedures including digital, nail, and soft tissue procedures	_____
Demonstrates proficiency in giving local anesthetic blocks and/or therapeutic injections	_____
Demonstrates ability to evaluate, diagnose, and treat various ulcers of foot and/or leg	_____
Recognizes foot conditions associated with systemic or chronic diseases	_____
Able to perform biomechanical examination and identify the proper interventional devices needed to treat	_____
Able to communicate effectively with patient, family, and health care professionals in planning proper total patient care	_____
Able to effectively order laboratory workup and proper interpretation	_____
Proper ordering of imaging studies with interpretation and evaluation	_____
Appropriate consultation to other health care professionals when needed	_____
Proficient in charting and dictation	_____
Accepts responsibility and demonstrates reliability and desire to learn	_____
Is well organized, punctual, and efficient	_____

Overall Evaluation/Expectations (please check one):

Exceeds: Has the skills to practice independently _____

Meets: Demonstrated required competencies _____

Fails: Fails to meet expectations or demonstrate required competencies _____

What skills require more practice / improvement?

What skills require formal remediation? If, none, please check here ☐

Attending / Faculty Comments:

Resident's Comments:

(Comments may be continued on back of form if necessary.)

	Printed Name:	Signature:	Date:
Attending:	_____	_____	
Resident:	_____	_____	
Program Director:	George Sich III, DPM	_____	

Charlie Norwood VAMC
Podiatric Resident Rotation Assessment – Internal Medicine

Resident: _____ PGY: _____
Rotation month/year _____
Rotation: INTERNAL MEDICINE

Rating Scale:
N/A – Not Applicable
1-3: Unsatisfactory – requires remediation to achieve expected competency
4-6: Satisfactory – meets expected competency for PGY level
7-8: Superior – what one would expect from a resident ready to graduate
9: Practitioner – what one would expect from an experienced licensed practitioner in Internal Medicine

Use Rating Scale Above to Grade Attainment of Competencies

Competencies Specific for Rotation:	Grade:
Obtain a comprehensive History showing attentiveness / good interviewing skills	_____
Perform comprehensive physical examination	_____
Obtaining and interpreting pertinent laboratory data	_____
Diagnosing and managing diabetic disease, including diet and pharmacology	_____
Familiarity with coagulation disorders and proper anticoagulation protocol	_____
Able to interpret EKG findings and familiar with normal vs abnormal heart rhythms	_____
Understand fluid and electrolyte imbalance	_____
Appropriate antibiotic coverage for various infections, i.e. cellulitis, pneumonia, UTI	_____
Orders appropriate consultation to specialties and ancillary services	_____
Effective communication with colleagues, other health care providers, and the patient	_____
Facilitates team approach to develop and implement a preventative treatment plan	_____
Derives treatment plan based on thorough history, physical exam, and appropriate diagnostic tests and imaging	_____

Accepts responsibility and demonstrates reliability and desire to learn _____

Is well organized, punctual, and efficient _____

Overall Evaluation/Expectations (please check one):
Exceeds: Has the skills to practice independently _____
Meets: Demonstrated required competencies _____
Fails: Fails to meet expectations or demonstrate required competencies _____

What skills require more practice / improvement?

What skills require formal remediation? If, none, please check here ☐

Attending / Faculty Comments:

Resident's Comments:

(Comments may be continued on back of form if necessary.)

	Printed Name:	Signature:	Date:
Attending:	_____	_____	
Resident:	_____	_____	
Program Director:	George Sich III, DPM	_____	

Charlie Norwood VAMC
Podiatric Resident Rotation Assessment – General Surgery

Resident: _____ PGY: _____
Rotation month/year _____
Rotation: GENERAL SURGERY

Rating Scale:
N/A – Not Applicable
1-3: Unsatisfactory – requires remediation to achieve expected competency
4-6: Satisfactory – meets expected competency for PGY level
7-8: Superior – what one would expect from a resident ready to graduate
9: Practitioner – what one would expect from an experienced licensed practitioner General Surgery

Use Rating Scale Above to Grade Attainment of Competencies

Competencies Specific for Rotation:	Grade:
Able to perform complete surgical history and physical	_____
Demonstrate ability to manage patient's medical status in the peri-operative period	_____
Demonstrate ability to order and evaluate diagnostic studies, labs, and imaging	_____
Able to work with colleagues to formulate a comprehensive treatment plan including appropriate consults and referrals	_____
Demonstrate fundamental knowledge and understanding of the following general areas and generalized disease processes such as: Hernias (inguinal, umbilical, epigastric, ventral), gallbladder disease, thyroid and parathyroids. GI bleeding, GERD, peptic ulcers, inflammatory bowel disease, pancreatitis, anal fissures, perirectal abscess and fissure-in-ano and the "acute abdomen"	_____
Diagnosis and care of patients with diseases and disorders affecting the abdomen, digestive tract, endocrine system, breast, skin, and blood vessels	_____
Understand peri-operative fluid requirements and electrolyte balance	_____
Accepts responsibility and demonstrates reliability and desire to learn	_____
Is well organized, punctual, and efficient	_____

Overall Evaluation/Expectations (please check one):
Exceeds: Has the skills to practice independently _____
Meets: Demonstrated required competencies _____
Fails: Fails to meet expectations or demonstrate required competencies _____

What skills require more practice / improvement?

What skills require formal remediation? If, none, please check here ☐

Attending / Faculty Comments:

Resident's Comments:

(Comments may be continued on back of form if necessary.)

	Printed Name:	Signature:	Date:
Attending:	_____	_____	
Resident:	_____	_____	
Program Director:	George Sich III, DPM	_____	

Charlie Norwood VAMC
Podiatric Resident Rotation Assessment – Medical Imaging

Resident: _____ PGY: _____
Rotation month/year _____
Rotation: MEDICAL IMAGING

Rating Scale:
N/A – Not Applicable
1-3: Unsatisfactory – requires remediation to achieve expected competency
4-6: Satisfactory – meets expected competency for PGY level
7-8: Superior – what one would expect from a resident ready to graduate
9: Practitioner – what one would expect from an experienced licensed practitioner in Radiology

Use Rating Scale Above to Grade Attainment of Competencies

Competencies Specific for Rotation:	Grade:
Familiarity with basic foot angles and the normal/abnormal values for proper preop surgical evaluation	_____
Familiarity with appropriate indications for particular diagnostic imaging: MSK MRI, MSK CT, nuclear medicine bone scans (lower extremity) and plain films	_____
Recognize fracture patterns in the foot and appropriate fracture classification systems	_____
Recognize fracture patterns in the ankle and know the Weber / Lauge-Hanson fracture classification systems	_____
Learn normal MRI anatomy of the foot and ankle, especially lateral ankle ligament structure, deltoid ligament, tendons, and MPJ regions	_____
Recognize infectious processes and abscess patterns on CT and MRI	_____
Recognize benign and malignant bone tumors	_____
Recognize different arthritides: i.e., RA, osteoarthritis, gout	_____
Recognize normal vs abnormal anatomy for x-rays, MRI, CT of lower extremities	_____
Recognize differences in signs and appropriate imaging for acute osteomyelitis vs. chronic osteomyelitis vs. Charcot foot	_____

Understand 3 phase bone scan imaging, tagged WBC studies (with sulfur colloid and SPECT/CT imaging) of the foot and ankle _____

Understand and recognize correlation between multiple modalities and their role in imaging in the podiatric setting _____

Accepts responsibility and demonstrates reliability and desire to learn _____

Is well organized, punctual, and efficient _____

Overall Evaluation/Expectations (please check one):
Exceeds: Has the skills to practice independently _____
Meets: Demonstrated required competencies _____
Fails: Fails to meet expectations or demonstrate required competencies _____

What skills require more practice / improvement?

What skills require formal remediation? If, none, please check here ☐

Attending / Faculty Comments:

Resident's Comments:

(Comments may be continued on back of form if necessary.)

	Printed Name:	Signature:	Date:
Attending:	_____	_____	
Resident:	_____	_____	
Program Director:	George Sich III, DPM	_____	

Charlie Norwood VAMC
Podiatric Resident Rotation Assessment – Behavioral Science

Resident: _____ PGY: _____
Rotation month/year _____
Rotation: BEHAVIORAL SCIENCE

Rating Scale:
N/A – Not Applicable
1-3: Unsatisfactory – requires remediation to achieve expected competency
4-6: Satisfactory – meets expected competency for PGY level
7-8: Superior – what one would expect from a resident ready to graduate
9: Practitioner – what one would expect from an experienced licensed practitioner in Behavior Science / Psychiatry

Use Rating Scale Above to Grade Attainment of Competencies

Competencies Specific for Rotation:	Grade:
Observe and familiarize with comprehensive psychiatric history/ mental status exam	_____
Recognize the mental impact lower extremity amputations have on the veteran	_____
Recognize various mental conditions: i.e. PTSD, schizophrenia, depression, substance abuse, and other psychotic disorders	_____
Knowledge of indications for dosing, side effects, and drug interactions of: mood stabilizers, antipsychotics, antidepressants, anxiolytics, etc.	_____
Understand the complexities of managing catastrophic conditions – limb loss, spinal cord injury	_____
Knowledge of substances of abuse and management of toxicity and withdrawal	_____
Accepts responsibility and demonstrates reliability and desire to learn	_____
Is well organized, punctual, and efficient	_____

Overall Evaluation/Expectations (please check one):
Exceeds: Has the skills to practice independently _____
Meets: Demonstrated required competencies _____
Fails: Fails to meet expectations or demonstrate required competencies _____

What skills require more practice / improvement?

What skills require formal remediation? If, none, please check here ☐

Attending / Faculty Comments:

Resident's Comments:

(Comments may be continued on back of form if necessary.)

	Printed Name:	Signature:	Date:
Attending:	_____	_____	
Resident:	_____	_____	
Program Director:	George Sich III, DPM	_____	

Charlie Norwood VAMC
Podiatric Resident Rotation Assessment – Dermatology

Resident: _____ PGY: _____
Rotation month/year _____
Rotation: DERMATOLOGY

Rating Scale:
N/A – Not Applicable
1-3: Unsatisfactory – requires remediation to achieve expected competency
4-6: Satisfactory – meets expected competency for PGY level
7-8: Superior – what one would expect from a resident ready to graduate
9: Practitioner – what one would expect from an experienced licensed practitioner in Dermatology

Use Rating Scale Above to Grade Attainment of Competencies

Competencies Specific for Rotation:	Grade:
Diagnosis and treatment of general dermatologic conditions	_____
Diagnosis of skin conditions related to the lower extremities and following medical conditions: i.e. diabetes, rheumatoid, endocrine disorders, infection	_____
Knowledge of topical and oral medication commonly prescribed in dermatology	_____
Knowledge of oral antifungal medications and risks and complications of their use, including drug-drug interactions	_____
Participating and/or observing skin procedures such as: skin biopsies (punch vs shave), curettage, cryofreeze	_____
Understanding of skin care / wound care after biopsy	_____
Knowledge of skin cancers, their recognition, and protocol of their treatment	_____
Identify and procuring fungal KOH samples	_____
Understand the difference between PAS and GMS stains	_____
Knowledge of different types of moisturizers and when to use what product	_____
Knowledge on the use of a dermatoscope.	_____

Accepts responsibility and demonstrates reliability and desire to learn _____

Is well organized, punctual, and efficient _____

Overall Evaluation/Expectations (please check one):
Exceeds: Has the skills to practice independently _____
Meets: Demonstrated required competencies _____
Fails: Fails to meet expectations or demonstrate required competencies _____

What skills require more practice / improvement?

