I. **SCOPE:** All Providence St. Peter-Summit Pacific Rural Family Medicine Program faculty, residents, and non-faculty attending physicians.

II. **PURPOSE:** To outline guidelines for supervision of patient care.

III. **POLICY:** This policy is directed at clarifying the supervision of residents caring for patients, across all care settings where clinical care is delivered. In all clinical learning environments, the patient will have an identifiable, appropriately credentialed and privileged attending physician who is ultimately responsible for the patient’s care. This policy is available to all residents, faculty, the Graduate Medical Education Committee, and patients.

**Resident Competence & Delegated Authority**

The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident is assigned by the program director and faculty members. The program director evaluates each resident’s abilities based on specific criteria, including:

- Initial and on-going evaluation of residents’ abilities is based on direct observations with patients, basic skills qualifications such as chest radiograph and EKG reading, In-Training exam results, a system of regular evaluations, and 360 evaluations from patients and staff and colleagues.

**Family Medicine Residency Continuity Clinic**

Residents are assigned a panel of patients and scheduled to see these and colleague’s patients in the clinic. During the first six months of training, they are under the direct supervision and confer with precepting faculty for every patient seen. After their semi-annual review and with consensus approval of faculty, they may be promoted to indirect supervision of eligible patients in the clinic.

**Supervising physician faculty (preceptors)** are always physically present while residents are seeing patients in the clinic, at a ratio of no more than 4 residents to 1 preceptor (typically 2 or 3:1 ratio) during all clinic sessions for all residents. All patients are precepted, either with immediate supervision and directly evaluated by the supervising physician, or via a case discussion with the preceptor before the end of the clinic session for feedback and review of patient care. Advanced medical decision making for specialty referrals, advanced imaging (such as CT or MRI), or surgical consultation is to be reviewed with faculty preceptors for appropriateness before initiating. The resident routes clinic notes to the supervising physician or their faculty supervisor for review and co-signature via the EMR. Supervising physician preceptors service as faculty and are free of other service obligations when precepting but may be called upon for direct assistance or supervision of critically ill patients in the clinic.
For patients with Medicare and Medicaid coverage, the residency follows the CMS primary care exception, allowing for indirect supervision of patient care that is lower complexity (billed a 99213 equivalent or less) for residents beyond their first 6 months of training. For level 99214 or higher complexity, the supervising physician engages with the patient and resident for key history, exam, and medical decision making. In addition, all procedures are performed for these patients under Direct Supervision. Time-based counseling billing is only applied if the supervising physician is present for the entire time billed by the resident.

Residents are directly observed in the clinic periodically with direct shadowing in each year of their training. Family physician faculty, behavioral scientists, clinical pharmacists, and others are involved and use different methods of evaluating resident in communication skills, efficiency, and medical decision-making. Increased direct supervision may also be implemented as part of remediation and probationary plans.

Supervising physicians document in the patient’s electronic medical record the degree to which supervision was performed. In addition, they are asked to complete evaluations for formative feedback to residents and the program on their observations and oversight.

For details on Obstetrical patients, please see policy on Supervision of Maternity Care.

Home Visits

Home visits occur throughout the resident’s training. Please see the curriculum for details. A faculty member must accompany the resident for direct supervision of this visit, which is then documented in the electronic medical record (EMR) with oversight and billed accordingly. Faculty document with a Medicare/Medicaid compliant attending note and co-sign the resident’s visit note. Home visits may also be supervised by PharmD and behavioral science faculty for visits that focus on areas within the respective scope of care and treatment and are billed accordingly.

Nursing Home Visits

R2’s and R3’s are scheduled for four nursing home visits per year under the direct supervision of the family medicine adjunct faculty. Additional supervision is provided by pharmacy faculty during some of these visits.

Patient Care in Providence St Peter Hospital or Providence Centralia Hospital:

The faculty attending physician is ultimately responsible for the care of patients in the hospital, but residents achieve increasing levels of responsibility as they progress through training. R1 level residents are never on hospital service without an upper-level resident or attending immediately available.

During daily rounding, a combination of direct supervision and indirect supervision with direct
supervision immediately available are used. Residents build evaluation and treatment plans independently to foster autonomy and critical thinking, but these are always discussed in real time with faculty or hospitalist attending physicians before plans or major orders are initiated.

The family medicine resident will request a co-signature line and provide the name of the attending physician for all required documents listed below. Hospital medical records requiring co-signature by the attending physician include the following:


Circumstances in which Supervising Practitioner MUST be Contacted

For all non-pregnant patients in the hospital, the attending physician must be contacted for all major changes of status, ICU transfers, deaths, and changes in code status. The family medicine attending must also be informed of pending admissions, and then updated with the full H&P in a timely fashion. Attendings have remote access to the EMR as well. For Obstetrical patients, please see Supervision of Maternity Care.

Overnight

PSPH during Night Rotation

During night rotation at PSPH, residents may evaluate and admit stable SPFM patients overnight, with indirect supervision by telephone from an attending physician at all times. The night team is responsible for direct patient care of the inpatient service and contacts the St Peter Family Medicine Resident R3 who is on call from home for all concerns and admissions. The SPFM R3 then contacts the attending for all admissions and serious concerns. At any time, the inpatient team may contact the attending directly. Specialty consultation without attending notification is encouraged in emergent situations. Otherwise, such consultation would occur after discussion with the attending.

