1.0 Purpose

The purpose of this document is to establish and communicate the institutional standards regarding faculty involvement in the care of patients. Augusta University houses an academic medical center with multiple missions including providing medical care, teaching medical professionals, and conducting clinical research. Augusta University and the Augusta University faculty have embraced the concept of faculty driven care based on the belief that the faculty physician leadership is essential in the provision of high quality and cost effective care. These objectives are consistent with the AAMC policy on guidance on Graduate Medical Education.

2.0 Procedure

For each patient, there must be a member of the medical staff, the faculty attending, who is directly responsible for the care being provided. This is true in all settings including inpatient and outpatient venues. Residents and fellows will provide care under this faculty supervision. The level of supervision should be determined by the experience of the individual resident or fellow and the guidelines outlined below. While medical students will often participate in patient care, under no circumstances should a medical student be the only individual seeing the patient.

The Program Director shall provide explicit written descriptions of lines of responsibility for the care of patients, which shall be made clear to all members of the teaching teams. Residents/Fellows shall be given a clear means of identifying supervising physicians who share responsibility for patient care on each rotation. In outlining the lines of responsibility, the Program Director will use the following classifications of supervision:

Direct Supervision: the supervising physician is physically present with the resident/fellow and patient during key portions of the interaction.

Indirect Supervision with Direct Supervision immediately available: the supervision physician is physically within the hospital or other site of patient care and is available to provide Direct Supervision.

Indirect Supervision with Direct Supervision available: the supervising physician is not physically present within the hospital or other site of patient care but is available to provide Direct Supervision.

Oversight: the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

2.1 Supervision vs. Coding and Billing – Meeting Teaching Physician Requirements

This document describes the expectations regarding supervision of clinical care by the faculty. It is very important to note that while these guidelines meet regulatory requirements for faculty attending involvement and is consistent with excellent clinical care, billing for teaching faculty is a separate issue. Please refer to the Augusta University Compliance Manual for information regarding the faculty responsibilities for appropriate coding and billing in the academic medical setting. Compliance requirements for billing are specialty specific. Faculty attending are expected to be familiar with CMS Rules for the Teaching Setting as well as other billing regulations and to comply with all such requirements if a bill for professional services is to be submitted.

2.2 Levels of Supervision and Documentation Required by Setting

Residents/Fellows assist in providing care in many settings. Each is unique in the role of the resident/fellow, acuity of patients, and established standards of supervision. Guidelines for supervision and documentation in common settings are described below.

2.3 Ambulatory Care Clinics

Faculty driven care is the standard for all clinics within the system. This includes both hospital based and faculty clinics. Residents in the first 6 months of training require particularly close observation; therefore, the guidelines below hold supervision of these residents to a higher standard.

2.3.1 Direct Supervision during the first 6 months

a) Initial Clinic Visits. It is very important that the faculty attending establish a relationship with patients immediately. Since the initial visit establishes that relationship and determines the direction of the medical care provided, the faculty attending should be directly involved by interviewing and examining patients, discussing and planning the course of treatment, and communicating with the patient and family.

b) Established Patients. Once the treatment plan is established and underway, the faculty attending may rely on residents to play a major role in providing care and assessing the results. The faculty attending remains responsible and is expected to be up-to-date on the patient's status. Hospital based clinics must have an assigned faculty attending present in the clinic and available to supervise. Faculty should interview and examine patients when significant changes in care occur. Faculty should meet with stable patients receiving ongoing care periodically to maintain the attending/patient relationship. The level of supervision will depend on the faculty's comfort with the individual resident's skills and the level of training within program.

c) Screening Exams. Screening examinations performed on patients who are well and without medical complaint may be done independently by the resident once the resident has demonstrated competence in performing the examination. Examples of these exams include basic eye exams done to evaluate patient's refraction correction, or well-baby checks. Competency should be documented by the residency program and available to clinic staff. Faculty attendings must be notified and involved in clinical decisions when these examinations uncover evidence of clinical disease.

d) Documentation. When faculty attending is billing a professional fee, CMS Rules for Teaching Hospitals must be met. In the event that the faculty attending is not billing separately, the expectation is that the faculty attending will document that the level of supervision described above has been provided. This would include relevant history, exam findings, and medical decision-making at key points in the care such as the initial visit or visits when a change in treatment occurs.

2.3.2 Indirect and Oversight Supervision of Experienced Residents (Post 6 months)

The faculty attending may rely on experienced residents/fellows to play a major role in providing care and assessing the results. The faculty attending remains responsible and is expected to be up-to-date on the patient's status. All clinics including hospital-based clinics must have an assigned faculty attending present in the clinic and available to supervise. Faculty should interview and examine patients when significant changes in care occur. Faculty should meet with stable patients receiving ongoing care periodically to maintain the attending/patient relationship. The level of supervision will depend on the faculty comfort with the individual resident/fellow's skills and the level of training within the program.

a) Documentation. When faculty attending is billing a professional fee, CMS Rules for Teaching Hospitals must be met. In the event that the faculty attending is not billing separately, the expectation is that the faculty attending will document that the level of supervision described above has been provided. This would include relevant history, exam findings, and medical decision-making at key points in the care such as the initial visit or visits when a change in treatment occurs.

