



<b>POLICY: Student/Resident Rotation</b>	<b>POLICY NUMBER: SF_020_MS</b>
<b>CATEGORY: Structures with Functions</b>	<b>EFFECTIVE DATE: 7/20/2011</b>
<b>CHAPTER: Medical Staff</b>	<b>SUPERSEDES: 2001</b>

**I. POLICY:**

It is the policy of Yukon Kuskokwim Health Corporation (YKHC) to ensure appropriate selection, training, and supervision of a limited number of medical students, Physician Assistants (PA) and Nurse Practitioner (NP) students, resident physicians, optometry interns and dentist externs at YKHC.

**II. PURPOSE:**

The purpose of this policy is to ensure selection of an appropriate quantity and quality of students, residents, interns and externs (subsequently defined in this policy as "trainees") and establish an appropriate supervisory structure.

**III. PROCEDURE:**

- A. Trainee programs are supported by YKHC because students, residents, externs, and interns are considered an excellent recruitment tool. Training program affiliations help keep proctoring medical staff up to date on current, clinical practices therefore maintaining higher standards of care at this institution. Residents, externs, and interns also generate revenue, which supports their rotations
- B. All trainee financial support is determined by and budgeted for by individual departments (see attachment 3).
- C. Requests for training rotations at YKHC must be submitted to the Director of Residents and Students of Family Medicine, Pediatrics, Optometry or Dentistry.
- D. The Director of Residents and Students is responsible for approving and coordinating the number of students, residents, externs and Interns accepted for training experiences at YKHC. This is to be done under the direction of the Chief of Staff and in conjunction with the attached guidelines (see attachment 1)
- E. Supervision of trainees will be performed by a Licensed Independent Practitioner (LIP) with appropriate clinical privileges granted by the medical staff. This will be done in accordance with The Joint Commission (TJC) and Health Care Financing Administration (HCFA) standards as well as the attached YKHC guidelines (see attachment #2).
- F. Prior to beginning a rotation, each trainee must provide the Director of Residents and Students with each of the following:



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1. A signed Memorandum of Agreement (MOA) between YKHC and their training program
2. A letter of good standing from their training program including Social Security Number (SSN) and Date of Birth (DOB)
3. Certificate of Insurance
4. Copy of Drug Enforcement Administration (DEA)( and # used for offsite pharmacies)
5. Copy of National Provider Identifier (NPI)
6. Copy of Medical School Diploma
7. Copy of home state and Alaska Resident’s license.
8. A copy of their current immunization status

- G. Trainees will follow YKHC Policies and Procedures.
- H. Trainees and attending provider will comply with supervision requirements as outlined in Attachment 2.
- I. Trainees will complete all necessary documentation and medical records prior to completing rotation.
- J. All trainees must be supervised by a YKHC licensed independent practitioner with appropriate privileges granted by the Medical Staff.



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**Attachment 1 – Selection Guidelines**

1. Only one 3rd or 4th year Medical Students and one Mid-level student may be in training at YKHC at any one time.
2. Only one second or third year Family Practice resident and one other type of resident (Peds, OB/GYN, IM) may be in training at YKHC at any one time.
3. Up to three dental externs may be in training at YKHC at any one time.
4. Up to seven Optometry Interns may be in training at YKHC at one time.
5. The Chief of Staff may grant exceptions to the above guidelines. Exceptions should be given primarily to Native Americans, people from the YK Delta region, and others who have demonstrated a strong interest in practicing at YKHC and when rotations overlap.



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**Attachment 2- Supervision and Documentation Guidelines**

***Medical Students, Mid-level Students, Externs and Interns***

1. All orders and prescriptions must be countersigned
2. All notes must be reviewed for accuracy, corrected and countersigned
3. Trainees need to be introduced, and permission received from the patient to have them involved in their care
4. Supervising Licensed Medical Practitioner’s must directly supervise medical care and see every patient seen by a trainee. Billing can only be submitted for the Level of Service (LOS) the LIP provides/oversees. Documentation must support the LOS billed.

***Resident Supervision and Documentation***

Residents need direct supervision by an attending physician until he or she feels the resident has demonstrated medical competency and the ability to recognize the need to obtain consultation when the case falls outside of the resident’s knowledge, experience, and orientation.