What skills require formal remediation? If, none, please check here ☐

Attending / Faculty Comments:

Resident's Comments:

(Comments may be continued on back of form if necessary.)

Printed Name: Signature: Date:
Attending: _____ _____

Resident: _____ _____

Program Director: George Sich III, DPM _____

Charlie Norwood VAMC
Podiatric Resident Rotation Assessment – Emergency Medicine

Resident: _____ PGY: _____
Rotation month/year _____
Rotation: EMERGENCY MEDICINE

Rating Scale:
N/A – Not Applicable
1-3: Unsatisfactory – requires remediation to achieve expected competency
4-6: Satisfactory – meets expected competency for PGY level
7-8: Superior – what one would expect from a resident ready to graduate
9: Practitioner – what one would expect from an experienced licensed practitioner in Emergency Medicine

Use Rating Scale Above to Grade Attainment of Competencies

Competencies Specific for Rotation:	Grade:
Ability to "triage" patients to appropriate level of care, understanding of initial assessment processes and emergency protocols	_____
Recognition and initial management of common systemic emergencies which may be encountered incidentally in field / office / OR / inpatient settings (including polytrauma, sepsis, cardiac arrest, stroke, hypoglycemia, hyperglycemic emergencies, electrolyte abnormalities, chest pain, abdominal pain)	_____
Management of common emergency presentations pertinent to podiatry (including fractures, lacerations, burns, and other wounds)	_____
Routine management of common systemic comorbidities such as hypertension, diabetes, fluid and electrolyte repletion, choice of antibiotics	_____
Thorough and accurate histories and other subjective patient evaluations, including ability to elicit subtle information sometimes not readily offered by patient.	_____
Thorough and accurate exams and other objective patient evaluations, including ability to notice subtle exam findings sometimes not readily apparent	_____
Ability to develop a differential diagnosis on an undifferentiated patient based on initial presentation	_____
Ability to choose appropriate stat emergent studies (laboratory and radiology) versus indicated but routine nonemergent outpatient studies	_____

Understanding and application of pertinent laboratory and radiologic findings _____

Understanding of social factors which complicate care such as financial resources, family support, homelessness, low health literacy _____

Work ethic, efficiency, reliability, personal responsibility, able to see multiple patients simultaneously, reevaluate and follow results, and otherwise and participate in emergency department workflow _____

Responsiveness to feedback and commitment to self-improvement _____

Attitude, interpersonal skills, and bedside manner _____

Accepts responsibility and demonstrates reliability and desire to learn _____

Is well organized, punctual, and efficient _____

Overall Evaluation/Expectations (please check one):
Exceeds: Has the skills to practice independently _____
Meets: Demonstrated required competencies _____
Fails: Fails to meet expectations or demonstrate required competencies _____

What skills require more practice / improvement?

What skills require formal remediation? If, none, please check here □

Attending / Faculty Comments:

Resident's Comments:

(Comments may be continued on back of form if necessary.)

Printed Name: Signature: Date:
Attending: _____ _____

Resident: _____ _____

Program Director: George Sich III, DPM _____

Charlie Norwood VAMC
Podiatric Resident Rotation Assessment - Pathology

Resident: _____ PGY: _____
Rotation month/year _____
Rotation: PATHOLOGY

Rating Scale:
N/A – Not Applicable
1-3: Unsatisfactory – requires remediation to achieve expected competency
4-6: Satisfactory – meets expected competency for PGY level
7-8: Superior – what one would expect from a resident ready to graduate
9: Practitioner – what one would expect from an experienced licensed practitioner in Pathology

Use Rating Scale Above to Grade Attainment of Competencies

Competencies Specific for Rotation:	Grade:
Understands proper techniques in procuring pathology specimens	_____
Able to recognize normal and abnormal gross features	_____
Observed automated process of laboratory testing in the following areas: Hematology, Immunology, Toxicology and Microbiology	_____
Can interpret the results of: blood chemistries, drug screens, coagulation studies, blood gases, synovial fluid analysis, urinalysis and tissue cultures	_____
Understands the limitations of such studies to be able to critically select proper tests suited to a particular diagnostic problem	_____
Understands the principles considered in test selection for screening, diagnosis, treatment and monitoring of disease	_____
Accepts responsibility and demonstrates reliability and desire to learn	_____
Is well organized, punctual, and efficient	_____

Overall Evaluation/Expectations (please check one):
Exceeds: Has the skills to practice independently _____
Meets: Demonstrated required competencies _____
Fails: Fails to meet expectations or demonstrate required competencies _____

What skills require more practice / improvement?

What skills require formal remediation? If, none, please check here □

Attending / Faculty Comments:

Resident's Comments:

(Comments may be continued on back of form if necessary.)

Printed Name: Signature: Date:
Attending: _____ _____

Resident: _____ _____

Program Director: George Sich III, DPM _____

Charlie Norwood VAMC
Podiatric Resident Rotation Assessment – Infectious Diseases

Resident: _____ PGY: _____
Rotation month/year _____
Rotation: INFECTIOUS DISEASE

Rating Scale:
N/A – Not Applicable
1-3: Unsatisfactory – requires remediation to achieve expected competency
4-6: Satisfactory – meets expected competency for PGY level
7-8: Superior – what one would expect from a resident ready to graduate
9: Practitioner – what one would expect from an experienced licensed practitioner in Infectious Disease

Use Rating Scale Above to Grade Attainment of Competencies

Competencies Specific for Rotation:	Grade:
Perform thorough problem-focused history and physical exam being evaluated for infectious disease	_____
Able to order and interpret appropriate laboratory studies	_____
Able to order and interpret appropriate diagnostic modalities	_____
Can properly collect culture specimens (soft tissue, fluid, bone)	_____
Can interpret culture and sensitivity results and place patient on appropriate antibiotic(s)	_____
Knowledgeable of the various laboratory testing/cultures for various infectious organisms	_____
Understand antibiotic therapy, oral and parental, in both the normal and compromised patients, including drug pharmacology, potential interactions, side effects, and cost factors	_____
Accepts responsibility and demonstrates reliability and desire to learn	_____
Is well organized, punctual, and efficient	_____

Overall Evaluation/Expectations (please check one):
Exceeds: Has the skills to practice independently _____
Meets: Demonstrated required competencies _____
Fails: Fails to meet expectations or demonstrate required competencies _____

What skills require more practice / improvement?

What skills require formal remediation? If, none, please check here □

Attending / Faculty Comments:

Resident's Comments:

(Comments may be continued on back of form if necessary.)

Printed Name: Signature: Date:
Attending: _____ _____

Resident: _____ _____

Program Director: George Sich III, DPM _____

Charlie Norwood VAMC
Podiatric Resident Rotation Assessment - Rheumatology

Resident: _____ PGY: _____
Rotation month/year _____
Rotation: RHEUMATOLOGY

Rating Scale:
N/A – Not Applicable
1-3: Unsatisfactory – requires remediation to achieve expected competency
4-6: Satisfactory – meets expected competency for PGY level
7-8: Superior – what one would expect from a resident ready to graduate
9: Practitioner – what one would expect from an experienced licensed practitioner in Rheumatology

Use Rating Scale Above to Grade Attainment of Competencies

Competencies Specific for Rotation:	Grade:
Demonstrate ability to perform complete joint examination	_____
Demonstrate the knowledge to diagnose the following: rheumatoid arthritis, SLE, scleroderma, polymyositis, spondyloarthropathies, vasculitis, crystal -induced synovitis, osteoarthritis, regional musculoskeletal pain syndrome, fibromyalgia	_____
Develop competence in diagnostic lab work, joint fluid analysis, and imaging which aid in diagnosing arthropathies	_____
Develop competence in the therapeutic injection of diarthrodial joints, bursae, and tenosynovial structures	_____
Develop competence in rheumatoid pharmacology: NSAIDs, analgesics, Glucocorticoids, anti-hyperuricemic drugs, steroids, etc.	_____
Accepts responsibility and demonstrates reliability and desire to learn	_____
Is well organized, punctual, and efficient	_____

Overall Evaluation/Expectations (please check one):
Exceeds: Has the skills to practice independently _____
Meets: Demonstrated required competencies _____
Fails: Fails to meet expectations or demonstrate required competencies _____

What skills require more practice / improvement?

What skills require formal remediation? If, none, please check here □

Attending / Faculty Comments:

Resident's Comments:

(Comments may be continued on back of form if necessary.)

Printed Name: Signature: Date:
Attending: _____ _____

Resident: _____ _____

Program Director: George Sich III, DPM _____

Charlie Norwood VAMC
Podiatric Resident Rotation Assessment – Anesthesiology

Resident: _____ PGY: _____
Rotation month/year _____
Rotation: ANESTHESIOLOGY

Rating Scale:
N/A – Not Applicable
1-3: Unsatisfactory – requires remediation to achieve expected competency
4-6: Satisfactory – meets expected competency for PGY level
7-8: Superior – what one would expect from a resident ready to graduate
9: Practitioner – what one would expect from an experienced licensed practitioner in Anesthesiology

Use Rating Scale Above to Grade Attainment of Competencies

Competencies Specific for Rotation:	Grade:
Understands the components, techniques, and normals/abnormals of the history and physical examination pertinent to the preanesthestic assessment	_____
Understands the laboratory tests pertinent to the preanesthetic assessment and their normals/abnormals	_____
Understands ASA Physical Status classification system and the impact of medical comorbidities on preanesthetic assessment and management	_____
Understands the advantages/disadvantages of general, spinal, epidural, regional, and conscious sedation anesthesia versus other potentially applicable forms of anesthesia	_____
Understands anesthetic complications and their management	_____
Understands pertinent regional anatomy, including the airway	_____
Understands the technical aspects of maintaining an airway	_____
Understands the technical aspects of intubation	_____
Understands the technical aspects of introducing an LMA	_____
Understands the technical aspects of obtaining IV access	_____
Understands the technical aspects of administration of spinal anesthesia	_____

Understands the technical aspects of perianesthesia monitoring of a patient _____

Accepts responsibility and demonstrates reliability and desire to learn _____

Is well organized, punctual, and efficient _____

Overall Evaluation/Expectations (please check one):
Exceeds: Has the skills to practice independently _____
Meets: Demonstrated required competencies _____
Fails: Fails to meet expectations or demonstrate required competencies _____

What skills require more practice / improvement?