2.4 Emergency Department. The attending emergency physician is responsible for all care provided in the emergency department. Supervision in this setting is similar to that of an initial visit in the clinic. Cases initially assessed by a resident/fellow will be presented to the staff physician. Faculty should then evaluate the patient and document participation in the pertinent history, exam findings, and medical decision-making. The attending physician will make final decisions regarding treatment and disposition. Other faculty may see patients in the ED and assume responsibility of care. This must be done in person. Supervision of care in the Observation Unit should meet the same standards as listed for other inpatient admissions.

2.5 Inpatient Services. Every patient that is admitted must have care supervised by a member of the AU Health medical staff with admitting privileges. That faculty attending is expected to evaluate the patient and place an admission assessment in the chart within 24 hours of admission. While much of the care in the hospital may be carried out by residents/fellows on the service, the faculty attending is expected to assess the patient personally on a daily basis, verify findings documented by residents/fellows, and document these activities emphasizing medical decision-making and supervision of invasive procedures. Communication with the referring physician,

patient, and family will be directed by the faculty attending. The faculty attending must be accessible by phone or pager and in close enough proximity to evaluate the patient within one hour in emergencies. When this is not possible, an alternate member of the medical staff with appropriate privileges must be designated, agree to be available, and be added to the call list. If the attending physician is not reachable, then the service chief (or program director) should be called to support the resident/fellow.

2.6 Intensive Care Units (ICU). Every patient that is admitted to an intensive care unit must have care supervised by a member of the medical staff with ICU privileges. Faculty attending that do not routinely admit to the ICU will admit to one of the critical care teams based on the established hospital policy. Faculty must place an admission assessment in the chart within 24 hours of admission of seriously or critically ill patients or allow an evaluation by a critical care physician on duty in the ICU. The attending faculty is expected to assess the patient personally on a daily basis, verify findings documented by residents/fellows, and document these activities emphasizing medical decision-making. Close supervision is expected during invasive procedures and when the patient is unstable. Critical care faculty should be involved when primary faculty are not available to supervise at these times. Communication with the referring physician, patient and family will be directed by the faculty attending. The faculty attending must be accessible by phone or pager and in close enough proximity to evaluate patients within one hour in emergencies. When this is not possible, an alternate member of the medical staff with appropriate privileges must be designated, agree to be available, and added to the call list. Documentation must describe this level of involvement.

2.7 In all instances, the resident/fellow (level as designated by each program) must notify the attending physician for:

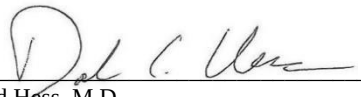
- A patient death or significant adverse event
- An identified patient error associated with patient harm or other patient safety or quality of care concerns
- The transfer of a patient to a higher level of care
- For consultation when the resident/fellow believes there is a difference of opinion or concern about a patient's care that requires attending involvement
- A patient is to designate a Allow Natural Death (AND)

A service may designate additional times when residents/fellows are required to notify the attending physician, e.g., patient admissions to the hospital. In addition, programs must set guidelines for circumstances and events in which fellows must communicate with the supervising faculty members.

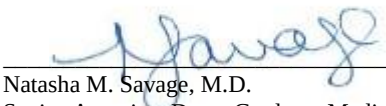
2.8 Supervision of Major Procedures. The faculty attending is responsible for evaluating resident/fellow capabilities and supervising accordingly. It is the joint responsibility of the faculty and training programs to assure that residents/fellows have demonstrated competence in procedures before invasive procedures are done without supervision.

2.9 Supervision in the Operating Rooms. In the operative suite, the faculty attending is responsible for the technical supervision and outcome of the surgery. The faculty attending should be directly supervising during key portions of the surgery. At all other times, such as during patient preparation or closing procedures, the faculty physician must be on campus and with 10 minutes of the operating suite. Operative notes must reflect this level of supervision.

2.10 Inpatient Consultation. Each service is responsible for providing inpatient consultation as needed. A schedule will be maintained by the division or department and provided to the hospital. Resident/fellows/students may perform the initial history and physical. The case must be evaluated by the attending faculty before recommendations are made to the treatment team. This evaluation should occur on the day of the request or, on cases referred late, that are not urgent, on the following day. While co-signature of the consult is sufficient to demonstrate this involvement, billing requirements must also be considered where appropriate.



David Hess, M.D. 7/1/21 Date
Dean, Medical College of Georgia



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