

Utilizing Medical Students to Document in the Medical Record

Elizabeth McMurtry, DO, FACEP

Assistant Dean for Clinical Education
and Faculty Development
Pacific Northwest University
of Health Sciences




Disclaimer


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What information would you like about allowing students to document the medical record?



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 No responses received yet. They will appear here...



Which components of the medical record can currently be independently documented by medical students?

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History of present
illness

Review of systems

Past medical, family,
social history

Physical exam


Medical decision
making

When did this change?




Do you currently allow medical students to document complete encounters in the medical record?



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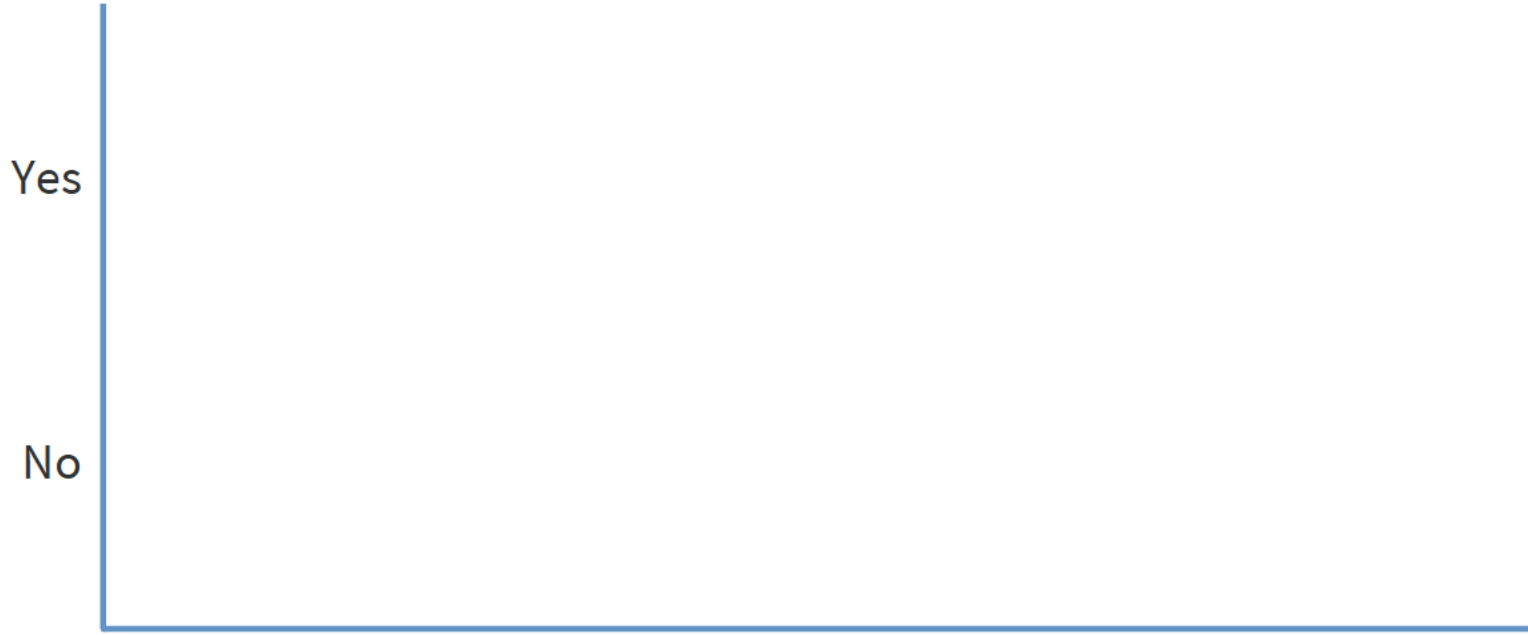
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Why allow students to document in the medical record?