For adult and pediatric patients that are unstable or admitted to the ICU, the R3 and faculty attending must be physically available within 30 minutes of phone contact with the resident and are required to come to the hospital for direct supervision. For more immediate back-up, ER physicians and hospitalists are present for emergency assistance. At any time, any resident may request direct assistance from the R3 and attending for any reason where patient safety is a concern. R3s are encouraged to provide direct supervision when the patient's condition, diagnosis, or treatment plan is unclear by phone.

SPMC Phone Call

While on night rotation at SPMC, residents are directly supervised by the nocturnal hospitalist or Emergency Medicine physician who is directly present for supervision.
Rural program residents will take call overnight and on weekends for one night in 7 most weeks out of the year for "clinic call" to respond to patient phone calls. These are discussed with the attending immediately if needed or are batched twice daily for discussion with the attending. When attending faculty judge that the resident has demonstrated adequate competence and sound judgment, these phone calls can be documented in the EMR and routed to the attending the next day for review and co-signature.

**Supervision of Hand-Offs**

Faculty attendings are present for morning hand-offs for direct supervision; residents are present for evening hand-offs. Handoffs are performed with a formalized electronic system and in-person discussion between residents.

**Faculty Development and Resident Education around Supervision and Progressive Responsibility**

Residency programs must provide faculty development and resident education on best practices around supervision and the balance of supervision and autonomy.

**Best practice utilizes the SUPERB SAFETY model:**

Attendings adhere to the SUPERB model when providing supervision

1. **Set Expectations:** set expectations on when they should be notified about changes in patient’s status.
2. **Uncertainty is a time to contact:** tell the resident to call when they are uncertain of a diagnosis, procedure, or plan of care.
3. **Planned Communication:** set a planned time for communication (i.e., each evening, on-call nights)
4. **Easily available:** Make explicit your contact information and availability for any questions or concerns.
5. **Reassure resident not to be afraid to call:** Tell the resident to call with questions or uncertainty.
6. **Balance supervision and autonomy.**

Residents seek supervisor (attending or senior resident) input using the SAFETY acronym.

1. **Seek attending input early**
2. **Active clinical decisions:** Call the supervising resident or attending when you have a patient whose clinical status is changing, and a new plan of care should be discussed. Be prepared to present the situation, the background, your assessment, and your recommendation.
3. **Feel uncertain about clinical decisions:** Seek input from the supervising physician when uncertain about clinical decisions. Residents are instructed to be prepared to present the situation, the background, assessment, and recommendation.

4. **End-of-life care or family/legal discussions:** Residents are always to call the attending when a patient may die, or there is a concern for a medical error or legal issue.

5. **Transitions of care:** Always call the attending when the patient becomes acutely ill, and if considering transfer to the intensive care unit (or have transferred the patient to an ICU or outside the hospital for a higher level of care.).

6. **Help with system/hierarchy:** Call the supervisor if the resident is not able to advance the care of a patient because of system problems or unresponsiveness of consultants or other providers.

Residents and faculty should also refer to *Procedure Supervision Guidelines Policy* and *Supervision of Maternity Care Policy* for specific policy, procedures, and guidelines.

### IV. DEFINITIONS:

- **Resident:** A physician who is engaged in a graduate training program in medicine, and who participates in patient care under the direction of attending physicians (or licensed independent practitioners) as approved by each review committee. As part of the training program, residents are given graded and progressive responsibility according to the individual resident’s clinical experience, judgment, knowledge, and technical skill. Each resident must know the limits of his/her scope of authority and the circumstances under which he/she is permitted to act with conditional independence. Residents are responsible for asking for help from a supervising physician or other appropriate licensed practitioners when they are uncertain of the diagnosis, how to perform a diagnostic or therapeutic procedure, or how to implement an appropriate plan of care. An “Upper Level” resident is one in good standing in the PGY2 or PGY3 year.

- **Attending of Record (Attending):** An identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for the management of the individual patient and the supervision of residents involved in the care of the patient. The attending physician delegates portions of care to residents based on the needs of the patient and the skills of the residents.

  Residents and attending physician faculty clearly inform patients of their respective roles in each patient’s care.

- **Supervision:** To ensure oversight of resident supervision and graded authority and responsibility, the following levels of supervision are recognized:
Title: Patient Care Supervision

1. **Direct Supervision** – the supervising physician (or “supervisor” if supervision by non-physicians) is physically present with the resident and patient.

2. **Indirect Supervision:**
   a) *with direct supervision immediately available* – the supervising physician is physically within the hospital or another site of patient care and is immediately available to provide Direct Supervision.
   b) *with direct supervision available* – the supervising physician is not physically present within the hospital or another site of patient care but is immediately available by means of telephonic and/or electronic modalities and is available to come to the site of care to provide Direct Supervision.

3. **Oversight** – the supervising physician reviews procedures and encounters with feedback provided after care is delivered.

*Levels of Supervision* will vary according to graded authority and responsibility awarded to each resident based on resident experience and demonstrated competency, patient acuity and need, insurer requirements, and state or national laws.

---

**CREATION**

Creation Date: 7/24/2018
Department: Residency Program
Replaced policy: 

Approved:

Laurie Belknap, DO  Signature  Date: 
Family Medicine Residency Program Director

Ken Dietrich, MD  Signature  Date: 
Chief Medical Officer

**REVISION HISTORY**

Revision Dates: 

Approved:
Title: Patient Care Supervision

Laurie Belknap, DO  
Family Medicine Residency Program Director  
Signature  
Date: ________

Ken Dietrich, MD  
Chief Medical Officer  
Signature  
Date: ________

REVIEW HISTORY

Review Dates: 6/11/19

RETIRED

Requested By:  
Date:  

Approved By:  
Date:  
Reason:  

Page 7 of 7