What skills require formal remediation? If, none, please check here □

Attending / Faculty Comments:

Resident's Comments:

(Comments may be continued on back of form if necessary.)

Printed Name: Signature: Date:
Attending: _____ _____

Resident: _____ _____

Program Director: George Sich III, DPM _____

Charlie Norwood VAMC
Podiatric Resident Rotation Assessment – Plastic Surgery

Resident: _____ PGY: _____
Rotation month/year _____
Rotation: PLASTIC SURGERY

Rating Scale:
N/A – Not Applicable
1-3: Unsatisfactory – requires remediation to achieve expected competency
4-6: Satisfactory – meets expected competency for PGY level
7-8: Superior – what one would expect from a resident ready to graduate
9: Practitioner – what one would expect from an experienced licensed practitioner in Plastic Surgery

Use Rating Scale Above to Grade Attainment of Competencies

Competencies Specific for Rotation:	Grade:
Able to perform complete surgical history and physical exam	_____
Able to perform elective skin incision planning and execution	_____
Knowledgeable of the types of closure and when it is appropriate. (primary, secondary, delayed)	_____
Knowledgeable of the various needle styles and when they are best used	_____
Knowledgeable of the various sutures and when they are best used	_____
Knowledgeable of the various suturing techniques to minimize scarring	_____
Knowledgeable in more advanced surgical plastic techniques, including Atraumatic tissue handling, suturing techniques, and instrumentation	_____
Participate in the comprehensive team approach to the medical and surgical management of diabetic foot ulcers	_____
Knowledgeable in the various techniques of soft tissue coverage, i.e., skin grafts, vascular flaps, skin plasty	_____
Management of basic and complex wounds and infections	_____
Accepts responsibility and demonstrates reliability and desire to learn	_____
Is well organized, punctual, and efficient	_____

Overall Evaluation/Expectations (please check one):
Exceeds: Has the skills to practice independently _____
Meets: Demonstrated required competencies _____
Fails: Fails to meet expectations or demonstrate required competencies _____

What skills require more practice / improvement?

What skills require formal remediation? If, none, please check here □

Attending / Faculty Comments:

Resident's Comments:

(Comments may be continued on back of form if necessary.)

Printed Name: Signature: Date:
Attending: _____ _____

Resident: _____ _____

Program Director: George Sich III, DPM _____

Charlie Norwood VAMC
Podiatric Resident Rotation Assessment – Private Practice Podiatry

Resident: _____ PGY: _____
Rotation month/year _____
Rotation: PRIVATE PRACTICE PODIATRY

Rating Scale:
N/A – Not Applicable
1-3: Unsatisfactory – requires remediation to achieve expected competency
4-6: Satisfactory – meets expected competency for PGY level
7-8: Superior – what one would expect from a resident ready to graduate
9: Practitioner – what one would expect from an experienced licensed practitioner in Podiatry

Use Rating Scale Above to Grade Attainment of Competencies

Competencies Specific for Rotation:	Grade:
Understand proper documentation for each patient visit and how this affects billing	_____
Understand use of radiology in office setting and the regulations and billing associated	_____
Know medications/products used in the office setting and expiration dates	_____
Understand proper ICD-10 and CPT coding to optimize your billing and collections	_____
Understand insurance guidelines for routine foot care, diabetic shoes & DME	_____
Understand time & schedule management for efficient patient flow	_____
Understand how to effectively use staff (CMAs, LPNs, RNs) to manage patients	_____
Accepts responsibility and demonstrates reliability and desire to learn	_____
Is well organized, punctual, and efficient	_____

Overall Evaluation/Expectations (please check one):
Exceeds: Has the skills to practice independently _____
Meets: Demonstrated required competencies _____
Fails: Fails to meet expectations or demonstrate required competencies _____

What skills require more practice / improvement?

What skills require formal remediation? If, none, please check here □

Attending / Faculty Comments:

Resident's Comments:

(Comments may be continued on back of form if necessary.)

Printed Name: Signature: Date:
Attending: _____ _____

Resident: _____ _____

Program Director: George Sich III, DPM _____

Charlie Norwood VAMC
Podiatric Resident Rotation Assessment – Orthopedics (VA)

Resident: _____ PGY: _____
Rotation month/year _____
Rotation: ORTHOPEDICS (VA)

Rating Scale:
N/A – Not Applicable
1-3: Unsatisfactory – requires remediation to achieve expected competency
4-6: Satisfactory – meets expected competency for PGY level
7-8: Superior – what one would expect from a resident ready to graduate
9: Practitioner – what one would expect from an experienced licensed practitioner in Orthopedics

Use Rating Scale Above to Grade Attainment of Competencies

Competencies Specific for Rotation:	Grade:
Identify the anatomy of the musculoskeletal system and explain the physiology of tissue and bone healing mechanisms	_____
Take a history which covers all areas pertinent to the presenting lower extremity orthopedic problem	_____
Conduct a physical examination which leads to a correct diagnosis of the lower extremity orthopedic problem	_____
Diagnose and treat arthropathies, such as gout and arthritis	_____
Diagnose common lower extremity athletic injuries	_____
Able to describe x-ray findings accurately and know appropriate classification systems (lower extremity biased)	_____
Observe minor procedures (e.g., cast application, arthrocentesis, insertion of traction pins)	_____
Observe various aspects of surgical management of orthopedic patients including total joint replacement, arthroscopy, operative reduction of fractures and reconstructive surgery in the adult patient	_____
Learn upper extremity and shoulder examination especially related to the use of crutches and gait assistive devices.	_____
Accepts responsibility and demonstrates reliability and desire to learn	_____
Is well organized, punctual, and efficient	_____

Overall Evaluation/Expectations (please check one):
Exceeds: Has the skills to practice independently _____
Meets: Demonstrated required competencies _____
Fails: Fails to meet expectations or demonstrate required competencies _____

What skills require more practice / improvement?

What skills require formal remediation? If, none, please check here □

Attending / Faculty Comments:

Resident's Comments:

(Comments may be continued on back of form if necessary.)

Printed Name: Signature: Date:
Attending: _____ _____

Resident: _____ _____

Program Director: George Sich III, DPM _____

Charlie Norwood VAMC
Podiatric Resident Rotation Assessment – Orthopaedics (AU Pediatrics)

Resident: _____ PGY: _____
Rotation month/year _____
Rotation: ORTHOPEDICS (AU - PEDIATARICS)

Rating Scale:
N/A – Not Applicable
1-3: Unsatisfactory – requires remediation to achieve expected competency
4-6: Satisfactory – meets expected competency for PGY level
7-8: Superior – what one would expect from a resident ready to graduate
9: Practitioner – what one would expect from an experienced licensed practitioner in Pediatric Orthopedics

Use Rating Scale Above to Grade Attainment of Competencies

Competencies Specific for Rotation:	Grade:
Be able to obtain a comprehensive pediatric history	_____
Be able to perform a complete pediatric physical exam	_____
Understand the etiology, diagnosis, and treatment of following diseases: -neuromuscular (CP, MD, spina bifida, CMT, Friedrich's ataxia) -infectious bone and joint diseases in children -congenital digital deformities (clinodactyly, polydactyly, syndactyly	_____
Evaluate the etiology, diagnose, and treat following disorders more specific to Lower extremities (metatarsus adductus, juvenile HAV, talipes calcaneovalgus, vertical talus, clubfoot, internal and external tibial torsion, tibial varum and valgum, genu varum and valgum, antetorsion, retrotorsion, coxa vara, coxa valgum, dislocated hip	_____
Diagnose and treat epiphyseal and bony fractures (Salter classification)	_____
Accepts responsibility and demonstrates reliability and desire to learn	_____
Is well organized, punctual, and efficient	_____

Overall Evaluation/Expectations (please check one):
Exceeds: Has the skills to practice independently _____
Meets: Demonstrated required competencies _____
Fails: Fails to meet expectations or demonstrate required competencies _____

What skills require more practice / improvement?

What skills require formal remediation? If, none, please check here □

Attending / Faculty Comments:

Resident's Comments:

(Comments may be continued on back of form if necessary.)

Printed Name: Signature: Date:
Attending: _____ _____

Resident: _____ _____

Program Director: George Sich III, DPM _____

Charlie Norwood VAMC
Podiatric Resident Rotation Assessment – Orthopaedics (AU Trauma)

Resident: _____ PGY: _____
Rotation month/year _____
Rotation: ORTHOPEDICS (AU - TRAUMA)

Rating Scale:
N/A – Not Applicable
1-3: Unsatisfactory – requires remediation to achieve expected competency
4-6: Satisfactory – meets expected competency for PGY level
7-8: Superior – what one would expect from a resident ready to graduate
9: Practitioner – what one would expect from an experienced licensed practitioner in Orthopedic Trauma

Use Rating Scale Above to Grade Attainment of Competencies

Competencies Specific for Rotation:	Grade:
Know patho-anatomy of skeletal injuries to the foot and lower leg	_____
Know classifications of fractures and dislocations of the lower leg and foot	_____
Understand the priorities for initial management, triage, and initial stabilization of skeletal injuries in the multi-injured patient	_____
Know the indications for various methods of operative and non-operative treatment of trauma to the lower leg and foot	_____
Recognize how to treat compartment syndromes of the foot and lower leg	_____
Understand the post operative care of trauma patients including the management of injury specific rehabilitation and DVT screening/prophylaxis	_____
Accepts responsibility and demonstrates reliability and desire to learn	_____
Is well organized, punctual, and efficient	_____

Overall Evaluation/Expectations (please check one):
Exceeds: Has the skills to practice independently _____
Meets: Demonstrated required competencies _____
Fails: Fails to meet expectations or demonstrate required competencies _____

What skills require more practice / improvement?

What skills require formal remediation? If, none, please check here □

Attending / Faculty Comments:

Resident's Comments:

(Comments may be continued on back of form if necessary.)

Printed Name: Signature: Date:
Attending: _____ _____

Resident: _____ _____

Program Director: George Sich III, DPM _____

Charlie Norwood VAMC
Podiatric Resident Rotation Assessment – Vascular Surgery

Resident: _____ PGY: _____
Rotation month/year _____
Rotation: VASCULAR

Rating Scale:
N/A – Not Applicable
1-3: Unsatisfactory – requires remediation to achieve expected competency
4-6: Satisfactory – meets expected competency for PGY level
7-8: Superior – what one would expect from a resident ready to graduate
9: Practitioner – what one would expect from an experienced licensed practitioner in Vascular Surgery

Use Rating Scale Above to Grade Attainment of Competencies

Competencies Specific for Rotation:	Grade:
Able to perform complete surgical history & physical and preop and postop orders	_____
Surgical management of patients including preoperative, operative, and postoperative care of patients with arterial, venous, and lymphatic disease	_____
Acquainted with the techniques and reading of vascular radiology	_____
Familiarize with vascular procedures including carotid, peripheral, and visceral stenting, thoracic and AAA stent grafts, and advanced open and endovascular surgical procedures	_____
Understand the multi-disciplinary approach with various departments when it comes to limb salvage and being a team member in VA PAVE	_____
Accepts responsibility and demonstrates reliability and desire to learn	_____
Is well organized, punctual, and efficient	_____

Overall Evaluation/Expectations (please check one):
Exceeds: Has the skills to practice independently _____
Meets: Demonstrated required competencies _____
Fails: Fails to meet expectations or demonstrate required competencies _____

What skills require more practice / improvement?