- Enhance student educational experience
- Learn by doing
- Fulfill EPAs
- Be a helper in the workforce
- Participate in preceptor production



New Regulations for Medical Students Documenting in the EMR

Effective January 1, 2018:

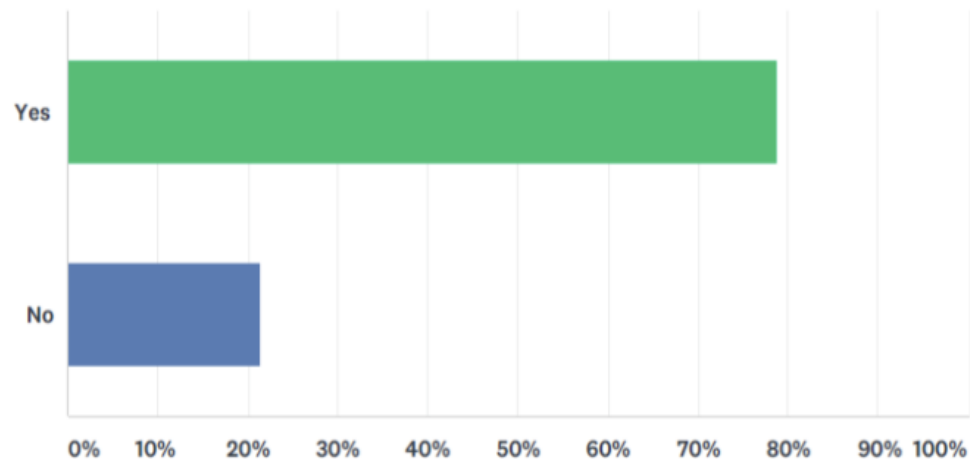
The Centers for Medicare & Medicaid Services (CMS) is revising the Medicare Claims Processing Manual, Chapter 12, Section 100.1.1, to update policy on Evaluation and Management (E/M) documentation to **allow the teaching physician to verify in the medical record any student documentation** of components of E/M services, **rather than re-documenting the work**. Students may document services in the medical record.

However, the teaching physician must verify in the medical record all student documentation or findings, including history, physical exam and/or medical decision making. The **teaching physician must personally perform (or re-perform) the physical exam and medical decision making activities** of the E/M service being billed, but **may verify any student documentation of them** in the medical record, rather than re-documenting this work.

PNWU Survey Results

Q1 Does your facility allow medical students access to the electronic medical record?

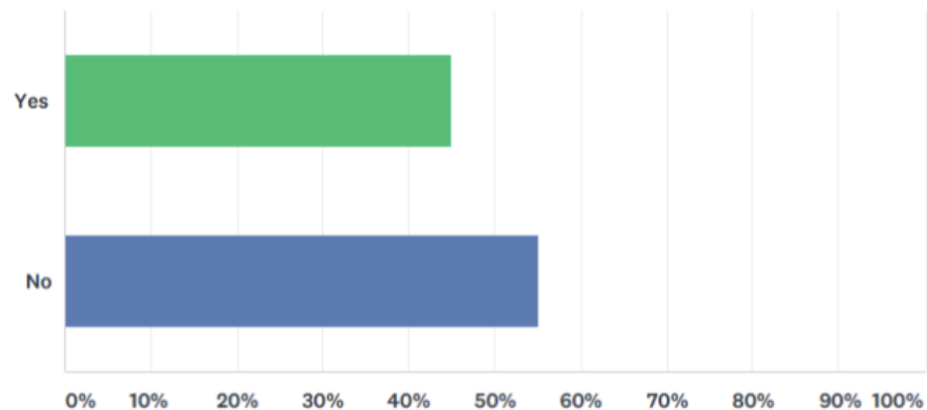
Answered: 80 Skipped: 0



PNWU Survey Results

Q2 Do medical students improve your efficiency when documenting into the medical record?

Answered: 80 Skipped: 0



Models utilizing medical learners for documenting clinical encounters

Student sees patient first and documents encounter...



