Maximizing Medical Student Documentation
In an era of new CMS Medical Student Documentation Rules

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Goals of session

• Learn where you are compared to your peers on recent national survey
• Learn about barriers from this national survey and compare to your own institutional barriers
• Hear potential solutions to barriers from four different perspectives
• Discuss solutions to common barriers
• With a partner, develop your own plan for improving maximizing student documentation
You are not alone... Recent CDIM survey
(unpublished data)

• Response rate 82.4% (110/134)
Are medical students at your institution allowed to **fully engage** in documentation activities on behalf of an attending physician, provided that the teaching attending verifies the content of the note? (N=110)

- Yes: 34.6% (n=38)
- No: 19.1% (n=21)
- Not yet, discussions under way: 14.6% (n=16)
- Other: 2.7% (n=3)
- Don't know: 29.1% (n=32)
Respondent barriers (implementers and non-implementers)

- Compliance especially for those who are trying to implement
- Workflows/attestations
- Faculty or resident development
- Affiliations
- Certain settings/stages in training
- Awaiting Rule Clarification
Can a resident attest student note to bill?

• Yes if there is independent performance of the history and physical by the resident - 34.4% (11/32)
• Yes, if the resident performs direct observation of history taking and physical exam by the student 31.3% (10/32)
• No, 34.4% (11/32)

• Suggest huge variation in process likely due to compliance issues
If resident can attest note (N=21), can attending then attest that note to be the note of record?

• 100% of respondents (20/21) said yes
• 1/21 did not respond.

This seems to suggest a leverage point. If resident attests note, than attending can do it, too. Getting to resident attestation leads to little variation in the attending process.
What about you?

• Barriers?
Policies current in place for implementers...

- Guidelines for residents on medical student documentation-71.0%
- Limits on the number of notes a student can write-32.3%
- Restrictions for whom students can write notes-16.1%
- Compliance requirements for when a student’s note can be used for billing-61.3%
- Faculty development on appropriate documentation practices with a student-61.3%
- Educational guidelines for medical student documentation-74.2%
- None-3.1%
- Don’t let perfect be the enemy of the good!!
If the rule were or is enacted at their SOM:

• 48.1% of respondents believe recruitment/retention of ambulatory preceptors
• 67.9% of respondents believe satisfaction of preceptors for ambulatory rotations
• 25.3% of respondent believe recruitment/retention of inpatient preceptors
• 51.4% of respondents believe that satisfaction of inpatient preceptors

Would be greatly or somewhat increased
Food for thought:

• Residents write bad notes and so do students assigned to them.
• How should faculty evaluate notes?
• EMR companies need to make this easier
• Should they be taught to write to bill or to communicate?
• Generational issues-new attendings have never used student notes
Sharing solutions from our institutions

**U of Wisconsin:** Compliance

**UNC:** Faculty development/workflow

**UAB:** RAT/resident development

**U of Chicago:** Service vs. education

**ALL:** EHR – variety, training, limited student access
University of Wisconsin-
Our Journey related to work With Compliance
University of Wisconsin-Tips for working with Compliance

Find your allies
Identify your compliance officers/team
Build a relationship
Understand their concerns/perspective
Educate them about medical student education
Connect them with others (preferentially who share your MAC)
Work to make their job easier

Provide them with samples from other institutions
UNC-Faculty development, workflow, and attestations

- Expectation that students are writing notes that matter
- Videos at med.unc.edu/teachingskills
- Emails at the start of each rotation outlining the rules and suggested workflows (inpatient vs outpatient) to attendings and residents
- Direct conversations with hospitalists
- Faculty development dinners and one-on-one feedback after mid course FB sessions if students report NOT writing notes for faculty either inpatient hospitalists or outpatient
Sample outpatient workflow

• 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.
• 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.
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)
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 teach back

• The student documents the history, physical exam, differential, and plan either while the attending is seeing another patient or later in the day.
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
University of Alabama-Birmingham

1. Clerkship directors & me (residency PD, VC-E)
2. Compliance officer
   Vice Chair clinical
3. Billing office (told, didn’t ask)
4. Chair and faculty communication

Pilot

- 6 months
- Alts only
- General Medicine services
  - Email each month to faculty starting service
  - Brief educational summary (1-pager)
Tips for success

- Compliance officer supportive
- Attestation perfected
- Start small, go slow
- Make life easier for faculty and residents, not more confusing
IV. CCRC Guidelines

a. The primary purpose of students completing patient documentation is for their education, not for completing necessary documentation services.

b. Students will only be expected to document notes on patients with whose care they are intimately involved (patients they are following and assigned i.e. they should not be used as scribes).

c. Students should not be expected to craft notes that satisfy specific billing requirements, but rather, notes that are of high quality for patient care purposes and communication.

d. The attending physician will have the primary responsibility for the content, accuracy, and completeness of the documentation.

e. Whether or not residents also complete patient documentation independent of student documentation, should be determined by the specific residency program in conjunction with the clerkship director in that specialty.

f. In ambulatory settings, students should not be expected to complete documentation outside of the allotted clinic hours. This is to allow time for studying outside of clinical time.

g. In ambulatory settings, students should not necessarily be expected to complete documentation on each patient they see. A goal of one to four notes per half day is reasonable dependent on the setting and their level of experience. Clerkship directors will provide more specific guidelines to their ambulatory faculty.

h. When residents directly supervise and observe students performing evaluations that they will use for documentation, students should lead the history-taking and physical exam. It should not be a shadowing experience.

V. Next Steps and Faculty Development
University of Chicago-Service versus Education

- Positive Educational implications for students thus far
- Note feedback has increased
- Ambulatory faculty giving too many notes at first
- Constant reminders needed for residents
- Plans to look at impact on amount of notes written and nighttime note writing (pajama time)
Other-ALL Comment

• Stage of learner
• Different campuses/settings
• EMR
Pair up and work on action plan

• Give hand outs