What skills require formal remediation? If, none, please check here □

Attending / Faculty Comments:

Resident's Comments:

(Comments may be continued on back of form if necessary.)

Printed Name: Signature: Date:
Attending: _____ _____

Resident: _____ _____

Program Director: George Sich III, DPM _____

Charlie Norwood VAMC
Podiatric Resident Rotation Assessment – Pain Medicine

Resident: _____ PGY: _____
Rotation month/year _____
Rotation: PAIN MEDICINE

Rating Scale:
N/A – Not Applicable
1-3: Unsatisfactory – requires remediation to achieve expected competency
4-6: Satisfactory – meets expected competency for PGY level
7-8: Superior – what one would expect from a resident ready to graduate
9: Practitioner – what one would expect from an experienced licensed practitioner in Pain Management

Use Rating Scale Above to Grade Attainment of Competencies

Competencies Specific for Rotation:	Grade:
Understand the multidimensional nature of pain and complexities. Differentiate between somatic, visceral, and neuropathic pain and treatment pathways	_____
Familiarize with various pain assessment and measurement tools	_____
Understand various approaches to pain management: pharmaceutical and non-pharmaceutical	_____
Understand podiatry's role in the context of pain management	_____
Demonstrate basic knowledge and understanding of anatomy and pathophysiology of pain mechanisms	_____
Accepts responsibility and demonstrates reliability and desire to learn	_____
Is well organized, punctual, and efficient	_____

Overall Evaluation/Expectations (please check one):
Exceeds: Has the skills to practice independently _____
Meets: Demonstrated required competencies _____
Fails: Fails to meet expectations or demonstrate required competencies _____

What skills require more practice / improvement?

What skills require formal remediation? If, none, please check here □

Attending / Faculty Comments:

Resident's Comments:

(Comments may be continued on back of form if necessary.)

Printed Name: Signature: Date:
Attending: _____ _____

Resident: _____ _____

Program Director: George Sich III, DPM _____

Remediation of Unsatisfactory Performance

Remediation Policy

(A) It is essential to fulfilment of the Residency Program mission that each resident performs at an adequate level of competence.

(B) Upon learning or observing a performance problem with a resident, the Program Director will present the resident's performance issue to the Podiatry Clinic staff and the chief resident for additional input, and may appoint a mentor to assist in correcting the performance deficiency. The Program Director will counsel the resident and will document this counseling in the resident's file.

(C) If a resident continues to perform below the adequate level of competence after counseling, demonstrates unprofessional or unethical behavior, engages in misconduct, or otherwise fails to fulfill his or her responsibilities with respect to the Residency Program, the Program Director will place the resident on formal academic remediation.

(D) Upon placement on formal academic remediation, a resident will be informed in person by the Program Director and will be provided with a written remediation plan, which will include:

1. A statement of the grounds for remediation, including identified deficiencies or problem behaviors;
2. The duration of the remediation period, from one to three months;
3. The plan for addressing the specific deficiencies or problem behaviors, and the criteria by which successful remediation will be judged;
4. The assignment of a mentor to meet with the resident on a weekly basis to take report and assist the resident in progress toward successful remediation; and
5. A notice that failure to meet the conditions of academic remediation could result in extended probation, additional training time, and/or suspension or dismissal from the program at the end of the remediation.

(E) If a resident does not complete successful remediation and is dismissed from the Residency Program, he or she may appeal the adverse decision according to the Podiatry Residents Dispute Resolution Process.

Evaluation, Correction, and Termination

Due Process and Mechanism of Appeal

The Podiatry resident is a temporary employee of the Department of Veterans Affairs (VA) appointed pursuant to 38 U.S.C. §7405.

The local governing instruction for CNVAMC is DM 110.509, "Supervision of Physician, Dental, Optometry, Chiropractic, and Podiatry Residents," which implement the terms of the following VHA documents:

1) VHA Directive 1400.01, "Supervision of Physician, Dental, Optometry, Chiropractic, and Podiatry Residents";
2) VHA Handbook 1400.04(1), "Supervision of Associated Health Trainees"; and
3) VHA Handbook 1400.08(1) "Education of Associated Health Professions"

All of these references area available in the Resident Manual document library in the Podiatry S: drive.[14]

The Podiatry Residency Program follows due process guidelines to assure that decisions are fair and nondiscriminatory. During their first week, as part of the orientation process, the Residency Manual (which includes the program's policies and procedures) is reviewed with the residents. A hard copy is kept in the residents' room (4C153). A protected electronic copy is kept on the S: drive as indicated in earlier in this document. Residents must sign an acknowledgement indicating that they have read and understand the program's policies and procedures. If changes are made to the Residency Manual, then the residents must sign again indicating acknowledgement of the changes.

The VA reserves the right to terminate a podiatry resident's participation in the podiatry residency program for lack of performance consistent with program standards deemed substandard by the Program Director and/or training committee. Such actions may include the failure to meet program requirements as identified by the Council on Podiatric Medical Education (CPME) and specific objectives stated by resident policy. This may include but is not limited to the following:

- Incompletion, failure to attend and/or complete minimum requirements for goals and objectives of any of the rotations and/or the program competencies in general.
- Consistently poor performance in any of the rotations.
- Gross incompetence where the resident is deemed dangerous to patients as defined and documented by podiatric and/or medical staff.
- Failure to keep medical/surgical logs and diary current (i.e., within 30 days of encounters).
- Failure to conduct inpatient rounds in a timely manner (i.e., within 24 hours of notification or as specifically directed by an Attending).

[14] S:\VHAAUGPODIATRY\Resident Manual\RESIDENT MANUAL AND ASSESSMENTS

- Failure to fulfill on-call duties satisfactorily. This may include not responding to on call pager messages and requests, not physically seeing patients upon consultation, not communicating with other team members, by not being within a vicinity allowing a reasonable response time to the hospital when on call and/or not assuring hospital coverage when call duties cannot be met.
- Demonstrating a pattern of failure to stay well informed or to remain prepared with medical and surgical status of both inpatients and outpatients.
- Poor attitude and/or disrespect towards patients, students and/or staff members.
- Failure to complete dictations and progress notes as prescribed in VA and training program policies (i.e., Medical Center policy usually requires note to be completed within 24 hours of the encounter).
- Demonstrating a pattern of failure to be prepared for mandatory didactic and academic activities (e.g., grand rounds and Journal Club duties, etc.).
- Demonstrating a pattern of consistent absences or tardiness to clinic, Operating Room and/other required meetings.

The VA has established a Drug-Free Workplace Program, and aims to create an environment that is safe, healthful, productive and secure, setting a goal to prevent Federal employee use of illegal drugs, whether on or off duty. The policy can be found on the VA website.[15]

If the Program Director considers the infractions minor, the resident will be counseled and provided corrective feedback verbally and in writing (Report of Contact VA Form 119 with a record kept in the resident's file) and resolution may be developed to mitigate the deficiency or problem. The remediation process for this program will guide all academic and training related deficiencies.

However, if consistent infractions are noted and/or the Program Director and/or training committee considers an infraction significant, the VA will notify the resident and in writing (Report of Contact VA Form 119 with a record kept in the residents file) of its intent to terminate his or her participation in the training program. In most cases, the resident's employment will also be terminated at this time. While, as noted above, the resident may not challenge termination of his or her employment, he or she may dispute (in writing) the termination of his or her participation in the training program pursuant to the following process.

If it is determined that a resident should be terminated from the program, his or her participation in the program will be immediately suspended and the resident will be placed on administrative absence with pay until a decision is finalized regarding his or her program status. A certified letter of intent to terminate will be sent by the Program Director to the resident with a list of the act or acts of misconduct or infractions leading to this action.

The resident will have seven (7) days from the date of receipt of the letter of intent to terminate to file a written request to respond with the Program Director. If the resident does not file a timely written request to respond, the Program Director will issue within ten (10) days of the end of the request-to-respond period a letter terminating the resident's participation in the training

[15] https://www.va.gov/OAA/onboarding/VHA_HPTsDrug-FreeWorkplaceOAA_HRA.pdf

program as of an effective termination date stated in the letter (copy to the Chief of Staff, Chief of Surgery, and Chief of Human Resources).

If the resident files a written request to respond within the request-to-respond period, the following process will be initiated:

1. A three-person ad hoc committee will be formed, consisting of (1) a Podiatry staff member, (2) the Chief of Surgery, and (3) a non-Podiatry member of the surgical or medical staff, to hear the resident's dispute. The committee members will choose a chair from among themselves. The committee chair will be responsible for causing a summary of the hearing to be made.
2. A hearing will be scheduled within fourteen (14) days of the Program Director's receipt of the resident's request to respond.
3. The VA and the resident may choose to have an attorney/representative present to provide advice. Neither the VA's nor the resident's attorney/representative may participate in the hearing.
4. The resident will present his or her argument of dispute to be considered by the committee members.
5. The committee will vote on a decision after the resident has presented his or her argument and both the resident and his or her attorney/representative have left the room. Each committee member will have one vote; abstention is not allowed.
6. The committee's finding and final vote will be forwarded to the Chief of Staff or Acting Chief of Staff, who may (a) concur with the committee's findings/action, (b) request additional information before proceeding to a decision, or (c) decide to take a different action. The Chief of Staff's decision will be final.
7. The resident will be notified of the Chief of Staff's decision within ten (10) days of the Chief of Staff making a decision.

Any person with a conflict of interest related to the dispute, including the Program Director, must be excluded from participation in all levels of the appeal process.

To the extent that any of the foregoing Podiatry Residents Dispute Resolution Process conflicts with VA Handbook 5021, Part VI, paragraph 15, or other federal regulation or statute, the VA Handbook procedures or other federal regulation or statute shall be controlling.

Problematic Resident Performance or Conduct

This section describes the program's procedures for identifying, assessing, and, if necessary, remediating problematic resident performance.

Definition of Problematic Behaviors

(A) Problematic behaviors are broadly defined as those behaviors that disrupt the resident's professional role and ability to perform required job duties, including the quality of

1. the resident's clinical services;

2. the resident's relationships with peers, supervisors, or other staff; or
3. the resident's ability to comply with appropriate standards of professional and/or ethical behavior.

(B) Problematic behaviors may be the result of the resident's inability or unwillingness to

1. acquire professional standards and skills that reach an acceptable level of competency;
2. minimize the impact of personal issues on training-related activities and competencies; or
3. mitigate stress induced by either work-related or non-work-related factors

(C) Behaviors reach a problematic level when they include one or more of the following characteristics:

1. The resident does not acknowledge, understand, or address the problem.
2. The problem is not merely a deficit in skills, which could be rectified by further instruction and training.
3. The resident's behavior does not improve despite feedback, remediation, effort, and/or time.
4. The professional services provided by the resident are negatively affected.
5. The problem affects more than one area of professional functioning.
6. The problem requires a disproportionate amount of attention from training supervisors.