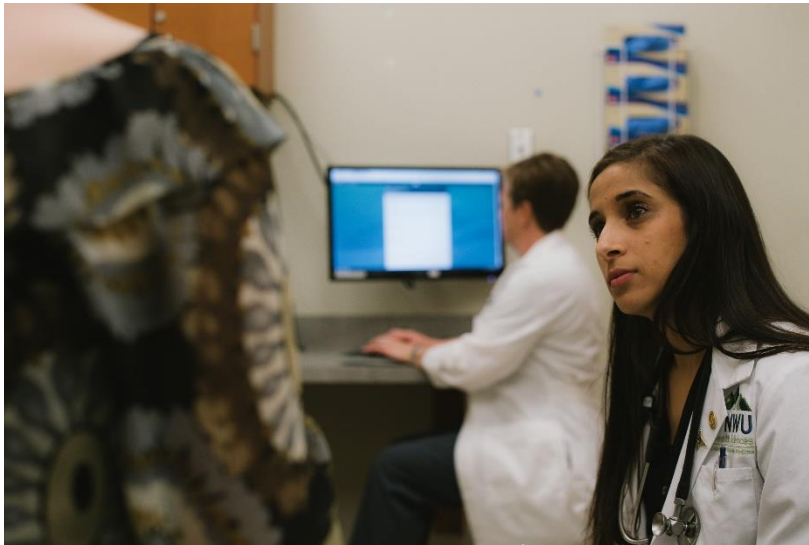
...then discusses with attending



...who performs independent physical exam and medical decision making components and finalizes documentation

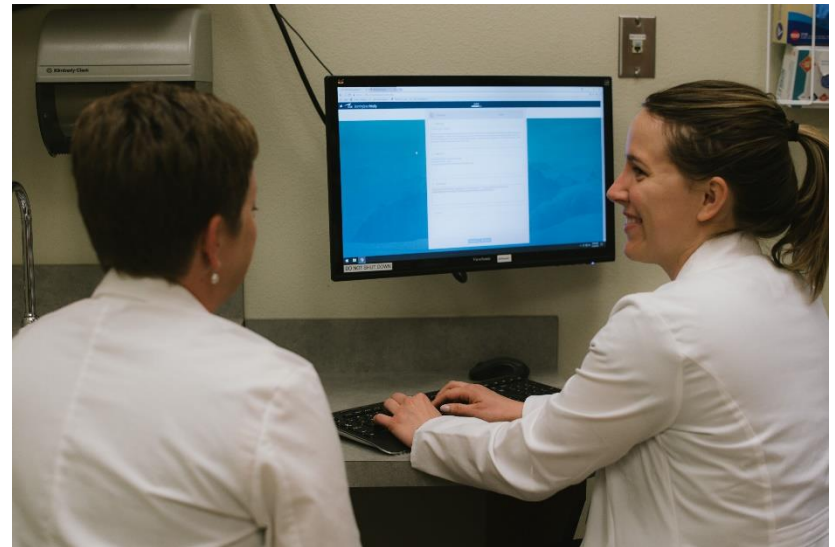


“Scribing Models”

