



# Documenting in the EHR as a Medical Student

# Purpose of this Training

- This presentation provides medical students with guidance on:
  - Rules for medical students to follow when documenting in the EHR
  - Where students can help with documentation
  - Suggested workflow students and supervising residents, attendings, and community physician preceptors
- In this presentation, “teaching physician” refers to supervising residents, attendings, and community physician preceptors

# A few notes to start

- This applies to work you will be doing with both residents and attending physicians who are teaching you
- What you will learn in this presentation applies to both inpatient and outpatient settings at UNC including the Physicians Network (PN) practices. It does not always apply to settings outside the UNC system. These settings may have different policies related to student documentation

# What students can do in the ambulatory setting (with permission of the attending or resident)

- **Pend orders:** medical students may pend orders to be signed by an authorizing physician
- **Problem List and Medication History:** The medical student may update the patient's medication history and problem list
- **Transcribing External Test Results:** The medical student may view and transcribe external test results in the "Enter/Edit Results" activity section of Epic@UNC to document a patient's outside health maintenance records
- **Schedule:** The medical student may update visit planning comments in the patient's schedule
- **After Visit Summary:** Medical students may participate in creating the patient "After Visit Summary"



# What students can do in the inpatient setting (with permission of the attending or resident)

- **Pend orders:** medical students may pend orders to be signed by an authorizing physician
- **Facilitate Care Team Communication:** Within the “Summary” activity section of Epic@UNC, the medical student may update their patient’s Plan Note
- **Problem List:** Medical Students may update their patient’s problem list
- **Contribute to the Hospital Course:** Within the “Discharge” activity tab, the medical student may contribute to the patient’s hospital course and keep this updated for their patients
- **Medication History:** Within Epic@UNC, the medical student may use navigators to pend medication reconciliation for Admissions and Discharges on their inpatients



# Make Meaningful Contributions

- Medical students always want to feel helpful and needed by the medical team
- By writing the note that will be a part of the legal medical record, you will be making an authentic contribution to the team
- The attending or resident will appreciate your contributions to patient care
- Helping with writing your patients' notes in the EHR may free up the attending or resident's time and allow for more teaching and education



## Important things to remember

- You must present your findings from the history, physical exam, and assessment/plan in the physical presence of the attending or resident. Ideally the patient should be present during the presentation as well
- The attending or resident must verify in the medical record all student documentation or findings including the history, the physical exam, and/or medical decision making
- The attending or resident must personally perform or re-perform the physical exam and medical decision making activities
- The attending and resident must review and edit as necessary your note and attest that the attending or resident verified the information in the note



Step 1:  
Student obtains  
H&P from patient



Step 2: Student presents  
to the attending or  
resident. The attending or  
resident verifies



Step 3: Student  
documents the encounter.  
The attending or resident  
edits the note so that only  
information verified is  
included and confirms that  
the note is verified.  
Student reads final note  
(for feedback)





## Other considerations

- Take documentation seriously. The attending or resident will review and edit your notes but you are still accountable for your documentation as a student
- Communicate with the teaching physician if you have ANY question regarding a patient's history, physical exam, plan or other aspects of the visit
- Ask for feedback on notes you complete



# Example – Clinical Case 1

Ambulatory Clinic Visit



## Chart Review & Patient Visit

- The student is assigned to see a patient in clinic presenting for an acute care visit with chief complaint of shortness of breath
- The student reviews relevant information in the chart before entering the patient's room
- The student enters the room to interview a patient and obtains a history relevant to the patient's complaint of shortness of breath. She performs a physical exam. She commits to a differential and management plan



# Patient Presentation

- She presents the patient's history and physical exam, along with her assessment and plan, **in the physical presence** of the teaching physician (ideally in front of the patient)
- The teaching physician makes it clear to the patient that the student is still learning and gives her feedback on her presentation
- The teaching physician asks follow up questions and repeats the physical exam with the student
- Now that the teaching physician has confirmed the diagnosis, the student and the attending discuss their plan for treatment with the patient