**Inpatient Supervision & Documentation**

Types of Supervision:

A. Direct supervision:

1. This occurs with invasive or surgical procedures, and may also be required under certain special circumstances, including rotations outside Providence Alaska Medical Center and Alaska Native Medical Center, and for residents experiencing difficulty.
2. Direct supervision requires that the procedure be attended directly by the attending physician during its performance.
3. All progress notes, procedure notes, and orders written by the residents must be co-signed by the attending physician.
4. Orders must be co-signed before being put into effect.

B. Close Supervision:

The attending will provide at least the level of supervision described under general supervision.

1. An attending or supervising resident will see the patient Within 12 hours of admission to the hospital, and will review admitting orders with the resident prior to their being accepted by the nursing staff.
2. The attending physician will review the resident’s daily progress notes and orders, and discuss any significant changes directly with the resident.

C. General Supervision:

1. The attending physician accepts legal responsibility for patient care.



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2. The attending will see the patient within 24 hours of admission to the hospital and daily during hospital care.
3. The attending physician will communicate daily with the resident regarding patient care, and review with the resident the ordering of all significant of invasive diagnostic tests, consultations and transfers of the patient to other nursing units.
4. All admit, discharge, and DNR/DNI orders will be reviewed by attending. Orders do not need countersignature.
5. For Non-Medicare patients the attending will document that they have seen the patient and reviewed the resident’s notes and care plan. They may use the resident’s documentation to assign the level of service.
6. For Medicare patients, the attending physician will document an independent History and Physical, daily progress notes and a discharge note and bill only for the LOS that they documented. These notes should refer to the resident notes but need to document the key aspect of each area needed to ascertain the LOS. Thus, the resident history and physical and notes do not need countersignature.
7. The attending is responsible for completing the patient’s charge sheet.
8. Residents will dictate discharge summaries for their attendings. The name of the attending they are dictating for must be referenced at the beginning of the dictation. The attending will sign the dictation and the resident should try to cosign the dictation before leaving Bethel.
9. All inpatient procedures must be directly supervised.

**Outpatient Supervision & Documentation**

**Types of Supervision:**

A. Direct Supervision:

All patients need to be seen by the attending who will review case and plan with resident. Co signature of attending is required.

B. Close Supervision:

All patient encounters need to be reviewed and co-signed by attending.

C. General Supervision:

1. Residents may see patients independently (except for Medicare patients see below). No attending co-signature necessary.
2. An attending physician must be available for consultation when requested by a resident.
3. Non-Medicare encounters do not need attending co-signature unless Direct/Close supervision is requested by attending physician.
4. All outpatient procedures will be directly supervised by attending physicians.
5. Medicare encounters require independent attending physician evaluation and documentation. Level of service is determined by attending physician documentation.
6. All ER encounters will require at least Close or Direct supervision and documentation.



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**Attachment 3- Guidelines for YKHC Payment Travel, Housing, and Meals**

	<b>Airfare</b>	<b>Housing</b>	<b>Meals</b>	<b>Stipend/Per Diem</b>
<b>Medical Students</b>		<b>X</b>	<b>X</b>	
<b>NP &amp; PA Students</b>		<b>X</b>	<b>X</b>	
<b>Residents*</b>	<b>X</b>	<b>X</b>	<b>-Lunch and Dinner tickets when on call.</b>	
<b>Dental CoStep Externs</b>				<b>X</b>
<b>Dental Externs</b>	<b>X</b>	<b>X</b>	<b>-Lunch tickets</b>	
<b>Optometry Interns</b>	<b>X</b>	<b>X</b>	<b>X</b>	

**\* Bethel will pay for one round trip airfare for family & significant other of Alaska Family Practice Residents. Will consider this option for potential other resident recruits.**



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**Attachment 4**

**Teaching Physician Documentation  
Guidelines for Working with Residents  
2004**

As medicine has changed, many of the rules around documentation have become more complex. The world of medical education is no exception. Many of us recall that the attending physician would write a cryptic “agree with the above” and co-sign the resident’s note to document their involvement in patient care. Such minimal documentation is no longer acceptable. However, neither is it necessary or desirable for the attending to completely reproduce the resident’s note. What follows is a description of the rationale for and levels of documentation required in different settings teaching residents (much more rigorous requirements apply to teaching medical students).

