

**SCOPE OF PRACTICE
PULMONARY, CRITICAL CARE MEDICINE FELLOWSHIP
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USF HEALTH MORSANI COLLEGE OF MEDICINE
UNIVERSITY OF SOUTH FLORIDA**

Scope of Practice in Pulmonary/ Critical Care Fellows

This document pertains to fellow rotations under the auspices of the Pulmonary Critical Care Fellowship at Tampa General Hospital, Moffitt Cancer Center and James A Haley Veterans Hospital. All Accreditation Council of Graduate Medical Education (ACGME), Joint Commission (JC), Agency for Health Care Administration (AHCA), and CMS guidelines pertaining to graduate medical education apply to this scope of practice.

The purpose of this policy is to ensure that fellows are provided adequate and appropriate levels of supervision during the course of the educational training experience and to ensure that patient care continues to be delivered in a safe manner. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each fellow is assigned by the program director and faculty members to ensure effective oversight of fellow supervision.

The supervision of trainees is designed to provide gradually increased responsibility according to the individual fellow's clinical experience, judgment, knowledge, and technical skill. Each fellow must know the limits of his/her scope of authority and the circumstances under which he/she is permitted to act with conditional independence. Fellows are responsible for asking for help from a supervising physician, more senior fellows, or other appropriate licensed practitioner when they are uncertain of diagnosis, how to perform a diagnostic or therapeutic procedure, or how to implement an appropriate plan of care. The appropriately supervised and qualified trainee should, at the end of training, have acquired the skills necessary to function as an independently functioning consultant in pulmonary and critical care medicine.

All patient care must be provided under a credentialed and privileged attending physician. The attending physician is ultimately responsible for management of the individual patients and the supervision of the fellows involved in the care of the patient. Supervision must be documented in the medical record in accordance with the Pulmonary Critical Care Medicine Fellowship at the University of South Florida compliance guidelines.

The program follows the ACGME classification of supervision as noted below. The supervising physician can refer to a faculty, fellow, or resident that who has been given supervisory privilege. These supervisory levels are used throughout the Scope of Practice document.

Definitions

The following definitions are used in this document:

Fellow: A physician who is engaged in a professional post-graduate training program in the specialty of Pulmonary/Critical Care Medicine and who participates in patient care under the direction of attending physicians.

Faculty Attending: An identifiable, appropriately-credentialed and privileged attending physician who is ultimately responsible for the management of the individual patient and for the supervision of the fellows involved in the care of the patient. The attending delegates portions of care to the fellows based on the needs of the patient and the skills of the fellows.

Levels of Supervision:

Level-1: Direct Supervision – The supervising physician is physically present with the Fellow and patient

Level-2: Indirect Supervision:

- A: Direct supervision immediately available – The supervising physician is physically within the confines of the site of patient care, and immediately available to provide Direct Supervision
- B: Direct supervision available – The supervising physician is not physically present within the confines of the site of patient care, is immediately available via phone and/or electronic modalities, and is available to provide Direct Supervision

Level-3: Oversight – The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered

Purpose

Pulmonary and Critical Care fellows, post graduate year IV, V, and VI, function under the supervision of the attending staff of the Pulmonary/Critical Care Medicine program. The medical staff of the University of South Florida's teaching hospitals or outpatient facilities have overall responsibility for the quality of the professional services provided to patients, including patients under the care of the Fellows. It is, therefore, the responsibility of the medical staff to ensure that each Fellow is supervised in his/her patient care responsibilities by a LIP (licensed independent practitioner) who has clinical privileges at the above sites by the medical staff credentialing process.