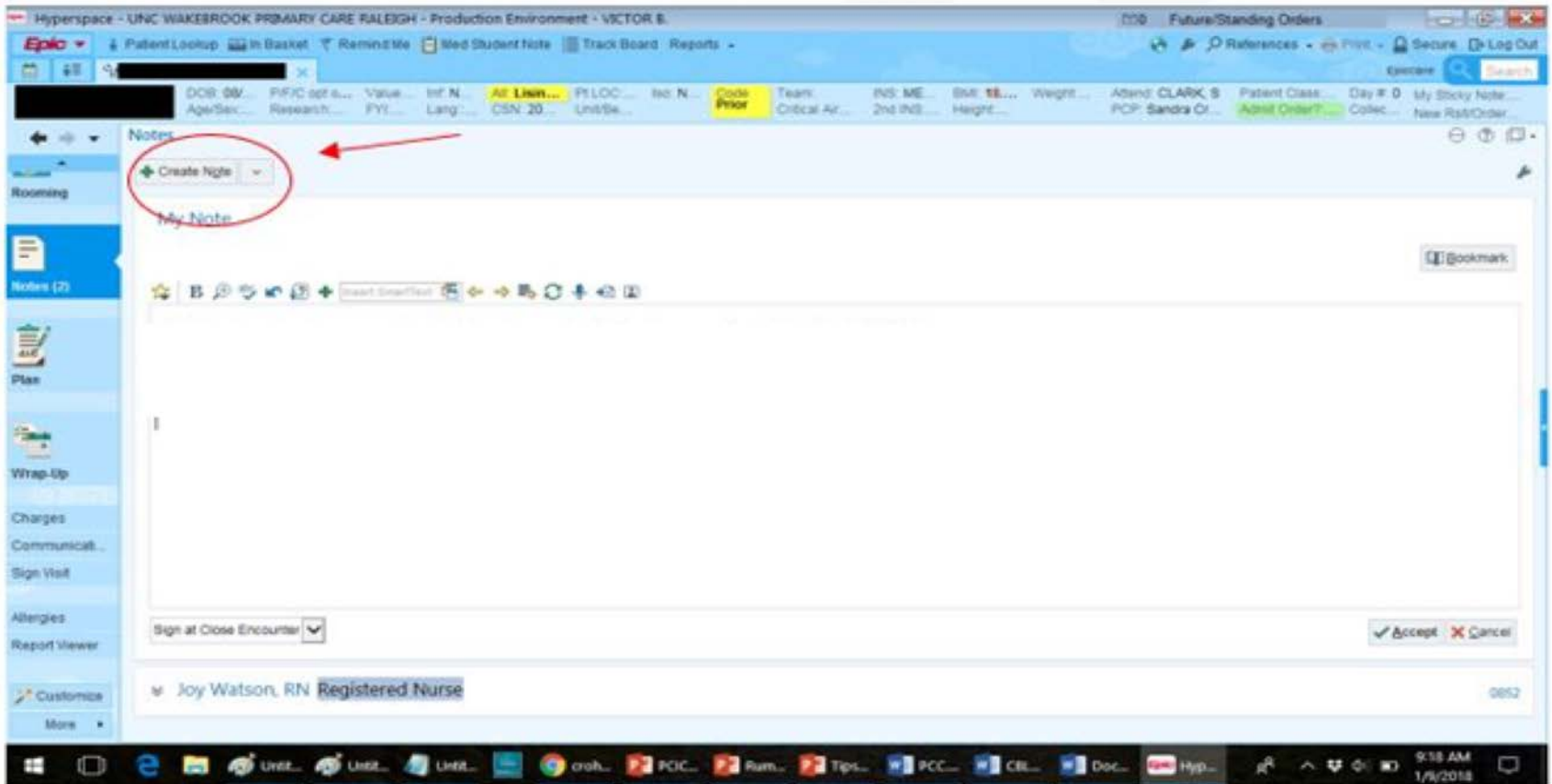


## Student/Faculty Workflow

- Student pends orders that he/she determines may be needed and fills out the after visit summary
- Student does teach back with patient on attending/student agreed upon plan
- Attending signs orders while student does teachback
- The student documents the history, physical exam, differential, and plan either while the attending is seeing another patient or later in the day.

# Student Note

- The student writes the patient's note, signs name on the note, and clicks accept when finished





# Teaching Physician Workflow

- The teaching physician opens the note, clicks edit, and then uses Make Me the Author (MMTA) function

Hyperspace - UNC WAKEBROOK PRIMARY CARE RALEIGH - Production Environment - BEAT S.

Epic Patient Lookup In Basket Track Board Patient Station Telephone Call Reports Orders Only Remind Me PT Outreach Appts

Iso: None Code **Prior** Team: Critical Airway? ... BMI: 18.04 kg... My Sticky Note: ↑  
INS: MEDICARE Height: 182.9... PCP: Clark, Sandra Covi  
2nd INS: NONE Weight: 60.3 k... **Health Maintenance**  
MyChart: Active

Notes

Synopsis

Chart Review

Care Everywh...