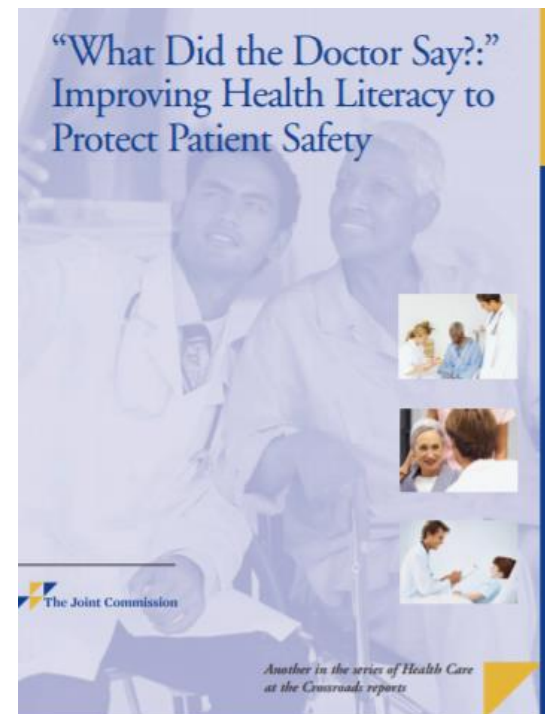
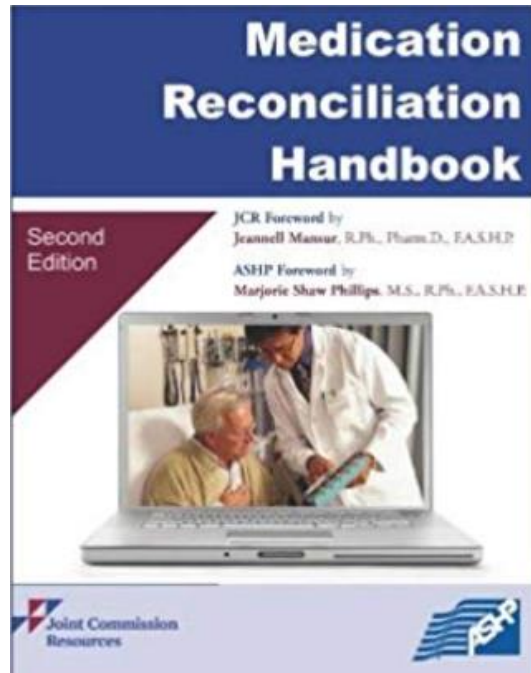


Attending documents while
student interviews and
examines

Student documents while
attending interviews and
examines



How else can students help with computer-based tasks?



Suggested Models for Medical Students Documenting in the EMR

The ideal rotation experience will involve **a combination of models** to maximize student learning while having the student assist the physician in documentation and in the delivery of healthcare.


In addition to entering H&P documentation into the medical record, the physician may ask the student to perform other computer-oriented tasks helpful in patient care:


- Deliver patient education
- Select patient educational handouts
- Look up research articles
- Verify drug dosages
- Check for drug/drug interactions


Which of these three models are you most likely to utilize in your clinical practice?



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Model 1: Medical student sees patient, documents, reports back for discussion

Model 2: Preceptor documents while student interviews and examines

Model 3: Student documents while preceptor interviews and examines



Entrustable Professional Activities for Entering Residency

EPAs are measurable, objective, and observable units of work

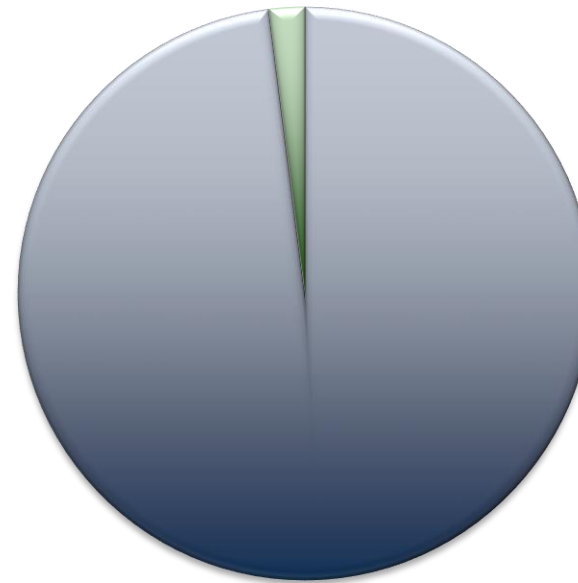
EPAs are tasks that every intern should be able to perform unsupervised from day one



Residency Program Director's Perception of Interns' Proficiency

Interns evaluated at 6 months into their first year were able to accurately document a clinical encounter **without supervision** 98% of the time

EPA 5



■ Proficient ■ Not Proficient ■ ■

Pearlman, R. E., Pawelczak, M., Yacht, A. C., Akbar, S., & Farina, G. A. (2017). Program Director Perceptions of Proficiency in the Core Entrustable Professional Activities. *Journal of Graduate Medical Education*, 9(5), 588-592. doi:10.4300/jgme-d-16-00864.1