There are four major rule-makers that control supervision and documentation with respect to residents: 1) the State Licensing Board; 2) the institution where the resident practices; 3) the training program’s requirements; 4) Medicare. Each of these imposes different requirements on the attending physician’s documentation.

*1. The State Licensing Board*

Residents are licensed to practice within the approved curriculum of the training program. As long as the resident is on an approved rotation, there are no specific documentation requirements.

*2. The Institution*

Each hospital or clinic should have documentation requirements that satisfy its needs. At Providence, the official dictated documents, such as H&P, discharge summary, and operative notes are done by residents but must be co-signed by the attending physician. Daily notes and orders are not co-signed.

Many outpatient clinics will require the attending to review and co-sign resident notes; others do not require this. Some require it only until they have confidence in the resident’s abilities.

*3. Program Requirements*

Alaska Family Practice Residency requires that the notes of each first-year resident be co-signed by the attending when the resident is away from the home program. Second- and third-year residents are exempt. However, all resident must have an attending physician available to see their patients if needed. (This can include call back-up from home, for example.)

*4. Medicare*

Medicare requirements are the most onerous. Medicare cannot be billed for services provided solely by a resident. Outside the residents’ home base Family Practice Center, the attending physician must personally see and examine the patient if Medicare is to be billed. This rule applies to all settings, including inpatient and outpatient.



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Medicare does recognize the value of work performed by the resident in gathering the history, examining the patient and documenting findings. However, they require that the attending personally perform the key history, key exam and key decision-making. The attending’s documentation must establish that the attending did these three key elements.

The attending is free to determine the key element in each case. Usually this will be the disease that causes the chief complaint or reason for the visit.

The attending’s documentation requirement is different depending on whether he/she saw the patient with the resident or separately. The most common scenario, especially in inpatient settings, is for the attending to see the patient separately from the resident. In that case, other than documenting his or her performance of the key elements, the attending can refer to the resident’s note for all other documentation, such as PMH, social history, family history, meds, ROS, allergies and exam of organ systems other than the key ones. The level of service billed is determined by the combined documentation done by the resident and attending.

For example, in admitting a diabetic patient with pneumonia, after reviewing the case with the resident, the attending could see the patient, gather the HPI, review the vital signs, examine the chest and discuss the plan with the resident. His/her note would read:

*Key History: 48 yr old diabetic with 3d hx cough, fever, sputum production and SOB.*

*Key Exam: T 101.2, mild respiratory distress O<sub>2</sub> SAT 88%, rales at RLL, CXR with RLL infiltration.*

*Key Decision-making: Community acquired pneumonia with hypoxemia. Admit to medical ward for oxygen and antibiotics.*

*See resident’s note for complete H&P details. Agree with findings and plan per resident.*

Medicare accepts a lesser level of documentation if the attending sees the patient with the resident. In that case, it is sufficient to document the attending’s presence and agreement with the resident’s note:

Seen with Dr. \_\_\_\_\_ . Agree with his/her findings and plan as documented.

When submitting a bill to Medicare for services provided in conjunction with a resident (a “teaching encounter”), the attending must attach a modifier “GC” t the CPT code. “GC” indicates to Medicare that a resident was involved and documentation by the resident may be included in the attending’s documentation. Do not use “GC” with any other third-party payor. The charge and payment when a resident is involved is no different.





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Committee Approval  
Committee Approval:

TJC STANDARD REFERENCE: MS.04.01.01

Author's Print Name: \_\_\_\_\_

Author's Signature: \_\_\_\_\_ Date \_\_\_\_\_

Department Director Signature: \_\_\_\_\_ Date: \_\_\_\_\_

MSEC President's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Governing Body Chair Signature: \_\_\_\_\_ Date: \_\_\_\_\_

P&P Committee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Vice President Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*If policy crosses divisions additional signatures needed.*

Vice President Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Vice President Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Vice President Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Vice President Signature: \_\_\_\_\_ Date: \_\_\_\_\_

President/CEO Signature: \_\_\_\_\_ Date: \_\_\_\_\_