

CAROLINAS HEALTHCARE SYSTEM NORTHEAST GRADUATE MEDICAL EDUCATION

POLICY FOR RESIDENT SUPERVISION

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The Cabarrus Family Medicine Residency Program recognizes and supports the importance of graded and Progressive responsibility in graduate medical education. This policy outlines the requirements to be followed when supervising residents. The goal is to promote assurance of safe patient care and the resident's maximum development of the skills, knowledge and attitudes needed to enter the unsupervised practice of medicine.

1. The institution and its educational departments will conform to the current Institutional and applicable Program Requirements as published by the Accreditation Council for Graduate Medical Education.
2. Faculty supervision assignments will be of sufficient duration to assess the knowledge and skills of each resident and delegate to him/her the appropriate level of patient care authority and responsibility.
3. Carolinas HealthCare System Northeast has 24/7 coverage by one or more in-house attending physicians: Emergency Medicine, Obstetrics & Gynecology, neonatal intensive care unit (NICU), Critical Care (ICU), Acute Care Surgery, Neurology, Hospitalist, Pediatric Hospitalist, Cabarrus Family Medicine Residency.
4. There will be an attending call list for each rotation that will allow 24-hour consultations. Each department will have a formal backup mechanism in case the primary consulting attending is not available.
5. Residents are licensed, dependent practitioners as described by the CHS NorthEast Bylaws. As such, each patient cared for by a resident must have an attending physician who takes responsibility for the patient's medical care.
6. Resident physicians are learners whose primary function is education. In all activities that are a part of their training, a well-defined, continuous level of supervision and back up by an appropriately credentialed licensed physician or Advanced Care Practitioner (ACP) is necessary.
7. Residents are given increasing autonomy in patient care as they progress through their training and as their skills and knowledge develop.
8. Resident physicians are employees of CHS NorthEast. Billing for patient services should be based upon services rendered by or under the supervision of the attending physician and appropriately documented. Care should be taken to be in compliance with Medicare Teaching regulations.

D: DEFINITIONS:

Supervising Physician: A faculty physician, or a more senior resident/fellow.

Supervising Advanced Care Provider (ACP): Advanced Care Provider with appropriate qualifications and appointments with Carolinas Healthcare System.

Supervision:

Four levels of supervision are recognized. They are:

•**Direct:** The supervising physician is physically present with the resident and the patient

•**Indirect:** There are two types of indirect supervision:

> **Indirect supervision with direct supervision immediately available:**

The supervisor is present in the hospital (or other site of patient care) and is immediately available to provide Direct Supervision. The supervisor may not be engaged in any activities (such as a patient care procedure) which would delay his/her response to a resident requiring direct supervision.

A qualified supervisor must be in house 24/7 whenever a resident potentially requiring Direct Supervision or Indirect Supervision with direct supervision immediately available is on duty.

>**Indirect supervision with direct supervision available:** The supervising physician is not required to be present in the hospital or site of patient care, or may be in-house but engaged in other patient care activities, but is immediately available through telephone or other electronic modalities, and can be summoned to provide Direct Supervision

•**Oversight:** The supervising physician is available to provide review of procedures/encounters with feedback provided

E. PROCEDURE:

The principles which apply to supervision of residents include:

- The Cabarrus Family Medicine Residency Program establishes schedules which assign qualified **faculty physicians, ACP's, residents, or fellows** to supervise at all times and in all settings in which residents of the **Cabarrus Family Residency Program** provide any type of patient care.
- The minimum amount/type of supervision required in each situation is determined by the definition of the type of supervision specified, but is tailored specifically to the demonstrated skills, knowledge, and ability of the individual resident. In all cases, the faculty member functioning as a supervising physician should delegate portions of the patient's care to the resident, based on the needs of the patient and the skills of the resident.
- Senior residents and fellows serve in a supervisory role of junior residents in recognition of their progress toward independence.
- All residents, regardless of year of training, must communicate with the appropriate supervising faculty member, in the following situations:
 1. *All hospital admissions, discharges and consultations.*
 2. *Unexpected patient deterioration (e.g. transfer to higher level of care)*
 3. *All maternity patients (admissions, procedures, changes in status)*
 4. *End of life decisions.*
 5. *As defined by precepting requirements below.*
 6. *Any incident resulting in a care event report.*
- All PGY-1 residents are supervised either directly or indirectly with direct supervision immediately available.
- At every level of supervision, the supervising faculty member must review and sign progress notes, procedural and operative notes, discharge summaries, history and physicals, consultations and office visit notes.

F. Ambulatory Supervision

•Faculty members must be continuously present to provide supervision in ambulatory settings, and be actively involved in the provision of care, as assigned.