EPA 5: Document a Clinical Encounter in the Patient Record

- Provides comprehensive documentation containing important info **without unnecessary details** or redundancies
- Documents and interprets **osteopathic structural findings and procedure note** for OMT
- Provides documentation including **institutionally required elements** (e.g. date, time, signature)
- Creates **legible** handwritten documentation
- Enters documentation in a **timely manner**
- Communicates in bidirectional manner, **soliciting patient preferences, which are recorded** in the note
- Documents **clinical reasoning and interpretation** of results
- Engages in **help-seeking behavior** to fill gaps in knowledge, experience, and skill, enabling development and documentation of management plans
- Demonstrates general understanding of documentation systems leading to opportunities to **engage with others for system improvement**
- Documents one's **roles** in team care activities

Osteopathic Considerations for EPAs

Osteopathic considerations for EPAs designed to

- integrate osteopathic-specific skills and practices
- reinforce osteopathic philosophy
- promote collaboration and allow osteopathic graduates to remain competitive for residency

Osteopathic considerations specific to EPA 5:

- Document an osteopathic structural exam
- Document a procedure note

Developing feedback about EMR documentation

Choose a component from EPA 5 to develop feedback about the student's EMR documentation

- Was there too much or too little detail?
- Was there shared decision making documented?
- Was clinical reasoning and interpretation present and appropriate?
- Did the student ask for help to develop their documentation and management plan?

Developing feedback about EMR documentation

Based on the chosen component:

ASK what the student thinks went well

TELL what you think about what the student describes

ASK what the student will do to improve for the next time

Sample 1

The patient reports gradual, unprovoked increased swelling that started in his ankles and steadily progressed upward to his abdomen over the past 2 months. Swelling is equal in both legs, worse end of day (with dependency) and slightly reduced (about 1/3) in the morning (or if he remains seated during the day with his legs elevated for several hours). Swelling is greater in his feet, ankles, legs and abdomen but less in his thighs. His abdominal swelling started about 1 month after his legs. Patient denies any upper extremity or facial swelling. Patient reports moderate pain/tightness (5 out of 10) associated with the swelling in his legs and abdomen. Two weeks ago Mr. B. reported to his PCP who doubled his Lasix to 80 mg. This reduced the swelling slightly in his legs but not his abdomen...

Sample 1 (continued)

...Associated symptoms include fatigue, weight gain (approximately 5 lbs. in the past 2 months), cough (with minor clear sputum production), dyspnea on exertion, 2-pillow orthopnea, claudication and early satiety. Patient denies diaphoresis, fevers/chills, night sweats, chest pain/pressure, palpitations, syncope, asthma/wheezing, pneumonia, TB, positive PPD, positive CXR, PND, varicose veins, leg/foot ulcers, history or family history of DVT/PE. Patient denies dysphagia, nausea/vomiting, reflux/heartburn, diarrhea, constipation, melena/hematuria, incontinence, dysuria, and hematuria. Patient admits to increased urinary frequency and nocturia associated with diuretic increase. Patient reports similar symptoms during 2 previous exacerbations of his CHF (latest 1 year ago).

Sample 1

Choose a component from EPA 5 to develop feedback about the student's EMR documentation

- Was there too much or too little detail?
- Was there shared decision making documented?
- Was clinical reasoning and interpretation present and appropriate?
- Did the student ask for help to develop their documentation and management plan?

Sample 1

Based on the chosen component:

ASK what the student thinks went well

TELL what you think about what the student describes

ASK what the student will do to improve for the next time

Sample 2

Assessment:

Pt has a new-onset painful rash in a dermatomal distribution. This is most likely secondary to herpes zoster because of the location, distribution, and associated pain. A less likely possibility is contact dermatitis, given her recent gardening. She may also have a cellulitis, but the lack of a fever goes against this.

Plan:

Continue to use Tylenol for pain

Inform patient that pain may continue beyond resolution of the rash

Patient should return to clinic if the pain becomes more severe or if fever develops

Sample 2

Choose a component from EPA 5 to develop feedback about the student's EMR documentation

- Was there too much or too little detail?
- Was there shared decision making documented?
- Was clinical reasoning and interpretation present and appropriate?
- Did the student ask for help to develop their documentation and management plan?