(D) Some examples of problematic behaviors include:

1. Engaging in dual role relationships (inappropriate relationships with patients)
2. Violating patient confidentiality
3. Failure to respect appropriate boundaries
4. Failure to identify and report patients' high-risk behaviors
5. Failure to complete written work in accordance with supervisor and/or program guidelines
6. Treating patients, peers, and/or supervisors in a disrespectful or unprofessional manner
7. Criticism, insulting, or other overt disrespect of patients, peers, and/or supervisors in their absence, especially when done in the presence of patients and their families
8. Plagiarizing the work of others or giving one's work to others to complete
9. Repeated tardiness
10. Unauthorized absences
11. Cumulative absences that affect ability to complete program requirements within designated timeframe

NOTE: This list is not exhaustive. Problematic behaviors also include behaviors discouraged or prohibited by CPME standards, VA policies and procedures, and VHA Handbook 1400.08 Education of Associated Health Professions as outlined during orientation.

Remediation of Problematic Performance or Conduct

It should be noted that every effort is made to create a climate of access and collegiality within the service. The Program Director is actively involved in monitoring the training program and frequently checks informally with residents and supervisors regarding residents' progress and potential problems. In addition, Resident-Director meetings are held to provide another forum for discovery and resolution of potential problems. Residents are also encouraged to raise concerns with the Program Director as they arise. It is our goal to help each resident reach his/her full potential as a developing professional. Supervisory feedback that facilitates such professional growth is essential to achieving this goal.

Resident Evaluations

Residents will be evaluated by each rotation director based on the goals and objectives to achieve competencies of each rotation. These rotation evaluations will serve to evaluate the resident's performance in the areas of knowledge and skills, as well as their motivation and attitude. All written evaluations become a part of the resident's permanent file within the Podiatry Section. These records are maintained by the Program Director and kept in secure cabinets or electronically in the Program Directors' office. The Program Director also conducts and documents at minimum a semiannual meeting with each resident to review the extent to which the resident is achieving the competencies.

Residents are continuously evaluated and informed about their progress in the program. It is hoped that residents and supervisors establish a working professional relationship in which constructive feedback can be given and received. During the evaluation process, the resident and supervisor discuss such feedback and, in most cases, reach a resolution about how to address any difficulties. Although residents are formally evaluated at regular intervals, problematic behaviors may arise and need to be addressed at any given time.

If a resident fails to meet expectations at the time of the written evaluation, or at any time a supervisor observes serious deficiencies which have not improved through ongoing supervision, procedures to address problematic performance and/or conduct would be implemented. These include:

1. Supervisor meets with Program Director and/or full Training Committee to assess the seriousness of resident's deficient performance, probable causes, and actions to be taken. As part of this process, any deficient evaluation(s) are reviewed.
2. After a thorough review of all available information, the Program Director and/or Training Committee may implement one or more of the following steps, as appropriate
    a) Informal counseling;
    b) Formal counseling;
    c) Probation; or
    d) Termination
3. At any stage of the process, the resident may request assistance or consultation, as outlined in the section on Grievances.

Residents may also request assistance or consultation outside of the program, resources for which include the VA Office of Resolution Management (ORM),[16] the Council on Podiatric Medical Education (CPME) complaint form,[17] or independent legal counsel at their own expense.

ORM is a department within the VA with responsibility for providing a variety of services and programs to prevent, resolve, and process workplace disputes in a timely and high-quality manner. These services and programs include:

- *Prevention*: Programs that ensure that employees and managers understand the characteristics of a healthy work environment and have the tools to address workplace disputes.
- *Early Resolution*: ORM is the lead organization for workplace alternative dispute resolution (ADR) within the VA. This form of mediation is available to all employees. A fellow VA employee who has voluntarily agreed to mediate workplace disputes and has been specially trained in mediation techniques and conflict resolution will act as an impartial person helping people having a dispute to talk to each other and resolve their differences. The mediator does not decide who is right or wrong, but rather helps the parties to the dispute to create their own unique solution to their problem. Employees who elect to use mediation do not give up any other rights.
- *Equal Employment Opportunity (EEO) Complaint Processing*

Please note that union representation is not available to residents, as they are not union members under the conditions of their VA term-appointment.

All documentation related to the remediation and counseling process becomes part of the resident's permanent file within the Podiatry Section. These records are maintained by the Program Director and kept in secure, locked cabinets or electronic form in his or her office.

NOTE: See VHA Handbook 1400.08, Education of Associated Health Professions, 10.b, and VHA Handbook 1400.01, Supervision of Physician, Dental, Optometry, Chiropractic and Podiatry Residents

Remediation Plan

Once a determination is made that a formal remediation plan is necessary the timeline for reassessments will be defined based on the individual needs of the resident. (E.g., 1st reassessment at one month, 2nd reassessment if needed at two months, 3rd reassessment if needed at three months.) The Designated Education Officer should be notified of the remediation plan and the resident's involvement.

[16] Department of Veterans Affairs Office of Resolution Management (08), 810 Vermont Avenue NW, Washington, DC 20420, 1 + (202) 501-2800 or toll-free 1 + (888) 737-3361, http://www.va.gov/orm
[17] https://www.cpme.org/residencies/content.cfm?ItemNumber=2444&navItemNumber=2245

Upon reassessment at the planned checkpoint, one of five courses of action may be determined to be warranted: No further action, informal counseling, formal counseling, probation, or termination.

Informal counseling

Informal counseling is appropriate if the supervisor decides that the problem(s) are best dealt with in ongoing supervision.

Formal counseling

Formal counseling is appropriate if the supervisor decides that the problem(s) require structured correction. A written statement is provided to the resident including the following information:

1. A description of the problematic behavior(s);
2. Documentation that the Program Director and/or Training Committee is aware of and concerned about the problematic behavior(s) and has discussed these with the resident; and
3. A remediation plan to address the problem(s) within a specified time frame, setting clear objectives and identifying procedures for meeting those objectives.

Possible remedial steps include (but are not limited to):

1. Increased level of supervision, either with the same or with other supervisors;
2. Assigned readings or other forms of instruction;
3. Changes in the format, assigned rotations, or other areas of emphasis in supervision;
4. Recommendation of personal therapy, including clear objectives addressing the behavior in question;
5. Recommendation or requirement of further training to be undertaken; or
6. Recommendation or requirement of leave of absence

The resident is also invited to provide a written statement regarding the identified problem(s). As outlined in the remediation plan, the supervisor, Program Director, and resident will meet to discuss resident's progress at a specified reassessment date. As part of this process, the Program Director will contact the resident's graduate program (if the affiliate is the program sponsor) to notify them that resident requires a remediation plan and will seek the program's input to the plan. The Program Director documents the outcome and gives written notification to the resident and supervisor(s).

NOTE: See VHA Handbook 1400.08, Education of Associated Health Professions.

Probation

Probation is warranted when problematic behavior(s) are deemed to be more serious by the Training Committee or when repeated efforts at remediation have not resolved the issue. IN this circumstance the Designated Education Office should be notified.

The resident will be given written notice of probation, with a statement including the following:

1. A description of any previous efforts to rectify the problem(s);
2. Notification of and consultation with the resident's graduate program (if the affiliate is the program sponsor) regarding further courses of action;
3. Specific recommendations for resolving the problem(s); and
4. A specified time frame for the probation during which the problem is expected to be rectified and procedures for assessing this are established

The resident will be invited to provide a written statement regarding the identified problem(s). As outlined in the Probation Notice, the supervisor(s), Program Director, resident, and a representative from the resident's graduate program (optional) will meet to discuss the resident's progress at the end of the probationary period. The Program Director will document the outcome and give written notification to the resident, supervisor, the graduate program (if affiliate is the program sponsor), the Designated Education Officer, and the facility Chief of Human Resources.

NOTE: See VA Handbook 5021, Employee/Management Relations

Definition of Serious Infractions

Any illegal or unethical conduct by a resident must be brought to the attention of the Program Director as soon as possible. Any person who observes or suspects such behavior has the responsibility to report the incident. The Program Director will document the issue in writing, as well as consult with the appropriate parties, depending on the situation (see description below). Infractions of a very minor nature may be resolved among the Program Director, the supervisor, and the resident, as described above.

Examples of significant infractions include but are not limited to:

1. Violation of ethical standards for the discipline, for the training program, or for government employees.
2. Violation of VA regulations or applicable Federal, state, or local laws.
3. Disruptive, abusive, intimidating, or other behavior that disturbs the workplace environment or that interferes or might reasonably be expected to interfere with Veteran care. Disruptive behaviors include profane or demeaning language, sexual comments or innuendo, outbursts of anger, throwing objects, serious boundary violations with staff or Veterans, inappropriate health record entries, and unethical, illegal, or dishonest behavior.

Depending on the situation and the time-sensitivity of the issues, the Program Director may consult with the Training Committee and Designated Education Officer to get further information or guidance. Following review of the issues, the Training Committee may recommend either formal probation or termination of the resident from the program.

Probationary status will be communicated to the resident, his or her graduate program, VA OAA, and CPME in writing and will specify all requisite guidelines for successful completion of the

program. Any violations of the conditions outlined in the Probation Notice may result in the immediate termination of the resident from the program.

The Program Director may also consult with the Service and Section Chiefs, Human Resources, regional counsel, other members of hospital leadership (e.g., Designated Education Officer, Privacy Officer, Safety Officer, EEO Officer, Chief of Staff, Facility Director, etc.), VA OAA, or the resident's graduate program (if affiliate is the program sponsor) in situations where there may be an ethical or criminal violation. Such infractions may be grounds for immediate dismissal.

In addition, the Program Director may immediately put the resident on administrative duties or on administrative leave while the situation is being investigated. Under certain circumstances, the Residency Program may be required to alert the accrediting body (CPME) or other professional organizations (e.g., state licensing boards) regarding unethical or illegal behavior on the part of a resident. If information regarding unethical or illegal behavior is reported by the resident's graduate program (if affiliate is the program sponsor), the Residency Program may have to follow their policies and procedures regarding clinical duties, probation, or termination.

As described in the previous section on remediation of problematic performance or conduct, at any stage of the process, the resident may request assistance and/or consultation outside of the program and utilize the resources listed above.

All documentation related to serious infractions becomes part of the resident's permanent file with the Podiatry Section. These records are maintained by the Program Director and kept in secure, locked cabinets or electronically in his or her office or the Designated Education Officer's office.

Resident Grievance Procedure

This section details the program's procedures for handling any complaints brought by residents.