DEFINITIONS AND PRECEPTING

There are three levels of precepting: Active, Verbal and chart review. They are defined as follows:

A. Active Precepting (Patient seen and examined by faculty)

Documentation required

Resident: The resident should state in his or her note that they saw and
Evaluated the patient with Dr. X (faculty)

Faculty: A short note must be written or dictated specifying that the
Preceptor examined and reviewed the resident's history,
exam and assessment. If the preceptor agrees, he or she
may reference the resident's note.

Example: "I have seen and examined the patient, reviewed the resident's
History, exam and assessment and plan and agree with the findings
Stated in the resident's note" or

“I have seen and examined the patient, reviewed the resident’s history, exam and assessment and plan and agree with the findings stated in the resident’s notes. “Or

“I have seen and examined the patient, reviewed the resident’s history exam and assessment and plan and agree with the findings as stated with the following exceptions...”

B. Verbal Precepting (Patient not Seen)

In this instance, the resident must discuss the patient with the faculty member before the patient leaves the office.

Documentation required:

1. Residents: The residents should state in his or her note that they discussed the patient’s evaluation and management with Dr. X (faculty).
2. Faculty: Faculty should include a note stating the following: “I have discussed and reviewed with Dr. Y (resident) the history, exam, diagnosis, and plan on this patient prior to the final disposition.

C. Chart Review

The resident’s dictation and patient chart are discussed with Dr. X (faculty) after the Patient is discharged from the office and or the chart is retrospectively reviewed and signed by the preceptor. Resident office notes are reviewed on a regular basis by the faculty with written feedback provided to the resident and advisor.

C. Video Monitoring

Video monitoring of patient encounters does not substitute for precepting. Video monitoring may be used instead of history-taking; however, it does not eliminate the need for a face-to-face encounter between faculty and patient when required. (See Section IV)

IV. PRECEPTING REQUIREMENTS

A. Family Practice Centers and other Hospital-based Primary Care

Settings Precepting Requirements (First Year Requirements)

- For the first 3 months of training. All first year residents patients will be seen by the preceptor (actively precepted)
- For the first 6 months of training, all Medicare patients must be actively precepted per Medicare Regulation. For the remainder of the year all Medicare patients must be verbally precepted.
- All OB patients must be actively precepted.
- All Medicare patients with level of service other than 99201, 99202, 99203, and 99211, 99213 must be actively precepted with appropriate documentation. All first year residents’ patients must be verbally precepted with the faculty attending before the patient leaves the office.

Precepting Requirements (Second Year Residents)

1. All patient care must be reviewed and signed by the preceptor.
2. All Medicare patients must be verbally precepted
And approximately 50 percent of other patients should be verbally precepted. All patients’ care must be reviewed via chart below.
3. All OB patients must be verbally precepted before the patient leaves the office.

4. All Medicare patients with level of service other than 99201, 99202, 99203, 99211, 99212 and 99213 must be actively precepted with appropriate documentation.

Precepting Requirements (Third Year Residents)

1. All patient care must be reviewed and signed by the preceptor.
2. For First 6 (six) months: All Medicare patients must be verbally precepted and approximately 50 percent of patients should be verbally precepted.
3. Second six (6) months: All Medicare patients must be verbally precepted and approximately 25 percent of patients should be verbally precepted.
4. All OB patients must be verbally precepted before patient leaves the office.
5. All Medicare patients with level of service other than 99201, 99202, 99203, 99211, 99212 and 99213 must be actively precepted with appropriate documentation.

B. Non-Hospital-based Clinic Settings

1. All Medicare patients must be seen by the attending physicians and appropriately documented. The teaching physician must be present for key portions of the service if Medicare is billed for the service.
2. Other patient care must be reviewed, verbally or actively precepted at the discretion of the attending physician and based on the training level of the resident.
3. The care of the patient remains the responsibility of the attending physician and the degree of supervision should be dictated by the severity of the patient's condition and level of training of the resident. The attending physician must be immediately available to provide care of the patient if needed.

C. Hospital Settings

1. Attending physicians must see and examine all patient admissions and consultations. An admission note must be written by the attending physician although it can reference the resident's complete H&P. The care plan is discussed with the resident.
2. The attending physician must see hospitalized patients regularly to ensure quality of care and adequate supervision of care. Notes must be written by the attending physician when the patient is seen and there is a professional billing of service.
3. The attending physician must be present for all procedures to provide supervision and teaching and to bill for service, unless the resident has been approved for the procedure in which case indirect supervision with direct supervision immediately available is allowed.

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7-7-17

Date

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7.17.17

Date