Sample 2

Based on the chosen component:

ASK what the student thinks went well

TELL what you think about what the student describes


ASK what the student will do to improve for the next time

Suggested Physician Verification Template


The following template is one suggestion for the physician verification note required to complete the student's documentation:


“I performed an independent physical exam, I actively participated in the medical decision making components of this encounter, and I confirm (or correct) the details, findings, and medical decision making points in the student's note.”


Do you now feel medical students can improve your efficiency documenting clinical encounters?

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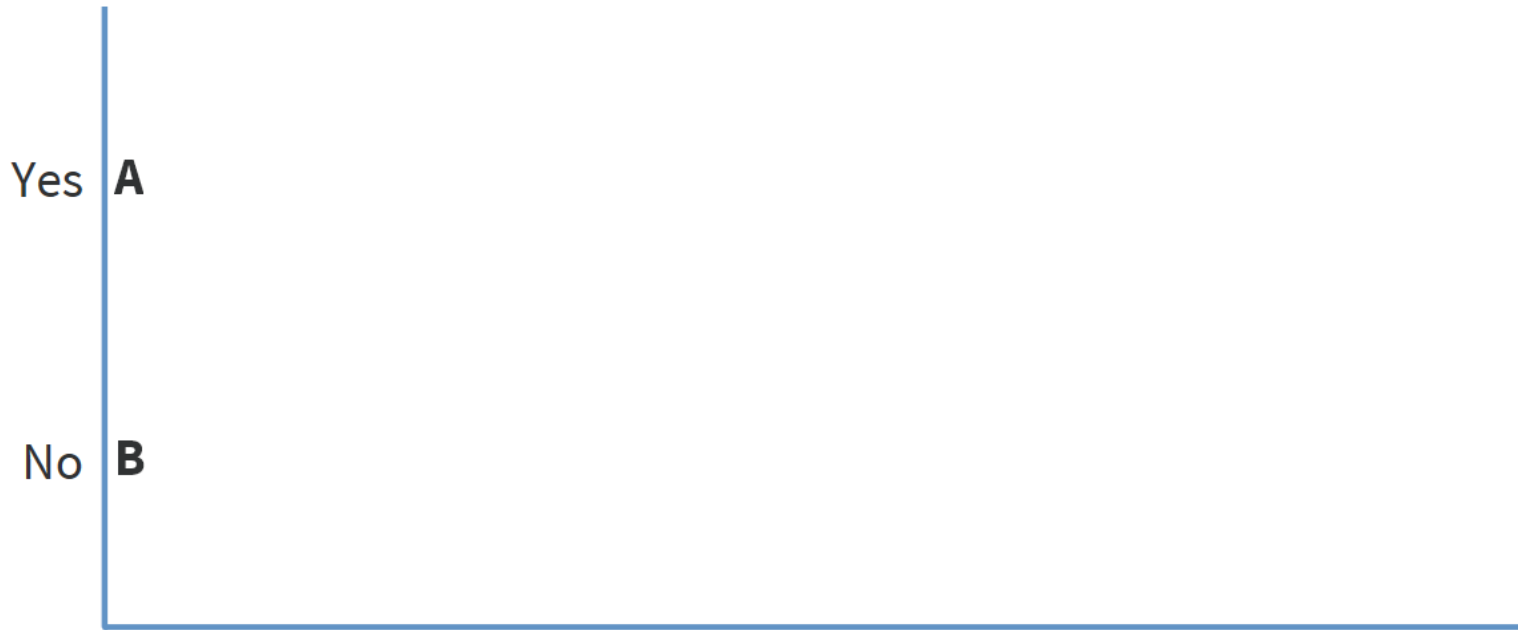
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Allowing students to document in the EMR

Fulfills learning goals

Enhances student experiences

Improves preceptor efficiency

For questions or comments,
please see
Elizabeth McMurtry, DO
or contact at
emcmurtry@pnwu.edu