1. Residents are encouraged to attempt informal conflict resolution at the lowest possible level when a grievance of any kind arises, such as conflict with peers, supervisors, or other hospital staffs, or a problem with a particular training assignment.
2. If a conflict cannot be resolved informally, the resident will bring the grievance to the Program Director, who may meet with the parties as appropriate.
    a. If the resident's grievance is with the Program Director, it will instead be brought to the Chief of Podiatry.
3. If the Program Director cannot resolve the conflict, the resident, supervisor, and Program Director will bring the grievance to the Chief of Podiatry, who will intervene as necessary.
4. The Chief of Podiatry will convene a meeting of the parties involved in the dispute within two weeks of being notified of the grievance, and will act as moderator during the meeting. The Chief of Podiatry will make a written notification of his or her recommendation as to how best to resolve the grievance to the parties involved within one week of this meeting.

5. If the Chief of Podiatry's recommendation is not satisfactory to any of the parties involved, he or she may move to present the issue to the Chief of Staff.
6. The Chief of Staff will review the particulars of the grievance and the Chief of Podiatry's recommendation, and will make a written notification as to his or her decision as to how best to resolve the grievance to the parties involved within one week of this review.
7. The Chief of Staff's decision will be final, and all parties involved will abide by this binding decision.

For the purposes of handling resident grievances, if the Chief of Podiatry has dual responsibility as Program Director or is otherwise unavailable (e.g., on extended leave), the Designated Education Officer will perform the functions assigned to the Chief of Podiatry in this procedure.

Date: _____

RESIDENCY MANUAL RECEIPT

Subject: Click or tap here to enter text.

1. I attest that I have received access to the digital copy of the Podiatry Resident's Manual on the Charlie Norwood VA Medical Center (CNVAMC) computer network, located at S:\AUG Service\VHAAUGPODIATRY\Resident Manual\RESIDENT MANUAL AND ASSESSMENTS, and that I can read the document at that location.

2. I attest that I have been shown where a printed copy of the Podiatry Resident's Manual is kept in the Residents' Room (801-4C153).

_____ _____
Click or tap here to enter text. Date/Time
Residency start date:07/01/Click or tap here to enter text.)

3. I attest that I have read and understand the content in the Podiatry Resident's Manual. I understand that I can ask questions for clarification at any time.

_____ _____
Click or tap here to enter text. Date/Time
Residency start date:07/01/Click or tap here to enter text.)

_____ _____
George Sich III, DPM Date/Time
Program Director

Resident's Evaluation of the Residency Program

To ensure that CNVAMC's Residency Program provides the best PMSR training possible, it is essential that residents themselves provide feedback on the program. To that end, we ask that you, the resident, evaluate the residency program as honestly as possible. Your evaluation will allow us to make corrections to whatever does not work, and make improvements on whatever does. You are free to evaluate the following areas either by confidential written document or by informal discussion with the Attendings.

The areas that we specifically would like your assessment are as follows:

1. The overall structure of the program, including podiatric and non-podiatric rotations
2. The quality of teaching and clinical supervision
3. The level of participation in patient care
4. The diversity and volume of cases
5. The appropriateness of goals and objectives
6. The coordination of didactic and clinical experience
7. The support staff and facilities
8. The strengths and weaknesses of the program
9. Any recommendations for improving the program

It is important that you be honest and constructive. You may have recognized a problem that we do not know exists, or you may have a solution to a problem that has us stumped. Medicine is a collaborative discipline, and our goal is to make you a colleague. Your input is appreciated!

— Dr. Kean, Dr. Madison, Dr. Sich, Dr. Castillo, Dr. Stapp, Dr. Bennett, Dr. Anna, and Dr. Payne

CNVAMC Podiatric Resident Faculty Evaluation Form

Program Year: 2023-2024

Faculty Member: Charles Kean, DPM

Evaluation Scale				
5 Excellent	4 Good	3 Adequate	2 Fair	1 Poor

Teaching ability/effectiveness: ___

Surgical skills/ability: ___

Offers variety of cases: ___

Offers complexity of cases: ___

Exhibits patience: ___

Willingness to let resident do surgery: ___

Availability to residents: ___

Rapport/patience with residents: ___

Rapport/patience with patients: ___

Offers encouragement: ___

Positive role model: ___

Comment on your interaction with the attending, any strengths or areas needing improvement.

CNVAMC Podiatric Resident Faculty Evaluation Form

Program Year: 2023-2024

Faculty Member: Terria Madison, DPM

Evaluation Scale				
5 Excellent	4 Good	3 Adequate	2 Fair	1 Poor

Teaching ability/effectiveness: ___

Surgical skills/ability: ___

Offers variety of cases: ___

Offers complexity of cases: ___

Exhibits patience: ___

Willingness to let resident do surgery: ___

Availability to residents: ___

Rapport/patience with residents: ___

Rapport/patience with patients: ___

Offers encouragement: ___

Positive role model: ___

Comment on your interaction with the attending, any strengths or areas needing improvement.

CNVAMC Podiatric Resident Faculty Evaluation Form

Program Year: 2023-2024
Faculty Member: Francis Castillo, DPM

Evaluation Scale				
5 Excellent	4 Good	3 Adequate	2 Fair	1 Poor

Teaching ability/effectiveness: ___

Surgical skills/ability: ___

Offers variety of cases: ___

Offers complexity of cases: ___

Exhibits patience: ___

Willingness to let resident do surgery: ___

Availability to residents: ___

Rapport/patience with residents: ___

Rapport/patience with patients: ___

Offers encouragement: ___

Positive role model: ___

Comment on your interaction with the attending, any strengths or areas needing improvement.

CNVAMC Podiatric Resident Faculty Evaluation Form

Program Year: 2023-2024

Faculty Member: George Sich III, DPM

Evaluation Scale				
5 Excellent	4 Good	3 Adequate	2 Fair	1 Poor

Teaching ability/effectiveness: ___

Surgical skills/ability: ___

Offers variety of cases: ___

Offers complexity of cases: ___

Exhibits patience: ___

Willingness to let resident do surgery: ___

Availability to residents: ___

Rapport/patience with residents: ___

Rapport/patience with patients: ___

Offers encouragement: ___

Positive role model: ___

Comment on your interaction with the attending, any strengths or areas needing improvement.

CNVAMC Podiatric Resident Faculty Evaluation Form

Program Year: 2023-2024

Faculty Member: Mickey Stapp, DPM

Evaluation Scale				
5 Excellent	4 Good	3 Adequate	2 Fair	1 Poor

Teaching ability/effectiveness: ___

Surgical skills/ability: ___

Offers variety of cases: ___

Offers complexity of cases: ___

Exhibits patience: ___

Willingness to let resident do surgery: ___

Availability to residents: ___

Rapport/patience with residents: ___

Rapport/patience with patients: ___

Offers encouragement: ___

Positive role model: ___

Comment on your interaction with the attending, any strengths or areas needing improvement.

CNVAMC Podiatric Resident Faculty Evaluation Form

Program Year: 2023-2024
Faculty Member: Trevor Payne, DPM

Evaluation Scale				
5 Excellent	4 Good	3 Adequate	2 Fair	1 Poor

Teaching ability/effectiveness: ___

Surgical skills/ability: ___

Offers variety of cases: ___

Offers complexity of cases: ___

Exhibits patience: ___

Willingness to let resident do surgery: ___

Availability to residents: ___

Rapport/patience with residents: ___

Rapport/patience with patients: ___

Offers encouragement: ___

Positive role model: ___

Comment on your interaction with the attending, any strengths or areas needing improvement.

CNVAMC Podiatric Resident Faculty Evaluation Form

Program Year: 2023-2024

Faculty Member: Christopher Menke, DPM

Evaluation Scale				
5 Excellent	4 Good	3 Adequate	2 Fair	1 Poor

Teaching ability/effectiveness: ___

Surgical skills/ability: ___

Offers variety of cases: ___

Offers complexity of cases: ___

Exhibits patience: ___

Willingness to let resident do surgery: ___

Availability to residents: ___

Rapport/patience with residents: ___

Rapport/patience with patients: ___

Offers encouragement: ___

Positive role model: ___

Comment on your interaction with the attending, any strengths or areas needing improvement.

CNVAMC Podiatric Resident Faculty Evaluation Form

Program Year: 2023-2024

Faculty Member: Joseph Colasurdo, DPM

Evaluation Scale				
5 Excellent	4 Good	3 Adequate	2 Fair	1 Poor

Teaching ability/effectiveness: ___

Surgical skills/ability: ___

Offers variety of cases: ___

Offers complexity of cases: ___

Exhibits patience: ___

Willingness to let resident do surgery: ___

Availability to residents: ___

Rapport/patience with residents: ___

Rapport/patience with patients: ___

Offers encouragement: ___

Positive role model: ___

Comment on your interaction with the attending, any strengths or areas needing improvement.

CNVAMC Podiatric Resident Faculty Evaluation Form

Program Year: 2023-2024

Faculty Member: _____, DPM

Evaluation Scale				
5 Excellent	4 Good	3 Adequate	2 Fair	1 Poor

Teaching ability/effectiveness: ___

Surgical skills/ability: ___

Offers variety of cases: ___

Offers complexity of cases: ___

Exhibits patience: ___

Willingness to let resident do surgery: ___

Availability to residents: ___

Rapport/patience with residents: ___

Rapport/patience with patients: ___

Offers encouragement: ___

Positive role model: ___

Comment on your interaction with the attending, any strengths or areas needing improvement.

CNVAMC Podiatric Resident Faculty Evaluation Form

Program Year: 2023-2024

Faculty Member: _____, DPM

Evaluation Scale				
5 Excellent	4 Good	3 Adequate	2 Fair	1 Poor

Teaching ability/effectiveness: ___

Surgical skills/ability: ___

Offers variety of cases: ___

Offers complexity of cases: ___

Exhibits patience: ___

Willingness to let resident do surgery: ___

Availability to residents: ___

Rapport/patience with residents: ___

Rapport/patience with patients: ___

Offers encouragement: ___

Positive role model: ___

Comment on your interaction with the attending, any strengths or areas needing improvement.

CNVAMC Podiatric Residency End-of-Year Evaluation Form

Year: 2023-2024

Evaluation Scale

5 Excellent	4 Good	3 Acceptable	2 Poor	1 Unacceptable

The planning and organization of the program was: ___

The resources of the program to accomplish goals and objectives were: ___

The director's administration was: ___

The program is having a positive effect on students and residents (Circle YES or NO)
Comment:

The program is having a positive effect on patients (Circle YES or NO)
Comment:

What are the strengths of the program?

What are the weaknesses of the program?

What would you like to see next year?

Appendix: Clinical Informatics

VA clinical staff use an Electronic Medical Record (EMR) system for all charting and clinical documentation, as well as placement of orders, prescriptions, and recording of laboratory tests and imaging. The primary EMR system is the Computerized Patient Record System (CPRS), a versatile and user-friendly interface for the Veterans Health Information Systems Technology and Architecture (VistA).

Residents will be asked to complete the "CPRS Tab by Tab: A Basic Orientation" in the online VA Talent Management System (TMS) 2.0 as part of their onboarding package received from the Podiatry Program Coordinator, and will provide the Coordinator with a copy of the TMS certificate of completion, as well as National Provider Identifier (NPI) and Drug Enforcement Agency (DEA) Registration Number, if applicable.

