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/training medical professionals including House Staff, 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, safe, and cost-effective care. These objectives are consistent with the AAMC policy on guidance on Graduate Medical Education (GME).

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. House Staff will provide care under this faculty supervision. House Staff and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. The level of supervision should be determined by the experience of the individual House Staff, acuity of the patient, program specific policies, participating site procedures and policies, and the guidelines outlined below.

The Program Director, in assistance with site directors, 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. House Staff 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 imperative 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 separate applicable documents for information regarding the faculty responsibilities for appropriate coding and billing in the specific medical setting. 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 In all instances, the House Staff must notify the attending physician for:

- A patient death or significant adverse event
- An identified patient error or near miss 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 House Staff believes there is a difference of opinion or concern about a patient's care that requires attending involvement
- Allow Natural Death (AND) designation is being considered

Each Program must have a program-specific supervision policy that includes when physical presence of a supervising physician is required and when a supervising physician must be notified of an event to include the

above. A service may also designate additional times when House Staff are required to notify the attending physician, e.g., patient admissions to the hospital.

2.3 Guidelines based on practice site are described below.

2.3.1 Ambulatory Care Clinics

Faculty driven care is the standard for all clinics within the system. This includes both hospital based and faculty clinics. The faculty attending may rely on experienced House Staff to play a major role in providing care and assessing the results. However, 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 House Staff's skills, patient acuity, and the level of training within the program as well as applicable policies and procedures.

Residents in their first 6 months to one year of training require closer supervision. Program specific supervision policies and participating site procedures and policies must be followed.

2.3.1.1 Initial Clinic Visits. It is imperative 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.

2.3.1.2 Established Patients. Once the treatment plan is established and underway, the faculty attending may rely on House Staff 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 House Staff's skills and the level of training within program.

2.3.1.3 Screening Exams. Screening examinations performed on patients who are well and without medical complaint may be done independently by the House Staff once the House Staff has demonstrated competence in performing the examination. Competency should be documented by the GME training program and available to clinic staff. Faculty attendings must be notified and involved in clinical decisions when these examinations uncover evidence of clinical disease.

2.3.1.4 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 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 House Staff 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. Supervision of care in the Observation Unit should meet the same standards as listed for other inpatient admissions. Residents in their first 6 months to one year of training require closer supervision. Program specific supervision policies and participating site procedures and policies must be followed.

2.3.3 Inpatient Services

Every patient that is admitted must have care supervised by a member of the 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 House Staff on the service, the faculty attending is expected to assess the patient personally on a daily basis, verify findings documented by House Staff, 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 House Staff. Residents in their first 6 months to one year of training require closer supervision. Program specific supervision policies and participating site procedures and policies must be followed.

2.3.4 Intensive Care Units (ICU)

Every patient that is admitted to an ICU 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 daily, verify findings documented by House Staff, and document these activities emphasizing medical decision-making. Close supervision is expected during invasive procedures as outlined by each participating site's procedures and policies and Program policies 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. Residents in their first 6 months to one year of training require closer supervision. Program specific supervision policies and participating site procedures and policies must be followed.

2.3.5 Supervision in the Operating Rooms

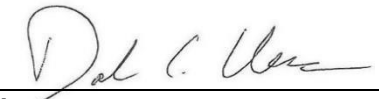
In the operative suite, the faculty attending is responsible for the technical supervision and outcome of the surgery. The faculty attending should be directly supervising during key portions of the surgery. At all other times, such as during patient preparation or closing procedures, the faculty physician must be on campus and with 10 minutes of the operating suite. Operative notes must reflect this level of supervision. Residents in their first 6 months to one year of training require closer supervision. Program specific supervision policies and participating site procedures and policies must be followed.

2.3.6 Inpatient Consultation

Services may be responsible for providing inpatient consultation as needed. A schedule will be maintained by the division or department and provided to the hospital. House Staff 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. Residents in their first 6 months to one year of training require closer supervision. Program specific supervision policies and participating site procedures and policies must be followed.

2.4 Supervision of Major Procedures

The faculty attending is responsible for evaluating House Staff capabilities and supervising accordingly. It is the joint responsibility of the faculty, nursing staff, House Staff, and training programs to assure that House Staff have demonstrated competence in procedures before invasive procedures are done without supervision.



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