Procedures

- A. Pulmonary/Critical Care Medicine Fellows are supervised by credentialed providers (Faculty Attendings) who are on the medical staff of University of South Florida's teaching hospitals or outpatient facilities in which they are attending. The Faculty Attendings must be credentialed in that hospital for the subspecialty care and diagnostic and therapeutic procedures that they are supervising. In this setting, the supervising Faculty Attending is ultimately responsible for the care of the patient.
- B. The Program Director defines policies to specify how trainees in the program become progressively independent in specific patient care activities in the program while being appropriately supervised by medical staff. Graduated levels of responsibility are delineated by a job description for each year of training. These Fellow supervision policies are in compliance with The Joint Commission (JC) policies on Fellow supervision. These policies delineate the role, responsibilities and patient care activities and delineate at what level of training a Fellow may write patient care orders, the circumstances under which they may do so, and what entries must be cosigned by Faculty Attendings.

- C. The supervision policies are distributed to and are followed by trainees and supervising medical staff. Compliance with the specialty fellowship supervision policy is monitored by the Program Director.
- D. The Fellow's progress to the next higher level of training is determined annually by the Program Director according to the standards delineated in the list of clinical activities and following verbal or written feedback given by the faculty. The assessment is documented in the Fellow's annual evaluation.
- E. In the following sections, the progression to independent (not directly supervised) practice for Fellows is delineated.

Clinical Responsibilities:

The clinical responsibilities for each resident are based on PGY-level, patient safety, fellow education, severity and complexity of patient illness/condition and available support services. The specific role of each fellow varies with their clinical rotation, experience, duration of clinical training, the patient's illness and the clinical demands placed on the team.

Supervision of Fellows in the Inpatient or Outpatient Setting

Fellows and Attending Staff should inform patients of their roles in the patient's care at every new patient encounter. Faculty Attendings should delegate portions of patient care to Fellows. Fellows should serve in a supervisory role to medical students assigned to their clinics/rotations. Senior fellows should serve in a supervisory role of junior fellows with appropriate patients, provided the junior fellows have demonstrated progress in the training program.

Assignment of Levels of Supervision:

The Fellow is responsible for knowing the limits of his/her scope of authority, and outlined below is the Level of Supervision for specific tasks assigned based on PGY level of training or numbers of competent procedures performed.

The Fellows are expected to evaluate patients in in-patient and out-patient settings, devise treatment plans, write orders and prescriptions and discharge patients from the hospitals or clinics with the concurrence of the faculty attendings. All patient care decisions are ultimately the responsibility of the attending faculty physician.

A Fellow is considered qualified to perform a procedure independently if, in the judgment of the Program Director and as indicated by the list of procedures (see below), the Fellow is competent to perform the procedure safely and effectively.

Competence in the performance of specialty-specific procedures is documented by the responsible Faculty Attending on end-of-rotation evaluation forms provided by the Program Director, by documentation in any semiannual evaluation by the Program Director, and by ascent to PGY-6 or greater. The Faculty Attending of record remains ultimately responsible for all procedures performed by Fellows of any training level. All procedures performed independently by the Fellow must be documented in the medical record or by computer entry and must indicate the Faculty Attending of record. (Note: Billing and coding regulations for reimbursement requires Level-1 supervision regardless of PGY level.)