This information allows the Surgery Service's Automatic Data Processing Application Coordinator (ADPAC), Ms. Georgia Bryant, ext. 32621, to file a request in the Electronic Permission Access System (EPAS) to have the Office of Information and Technology create VistA accounts for the residents. It also allows the ADPAC to ensure that residents are assigned the correct keys and team designations to perform all assigned tasks in CPRS (such as prescribing controlled substances). Once residents have completed their training, the ADPAC will assist them to configure their electronic signature block and signature code in CPRS. The ADPAC is the first point of contact if a resident cannot write notes, orders, or complete a consult in CPRS.

The Office of Information and technology (OI&T or OIT) is the point of contact for problems with computer hardware (e.g., keyboard, mouse, printer), network connectivity, operating system (Windows 10 Enterprise), or communications programs (Outlook and Teams). Requests can be filed by the user directly via YourIT,[18] or by calling the IT Enterprise Service Desk for the Department of Veterans Affairs, ext. 27633 (Uptown) or 37633 (Downtown). The Enterprise Service Desk can process PIV exemptions and password resets for residents who have forgotten or lost their PIV cards.

Clinical Informatics is the point of contact for issues with the EMR system itself, such as retraction/deletion of incorrect notes or reassignment of encounters wrongly entered into the system, or issues with the Dragon Medical One (DMO) dictation tool. Informatics can be reached via the LEAF Portal[19] to file a request, and maintains a SharePoint site[20] with training and information resources, including information on CPRS Booster, Brillians (SupraVistA), and the Joint Legacy Viewer (JLV), tools for enhancing user efficiency in writing notes (including dot phrases) and searching for information in patient records in VistA and Department of Defense and private sector partners' EMR systems.

[18] https://yourit.va.gov
[19] https://leaf.va.gov/VISN7/509/informatics/?a=newform
[20] https://dvagov.sharepoint.com/sites/vhaauginf/SitePages/Health-Informatics.aspx

Informatics provides in-person training on CPRS every other Monday after New Employee Orientation (NEO), led by CPRS Trainer Cindy White, ext. 31801. There are 18 seats available in this comprehensive training from 8:00 AM to 4:30 PM in the Downtown Division's Computer Classroom (2B-107). In addition to covering how to use CPRS and associated medical software, this training also features guest speakers to familiarize providers with reimbursement, coding/documentation, and scheduling requirements.

The Informatics team consists of the following personnel:

Supervisor, Health Informatics (Acting CHIO)	Dr. S. Joshua Walton	Ext. 26087
Program Analyst, CAC	Jennifer Kriegel	Ext. 33706
Program Analyst, CAC	Steve Marble	Telework: Teams Only
Program Analyst, CAC	Jennifer Mitchell	Telework: Teams Only
Program Analyst, CAC	C. Mike Page	Ext. 27670
Program Analyst, CAC	Seng Her	Ext. 32889
CPRS Trainer	White, Cindy	Ext. 31801

Appendix: Biomechanical Template

Biomechanical Template

Biomechanical exam:	L (degrees)	R (degrees)
Knee position		
Tibial varum		
AJ DF knee extended		
AJ DF knee flexed		
STJ total ROM		
STJ inversion		
STJ eversion		
RCSP		
NCSP		
Forefoot to Rearfoot		
1st ray excursion dorsally		
1st ray excursion plantarly		
1st MPJ ROM		
Loaded		
Unloaded		
Foot type		

Gait Analysis: Patient is noted to have an (antalgic, propulsive, normal heel to toe, scissoring, early heel lift, steppage, spastic, waddling) gait upon ambulation.

Biomechanical Assessment:

Biomechanical Plan:

The biomechanical must tell a story and make sense. It must be related to the patient's chief complaint and treatment plan. A biomechanical done when a patient's chief complaint is athlete's foot will not count.

Appendix: Pre-Anesthesia Patient Evaluation SOP[21]

PURPOSE: To outline an approach to the preanesthesia evaluation of patients presenting for scheduled or emergency surgical procedures. This is only intended to provide a framework upon which a detailed evaluation shall be developed. The Chief of Anesthesiology and the Medical Director of the Presurgical Clinic (PSC) have the ultimate responsibility for ensuring these standards of preoperative patient preparation are met.

1. The preanesthesia evaluation is defined as the process of clinical assessment that precedes the delivery of anesthesia for surgical or nonsurgical procedures. The purpose of this assessment is multifold: to risk stratify and assess the suitability of the patient to undergo the planned procedure; to identify possible perioperative complications; and to aid in the development of a thorough anesthetic plan of care. The preanesthesia evaluation is conducted by a member of the Anesthesia Care Team (MD/DO, CRNA, NP, PA). The majority of evaluations will be performed by the Nurse Practitioners in the PSC.

2. The preanesthesia evaluation should take place within 30 days of the planned surgery/procedure. The timing of the evaluation should ideally allow for any additional testing or work-up that is identified at the time of the evaluation to be completed prior to the schedule surgery date. Surgery should always be deferred until the patient's physical status has been optimized.

3. **Emergency procedures.** It is understood that the standard procedures for preanesthetic evaluation may be altered in the event of emergency situations in which delay of surgery would represent a threat to life, limb, or function.

4. **Scheduling.** The operative service is responsible for scheduling the preanesthesia evaluation appointment.

5. The preanesthesia evaluation may be conducted in person, by telephone, via VA Video Connect (VVC), or by chart review.

6. At a minimum, the preanesthesia evaluation should include: a pertinent medical and surgical history; a review of relevant laboratory and study results; physical exam to include auscultation of heart and lungs and airway exam; and an anesthetic plan. If the evaluation is done via telephone, VVC or chart review, the Anesthesia Care team will document the physical exam findings on the day of the procedure.

[21] This appendix is quoted from the Charlie Norwood VAMC Anesthesiology Section Standard Operating Procedure – Preanesthesia Patient Evaluation, March 1, 2023.

7. **Testing**. In general, tests, studies, or consultations should only be ordered when clinically indicated. The following is intended as a guideline and may be deviated from as medically necessary.

ECG Surgery Grade*

ASA Grade	Minor	Intermediate	Major
ASA 1	Not routine	Not routine	Consider for age over 50 if no ECG in last 12 months
ASA 2	Not routine	Consider for CV, renal, or DM comorbidities	Yes
ASA 3/4	Consider if no ECG in last 12 months	Yes	Yes

*Minor – excision of skin lesions, cataracts, etc.
Intermediate – tonsillectomy, knee arthroscopy, laparoscopic cholecystectomy, etc.
Major – bowel resection, vascular procedure, total joint replacement, etc.

BMP* Surgery Grade

ASA Grade	Minor	Intermediate	Major
ASA 1	Not routine	Not routine	Consider if risk of electrolyte disturbance or AKI
ASA 2	Not routine	Consider if risk of electrolyte disturbance or AKI	Yes
ASA 3/4	Consider if risk of electrolyte disturbance or AKI	Yes	Yes

CBC* Surgery Grade

ASA Grade	Minor	Intermediate	Major
ASA 1	Not routine	Not routine	Yes
ASA 2	Not routine	Not routine	Yes
ASA 3/4	Not routine	Yes	Yes

*May be indicated for any surgery if history of significant anemia or thrombocytopenia.

Coagulation Studies
• Per surgeon
• History or coagulopathy or liver disease

Type & Screen/Type & Cross for Blood Products
• Per surgeon and following the Blood Ordering Guidelines Memorandum dated 1/13/2021

• The PSC team should ensure that appropriate blood products are ordered and should notify the surgical team if they are not

CXR
• Not indicated unless concern for acute pulmonary process (e.g., pneumonia, pneumothorax)

PFT/ABG
• Not indicated unless history of significant pulmonary disease and concern for post-operative ventilator dependence

Echocardiogram/MPI
• Considered on a case-by-case basis in patients with concern for depressed cardiac function or cardiac ischemia.
• In patients with a history of CAD treated by PCI or CABG, further cardiac testing is rarely indicated if they are asymptomatic and have good exercise tolerance (> 4 METS).

Pregnancy Testing
• A negative pregnancy test within 72 hours of surgery should be documented in the medical record for any female patient of child-bearing age. This can be either qualitative or quantitative. Home test results are not acceptable.
• A patient may refuse the test and must then sign a waiver stating that they understand the risks of doing so.

8. **Consultations.** The surgical service should request appropriate preoperative consults at the time that the decision for surgery is made. Ideally, the results of these consultations should be available at the time of the preanesthesia evaluation. If further consults are deemed necessary, they will be ordered by the anesthesia team. In all cases, surgery will be deferred until the results of all consultations are available for review by the surgical and anesthesia teams.

9. **Consent.** Consent for anesthesia is included as part of the surgical consent in the VA system. As such, a separate consent for anesthesia is not required unless a distinct anesthesia procedure is planned that is not part of the operative anesthetic plan, such as a nerve block for postoperative pain control. In these cases, a separate written consent will be obtained by the Anesthesia Care Team prior to performance of the procedure.

Appendix: Final OR Set-up Checklist

OR Checklist

1. **Anesthesia.**
    a. Speak with Anesthesia about what anesthesia the patient will receive (MAC, IV sedation, general (ET/LMA), spinal, regional (popliteal/saphenous/sciatic), local ankle/foot blocks.
2. **Draw up local – determine if epinephrine needed or plain.**
    a. Usually, (2) 10ccs of 1:1 mix of 1%/2% lidocaine and 0.25/0.5% bupivacaine.
3. **Tourniquet – decide between ankle, calf, thigh, or no tourniquet.**
    a. Set desired pressure.
        i. 230-250mmHg (or) 100mmHg over systolic # → ankle (max 250mmHg)
        ii. Usually 250-300mmHg → thigh (max 300mmHg)
    b. Most of the time use an 18"-24" ankle tourniquet
        i. If calcifications seen on x-rays foot images, consider a thigh tourniquet.
    c. Apply a 10-10 or 10-20 plastic drape over the tourniquet.
4. **Hang X-ray printouts.**
5. **Bumps.**
    a. If patient's leg and foot is not in the desired position, use a jelly bump or rolled towel/blanket (secured with tape or Koban). Tape the bump to the bed.
6. **Lights – preposition the lights and determine intensity.**
7. **Gloves and Gowns**
8. **Draping - ¾ sheet, stockinette, lower extremity drape (long end towards the head)…**
    a. Post-scrubbing in : Dr. Kean, Dr. Madison and Dr. Castillo prefer a blue towel & towel clamp ; Dr. Sich prefers the stockinette.
9. **Sutures & needle types (SH & RB1 taper) (PS-2 reverse cutting)**
    a. Capsuloraphy = 2-0 or 3-0 polyester (Ethibond).
    b. Deep structures/periosteal/capsular structures = 2-0 or 3-0 Vicryl
    c. Subcutaneous tissue = deeper 2-0/3-0, more superficial 3-0/4-0 Vicryl.
    d. Tendons = 2-0 or 3-0 Vicryl, 4-0 Monocryl, or polyester depending on situation.
    e. Skin = 2-0 → 4-0 Nylon; 2-0 → 4-0 Prolene; 4-0 or 5-0 PDS for running subQ.
10. **Special Equipment**
    a. Hardware ordered : _____
    b. Specific tools (blades, saw blade size, burr, Pulsevac…)
    c. Vancomycin powder, Irrisept, 3 liter NSS with cysto tubing…
    d. For specimen cups, discuss with OR staff about specimens for histology/permanent (formalin) and microbiology (absolutely NO formalin!!!)
11. **Placement of C-arm**
12. **Dressings**
    a. Xeroform, betadine, kerlix, coban, tape..
    b. Posterior splint / AO splint
13. **Final Room Check**

Appendix: Different Types of Radiographic Imaging and Purposes

X—RAYS:

Purpose:

- Assess bone for injuries or conditions such as fractures, infection, arthritis, bone spurs, foreign bodies and tumors.
- **Always get WEIGHTBEARING** to better assess fractures/joints/surgeries
- Concern for bipartite sesamoid vs fracture or LisFranc injury → **get WB CONTRALTERAL films**
- Gives 2D information on site of bone tumors, characteristics of margin and edges, matrix mineralization, cortical involvement, and periosteal reaction.