Rooming

+ Create Note

Sandra Covi Clark, MD Physician Signed

Edit Attest

Expand All Collapse All

UNC WAKEBROOK PRIMARY CARE CLINIC NOTE



## Teaching Physician Workflow

- The teaching physician carefully reads the note and verifies the information
- The teaching physician edits the note to include only information verified by him
- The teaching physician uses the attestation button and chooses “Medical student documented the encounter and I have verified the accuracy of the note”
- The note now appears as the note of the physician. Contributions of the student can be seen by using the “hover” function





# Example – Clinical Case 2

Inpatient Hospital Experience



# Chart Review, Patient Visit & Presentation

- A medical student visits his patient in the morning before rounds, gets a history and performs a physical exam
- The medical student presents the patient at the bedside. The teaching physician gets some additional details about the chest pain and examines the patient to confirm the physical exam findings presented by the medical student
- Together they discuss the plan for the day



# Student Workflow

- The student selects the appropriate document type, in this case “Progress Note”

The screenshot shows the Epic EMR interface for a patient named 'GABRIELA'. The 'Notes' section is active, displaying a list of notes. A dropdown menu is open, showing the following categories and items:

Category	Item	Number
H&P	H&P	4
Labor Notes	Labor Notes	1000053
Lactation Note	Lactation Note	42
Medical Student	Medical Student	1000009
NC Medicaid FL2	NC Medicaid FL2	3043312
Non-Billable H&P	Non-Billable H&P	3040094
Nursing Notes	Nursing Notes	1000113
OB Triage	OB Triage	3041918
Op Note	Op Note	1000004
OB Nursing	OB Nursing	10
Patient Care Conference	Patient Care Conference	1000002
Plan of Care	Plan of Care	1000001
Procedures	Procedures	1
Progress Note - Non-Provider	Progress Note - Non-Provider	1000051
Resistant Assessment	Resistant Assessment	3040051
Solution Documentation	Solution Documentation	10001
Significant Event	Significant Event	1000017
SMP Facility Form (Non-NC Medicaid)	SMP Facility Form (Non-NC Medicaid)	3043311
Transition	Transition	1000011
Treatment Plan	Treatment Plan	1000003

The 'Progress Note - Non-Provider' option is highlighted in blue. A red circle highlights the 'Progress Notes' option in the dropdown menu.



## Student Workflow

- The student writes the progress note including the history, physical exam, other relevant parts of the hospital course, and management plan
- After completing the note, the student “shares” the note with the teaching physician



- Once the note has been shared, all others using Epic will have access to view the note in the “Incomplete” tab



# Teaching Physician Workflow

- The teaching physician goes to the incomplete note tab and opens the note.
- She reviews and edits the note. At this point the note will still appear to be a medical student note.

The screenshot displays the UNC EHR interface. At the top, the patient's name is redacted. The 'Notes' section is active, showing a list of notes. The selected note is a 'Daily Progress Note' by 'Gabriela Reed', a Medical Student, dated 01/10/2018. The note content includes:

- ASSESSMENT PLAN:**
- Principal Problem:** Alcohol use disorder, severe, dependence (RAF-HCC)
- Active Problems:** Essential Hypertension (RAF-HCC)
- Hypertension:** continue home hydrochlorothiazide 25mg daily, continue home diltiazem 300mg
- Depression:** Continue home fluoxetine 20mg every other day

The note also mentions 'alcohol withdrawal, who presents for withdrawal from alcohol' and 'of complicated withdrawal or seizures. OIWA-AJ of 10 this morning. Plan to discharge to inpatient rehab'.

# Post Module Assessment

You have completed your online training; however, you are not done yet!

Once you return to the Learner tab, please follow the steps below for accessing the *Required Assessment* for full completion of your training:

- 1) Search for, "**Medical Student Application Phase**" in the search field located in the top right side of your Self home dashboard in LMS.
- 2) Find the Assessment within the Search Results in LMS and choose **Register** from the Select dropdown menu to the right of the activity.
- 3) Select the button in the bottom right of the NEXT screen to register for the **Medical Student Application Phase Assessment**.
- 4) Click the button on the top right of the NEXT screen to begin your Assessment.

Contact [Epictraining@unchealth.unc.edu](mailto:Epictraining@unchealth.unc.edu), if you encounter any problems accessing the assessment.