1. Pulmonary and Critical Care Fellows (IV, V, VI) can take actions and perform procedures listed below with Oversight Supervision.
 - a. Perform history and physical examinations and write orders and prescriptions in all pulmonary and critical care areas.
 - b. After suitable training and evaluation as denoted above they may interpret exercise testing, pulmonary function testing, exercise testing, polysomnography and multiple sleep latency testing, interpretation and calibration of hemodynamic monitoring systems, and management of non-invasive and invasive mechanical ventilation with Oversight Supervision.
 - c. Final interpretation of exercise tests, polysomnography, MSLT, pulmonary function tests, methacholine challenge testing, and multiple sleep latency tests will be by faculty attending.
 - d. After suitable training, minimum number of procedures performed under direct supervision (as listed in table at the end of the document) and evaluation of competence, they may perform: thoracentesis, paracentesis, lumbar puncture, cardioversion, central venous access, arterial line insertion, advanced cardiopulmonary life support with Oversight supervision.
2. Pulmonary and Critical Care Fellows (IV, V, VI) can take actions and perform procedures listed below with indirect but direct supervision available after appropriate number of procedures are performed under direct supervision based on the table (at end of document):
 - a. Small and large bore tube thoracostomies, temporary cardiac pacemaker lead insertion, establishment of airway (including endotracheal intubation), pulmonary artery catheterization, and fiberoptic bronchoscopy on an intubated patient for therapeutic aspiration of mucus plugging.
3. Pulmonary and Critical Care Fellows (IV, V, VI) can take actions and perform procedures listed below under Direct Supervision:
 - a. Elective, non-emergent (see above caveat) flexible fiberoptic bronchoscopy and its associated procedures, percutaneous tracheostomy, cricothyroidotomy, pleural biopsy, and moderate conscious and deep sedation.
4. It is recognized that in the provision of medical care, unanticipated and life-threatening events may occur. The fellow may attempt any of the following procedures normally requiring supervision in a case where death or irreversible loss of function in a patient is imminent, and an appropriate supervisory physician is not immediately available, and to wait for the availability of an appropriate supervisory physician would likely result in death or significant harm. The assistance of more qualified individuals should be requested as soon as practically possible. The appropriate supervising practitioner must be contacted and apprised of the situation as soon as possible.
 - a. Thoracentesis, paracentesis, lumbar puncture, small and large bore tube thoracostomies, cardioversion, temporary cardiac pacemaker lead insertion, establishment of airway (including supraglottic airway, endotracheal intubation and cricothyroidotomy), pulmonary artery catheterization, central venous access, arterial line insertion, advanced cardiopulmonary life support, non-invasive and invasive mechanical ventilation management and emergent fiberoptic bronchoscopy on an intubated patient for therapeutic aspiration of mucus plugging.

Circumstances and events where Fellows must communicate with Faculty Attendings:

Fellows are encouraged to communicate with supervising Faculty Attendings any time that Fellow feels the need to discuss any matter relating to patient-care. The following are circumstances and events where Fellows **must** communicate with supervising Faculty Attendings:

- Encounters with any patient in emergency rooms
- All new patient encounters in intensive care or critical care units or inpatient units
- If requested to do so by other Faculty Attendings in any primary or specialty program
- If specifically requested to do so by patients or family

- If any error or unexpected serious adverse event is encountered at any time
- If any mis-administration of medication dose is encountered
- If the Fellow is uncomfortable with carrying out any aspect of patient care for any reason
- End of life care/treatment

Documentation Requirements:

Faculty attending supervision of care for hospitalized patients must be documented in the inpatient record. All new patient consultations performed by a Fellow must be documented in the medical record or by computer entry, must include the name of the responsible onsite Faculty Attending and must personally evaluate all new patient consultations and provide evidence of his/her concurrence with the assessment, diagnostic and therapeutic plan (usually as an attestation to the Fellow note). All follow-up outpatient consultations performed by Fellows must be documented in the medical record or by computer entry, and must be discussed and seen promptly with the responsible onsite Faculty Attending.

1. Documentation that must be performed by Faculty Attending:

Documentation in writing or by computer record of concurrence with admission history, physical examination, assessment, treatment plan and orders must be accomplished by the Faculty Attending within 24 hours of admission. The Faculty Attending must also document concurrence with major clinical decisions by specific written note in the medical record.

2. Documentation done by Fellow:

Fellows may document patient care and staff supervision by writing consultation notes, progress notes, and/or cosigning notes written by medical students. Faculty Attendings are required to make teaching attestation to Fellows' notes. The Fellow must take liberal discretion to provide documentation as the clinical situation demands. Fellows should assist in documentation of informed consent, and refusal of care.

Faculty Responsibilities:

1. Routinely review fellow's documentation in the medical record.
2. Be attentive to compliance with institutional requirements such as problem lists, medication reconciliation, and additional field defined document priorities.
3. Provide fellows with constructive feedback
 - a. Evaluations:
 - i. The Faculty Attending must provide written evaluation of the Fellow's performance through the New-Innovations on-line evaluation system to the Program Director at the end of each rotation. The faculty are encouraged to also provide verbal and/or written Fellow performance evaluation mid-way through each rotation block. Evaluations should be discussed directly with the Fellow in addition to the written evaluation.
4. Serve as a role model to Fellow in the provision of patient care that demonstrates professionalism and exemplary communication skills.