	Nonaggressive	Aggressive
Pattern of bone destruction	Geographic	Nongeographic (moth eaten/permeative)
Zone of transition	Narrow	Wide
Periosteal reaction	Smooth, solid	Irregular, interrupted, complex (Codman's triangle/Sunray speculation)
Cortical destruction	Absent	May be present
Soft tissue/Joint involvement	Absent	May be present

Terms:

- Sclerotic (white, dense) vs Lytic (dark)
- Erosion (infection vs arthritis/gout)

How to describe a fracture:

"**OLD ACIDS**"

- Open or Closed
- Location: long Bones ("physis", proximal, distal), Irregular Bones (proximal, distal, medial, lateral, superior, inferior)
- Degree: complete vs incomplete
- Articular Involvement: intraarticular vs extraarticular
- Complete: transverse, complete, spiral, or comminuted
- Incomplete: bowing, buckle, Greenstick
- Deformity: displaced, angulated, rotated, or shortened
- Dislocation
- Special: Salter-Harris, avulsion, osteoporotic fracture, pathologic fracture

CT:

Purpose:

- Superior depiction of skeletal anatomy, especially articular anatomy such as STJ

- Acute skeletal trauma or traumatic arthritis (can evaluated fracture pieces not seen on XR due to displacement)
- Osseous coalitions (abnormal union between two bones) and infections (**get CT scans to evaluate for osteomyelitis or gas infections if patient has hardware or cardiac implants**)
- Planning conservative or surgical treatment
- Neoplasms: most use MRI to diagnose bone tumors

Terms:

- Hypodensity (less dense)→ If an abnormality is less dense/black/grey than the reference structure
    - Air, fat, areas of tumor ischemia
- Hyperdensity (more dense)→ If an abnormality is bright/white
    - Blood, calcification, and IV contrast

ULTRASOUND:

Purpose:

- Detect a tear (tendons are best imaged under tension), tenosynovitis or tendon sheath effusion
- Evaluate ligaments and capsules (**plantar fascia, lateral collateral ligaments, deltoid ligament**)
- Effusions and synovial tissue are imaged with the joint relaxed
- Muscles are imaged during both passive stretching and resisted active contraction to observe muscle fibre recruitment

Hyperchoic: white (brighter), reflects majority of wave
- Bone, calcifications
- Tendon (appears striated)
- Fascia (appears non-striated)
- Ligament
- Air

Hypoechoic: gray (darker), reflects some of wave
- Muscle (striated)
- Nerve (“honey-combed”)
- Fat (with streaks of hyperechoic lines)
- Articular cartilage
-

Anachoic: black, reflects none of the wave
- Vessels
- Fluid

Terms:

- **Homogenous (uniform echo pattern)**
- **Heterogeneous (irregular echo pattern)**
    - **i.e. Achilles tendon**

MRI:

Purpose:

- Diagnose and investigate conditions that affect soft tissue, such as organs and muscles, which don't show up well on X-rays.
- Best tool for local staging of bone tumors. It is used to depict bone marrow and soft tissue involvement. Standard MRI helps to evaluate the structural changes in bones and extent of the disease and the morphology of the tumor. It also aids in differentiating benign from malignant etiology.

T1 images→ Fat is bright (used for anatomy)
- Short TE (echo time) & TR (repetition time)
- T1 weighted (contrast)
- Bone is white

T2 images→ Fat & water are bright (used for pathology)
- Long TE & TR
- Bone is dark

STIR images → Only water bright
- Water is bright
- Fat-suppression technique
- Works well around metallic implants
- Should NOT be used with contrast

Contrast: results in increased enhancement
- Not necessary for identifying soft tissue masses; however, it can be helpful in differentiating between various characteristics of suspected lesions
    - Homogenous contrast enhancement→ Highly specific for benign masses
    - Heterogeneous contrast enhancement→ Moderately specific for malignancies
- Gadolinium contrast injection is used in MRI scans to improve the diagnostic accuracy of the skin. Adding contrast to the images enhances the visibility of inflammation, tumors, blood vessels and the blood supply of certain organs
    - **Contraindications:**
        - Previous anaphylactic/allergic reaction
        - Chronic kidney disease (concern for contrast-induced nephropathy)
        - Pregnancy

Terms:

- Hypointense: abnormality is dark

- Isointense: abnormality is similar to a reference structure
- Hyperintense: abnormality is brighter

BONE SCANS:

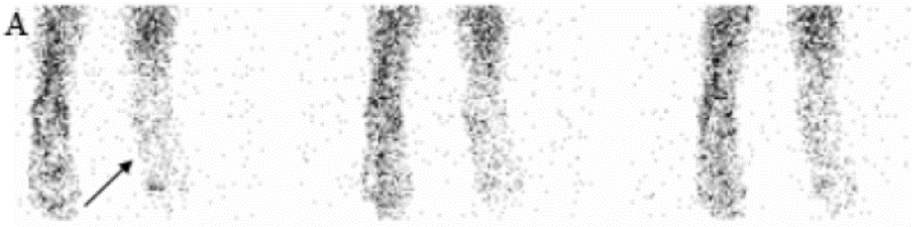
Purpose:

- Used to differentiate hypertropic versus atrophic non-unions:
  - Positive → hypertrophic or elephant foot type
  - Negative → atrophic (avascular)
- Can help identify stress fractures.
- Has sensitivity for assessing bony changes & a good screening tool for primary lesions and distant bony metastasis.

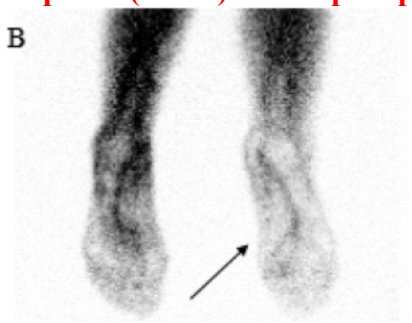
Tech-99:

- Rapid osteoblastic mediated chemical absorption on the surface of hydroxy appetite
- Uptake occurs with any type of bone growth or bone turnover
- Most common bone scan (sensitive, but not specific)
- 3-phase diagnostic study:

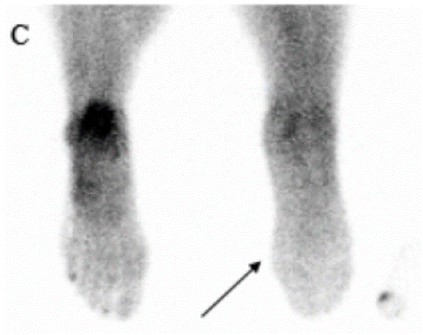
(a) 1st phase (3 sec): dynamic or blood flow phase;



(b) 2nd phase (3 min): blood pool phase or tissue phase



(c) 3rd phase (3 hours): delayed imaging phase (static) or bone imaging



(d) 4th phase (> 24 hours): delated phase, poor circulation (PVD patients)

Ceretec:

- Tc99-labelled WBC's
- Increased specificity for infectious processes
    - Positive:
        - Acute Osteomyelitis
    - Negative:
        - Inactive Chronic Osteomyelitis
        - Acute Cellulitis
        - Charcot Joint

Indium 111:

- Oxine labeled white blood cells
- Binds to the cytoplasmic component of WBC cell membrane
- Dependent on chemotaxis of leukocytes
- ½ life of approximately 67 hours

Gallium – 67 citrate:

- Diagnostic tracer used for neoplasms (lymphoma)
- Inflammatory disorders
- Less dependent on blood flow
- Less commonly used
- 3 primary mechanisms of localization
    - Leukocyte localization
    - Lactoferrin and transferrin binding & siderophores of bacteria
    - Bacterial uptake by phagocytes

	Acute Osteomyelitis	Inactive Chronic Osteomyelitis	Acute Cellulitis	Charcot Joint
Tc-99m Scan 3-4 hrs	Phase I + Phase II ++ Phase III +++	Phase I +/- Phase II + Phase III +++	Phase I +++ Phase II ++ Phase III +	Phase I +/- Phase II +/- Phase III +++ Phase IV ++/+++
Ga-67 Scan 24-48 hrs	Positive "focal" uptake	Negative	Positive "diffuse" uptake	Negative
Indium Scan 24 hrs	Positive	Negative *Persists for longer periods of time	Positive	Negative
Ceretec Scan "WBC Tc-99m" 6-7 hrs	Positive	Negative	Negative	Negative

Technetium 99m (99mTc) sulfur colloid:

- Useful for diagnosing osteomyelitis involving altered marrow distribution
- ~90% accurate
- Sulfacolloid (+), Indium (+) → Bone marrow inflammation, NO osteo
- Sulfacolloid (-), Indium (+) → Osteomyelitis

PECTCT/PETMRI:

Purpose:

- Provides a noninvasive method to assess the aggressiveness of a tumor. It's a one-stop solution for staging the tumor and to rule out distant bony and soft tissue metastasis.

Appendix: Penalties for Stated Offenses

Please refer to the Table of Example of Offenses and Penalties[22] in the Podiatry S: drive.[23]

[22] Excerpted from Appendix A. Title 5 Table of Examples of Offenses and Penalties, in Part I of VA Handbook 5021/15, "Employee/Management Relations."
[23] S:\VHAAUGPODIATRY\Resident Manual\RESIDENT MANUAL AND ASSESSMENTS

Appendix: EEO

Please refer to the Secretary of Veterans Affairs' Equal Employment Opportunity; Inclusion, Diversity, Equity and Access; No FEAR; and Whistleblower Rights and Protection Policy Statement in the Podiatry S: drive.[24]

[24] S:\VHAAUGPODIATRY\Resident Manual\RESIDENT MANUAL AND ASSESSMENTS