PGY 4:

1. Expected to become familiar with the role of a consultant in non ICU patients.
2. Will assume more independent responsibility for intensive care unit patients as the year progresses.
3. Is looked upon as a time to gather knowledge to form a very strong foundation in the CORE competencies and the CORE curriculum.
4. By the end of the first year, it is expected that the Fellow will comfortably don the role of a consultant with a good deal of expertise in the subspecialty.
5. In the outpatient setting, the Fellow will be given more responsibility in the interaction and work-up of patients. In the first year of this interaction, the Fellow and faculty member often will interact with patients together in the outpatient arena.
6. Will be mentored to either assume a previous research project or present a research project and work towards approval by the University IRB Committee. There may be a lengthy time to establish the IRB approval if the Fellow is starting a new project so that there will be accommodations for that Fellow to continue throughout the 3 years for completion of the project.

PGY 5:

1. Will assume more responsibility for patient care, in both inpatient and outpatient settings.
2. They will be encouraged to develop a specific interest with regard to Pulmonary and/or Critical Care Medicine.
3. Attend College of Medicine Lecture Series given and open to all house staff and faculty with regard to critical evaluation of the literature and data as well as establishing a research career.
4. Will continue research projects, present a research project, and develop a QI/PS project.
5. In the outpatient setting, the Fellow will be given more responsibility in the interaction and work-up of patients. In the second year of this interaction, the Fellow and faculty member often will interact with patients together in the outpatient arena.

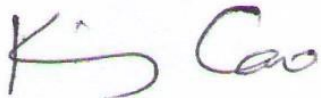
PGY 6:

1. The Pulmonary, Critical Care Medicine Fellow is expected to serve as a true consultant to the other physicians.
2. Will be Board eligible to take the Pulmonary certifying examination. Most of the Fellows do so and therefore become ABIM certified in Pulmonary Diseases before graduating from the program.
3. Expected to be able to speak to peers and serve as an educator to other physicians via presentations at courses and meetings. Training is geared towards encouraging Fellows to establish good reputations for themselves, the type of consultant who will become a major asset to the community and the consulting physicians.
4. By the 3rd year of training, the Fellow will see the patient first, formulate a treatment plan and present the information to the responsible faculty attending. Effort should be made to give the 3rd year Fellow a first-hand experience seeing patients referred by other pulmonologists and patients who have difficult outpatient diagnostic problems.

The fellowship program has a curriculum for providing knowledge and performance competence that includes (procedure training, simulation, number of procedures that need to be completed before obtaining indirect supervision). Fellow may be released for indirect supervision of a procedure that is within the usual scope of practice of pulmonary/critical care physicians, when the fellow has been directly supervised for a number of that procedure sufficient for faculty to assure the fellow's competency in knowledge and skill for independent practice relating to that procedure. In addition, annual decisions about competence are made by the program's clinical competency committee to ensure a successful transition and preparation for the next PGY level. All fellows need to maintain current ACLS training.

Abdominal paracentesis*	5
Thoracentesis*	5
Chest tube placement	10
Arterial line placement*	5
Central line placement*	5
Lumbar Puncture*	3
Establishment of Airway (endotracheal intubation)	10
Fiberoptic flexible bronchoscopy – therapeutic aspiration of tracheobronchial mucus plugging on an intubated patient	10
Cardioversion	3
Temporary Cardiac Pacemaker	3
ACLS	Once receives ACLS certification
Pulmonary Artery Catheter Placement	5

*While no longer required by the American Board of Internal Medicine, most fellows enter already trained to perform these procedures in their internal medicine residencies. If the fellow is deemed competent to perform these procedures by their residency program director they only require indirect supervision.



10/24/18

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Date