

Teaching using an EHR

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Use the EHR to optimize student learning

1. Enhance EHR-specific communication skills
2. Increase “just in time” learning for students and patients
3. Ability to improve a students’ clinical performance

Enhance EHR-specific Doctor-Patient Communication

Doctor-Patient- Computer triangle

Students should introduce themselves to the patient BEFORE turning to the computer

2. Start with the patients concerns
3. Adjust the screen so that the patient can see it easily (point to the screen)
4. Adjust their chair to maintain good eye contact with the patient (sign-posting, students should alert patients if typing for extended periods >30 seconds)
5. Integrate typing around patients needs
6. Explain to the patient what you are doing as you are doing it

- Picture of ideal triangle and poor layout

Increase “Just in Time” Learning

Clinical Decision Support Systems

Reference materials

- Clinical alert system

Examples

- Dyna med, Up to Date, 5 Minute CC, PEPID, ISABEL, Google, Epocrates, MD Consult, med calculators, ejournals, Cochrane reviews
- Drug-drug, drug-allergy and drug-diagnosis interactions

Increase “Just in Time” Learning

Clinical Decision Support Systems

- Drug dosing or prescribing assistance
- Preventive care reminders

Examples

- Renal dosing, age/wt dosing, eprescribing
- Vaccinations, cancer screens, lipid/diabetes screen, USPSTF recommendations

Increase “Just in Time” Learning

Clinical Decision Support Systems

- Chronic disease management reminders

Examples

- Diabetic foot and eye exams

Use the EHR to Improve Students' Clinical Performance

Electronic notes are legible

Easily reviewed by the preceptor

- They can be edited in real time in response to feedback

- Use EHR to print medication lists and laboratory results, vital sign graphs to give to the patient

Most prevalent concerns leading to restricting medical student notes in EMRs relate to:

1. Billing issues
2. Problems with the requirement of an attending co-signature
3. Theoretical concern of increased medical liability
4. Inability for EHR to allow student documentation

Worries about using EHRs in teaching

EHRs bypass the need for trainees to synthesize clinical information

- An important component of medical teaching is the ability to synthesize symptoms, signs, and laboratory results into a coherent story that allows for accurate and efficient medical care—a skill refined by presenting cases
- Transforming patient-specific details into abstract terms (“problem representation”) is a critical part of medical education

Worries about using EHRs in teaching

EHR as distractor

- Heads are buried in computer screens documenting lessening opportunity for interaction
- Attending is distracted by computer screen as student presents

- Video

Copy and Paste

- The pervasiveness of copy and paste within the EHR has been the topic of much debate, since it tends to perpetuate error and inflate volume without corresponding increases in content

Just in time is not good enough

Learning opportunities languish in unopened “tabs”
or deep within the branches of chart navigation “trees”

Challenge

How best can students learn the multiplicity of electronic templates and software-mandated work flows while simultaneously attempting to develop their patient-centered care skills (eg, establishing and sustaining rapport, eliciting the patient's agenda, active listening)?

Treat the Patient, Not the CT Scan

Abraham Verghese NYT Feb 26 2011

- “This computer record creates what I call an iPatient—this iPatient threatens to become the real focus of our attention, while the real patient often feels neglected, a mere placeholder for the virtual record.”

Keys to maximizing the EHR in teaching

1. Faculty should actively avoid referring to source data while evaluating clinical presentations by medical students and trainees (don't peek at EHR prior to case presentation)
2. Encourage students to avoid burying their heads in the computer screen
3. Ban copying and pasting
4. Encourage student to check for lab and radiology results rather than waiting for results to return electronically

Remember the basics of EHR communication skills

- 1. Introducing the EHR into the office encounter
- 2. Adjusting the room's geography to form a physician-patient-computer triad
- 3. Sign-posting to indicate periods of typing or reviewing the EHR for longer than 30 seconds
- 4. Sharing data with patients on the EHR screen.

Education Deans Attitudes Towards Student Documentation

- Acad Med. 2010;85:1440–1444. Friedman et al
Survey of 126 education deans at US allopathic medical schools
- 63% response rate
- 90% believed medical student notes belonged in the medical records but only 42% had a policy regarding this
- 93% indicated that without student notes, student education would be negatively affected

Electronic health records in outpatient clinics: Perspectives of third year medical students

Emran Rouf, Heidi S Chumley and Alison E Dobbie

BMC Medical Education 2008, 8:13

Most students (72%) reported asking more history questions due to EHR prompts

- 39% ordered more clinical preventive services. Most students (69%) reported that the EHR improved their documentation
- 39% of students responded that they received more feedback on their EHR notes compared to paper chart notes
- Only 64% of students were satisfied with the doctor-patient communication with the EHR, and 48% stated they spent less time looking at the patient

Compliance issues around the use of an EHR by a student

- **Medicare does not pay for any services furnished by a medical student.**
- **Medicare has promulgated the following rules related to medical students:**

Use of A Student's Contributions to a Service

Any contribution and participation of a student to the performance of a billable service **must be performed in the physical presence of a teaching physician or resident in a service that meets teaching physician billing requirements** (other than the review of systems [ROS] and/or past/family and/or social history [PFSH], which are taken as part of an E/M service and are not separately billable).

Student documentation

Students may document services in the medical record; however, the teaching physician may only refer to the student's documentation of an E/M service that is related to the ROS and /or PFSH. The teaching physician may not refer to a student's documentation of physical examination findings or medical decision making in his or her personal note. If the student documents E/M services, the teaching physician must verify and re-document the physical examination and the medical decision making activities of the services.

- Elements of medical student documentation that must be re-documented by a resident/provider include the history of the present illness, the physical exam, and medical decision making.**

Identified risks in an EHR

- Intentional use of medical student documentation that is not —re-documented by the teaching physician or resident (in accordance with Medicare rules) in support of a bill submitted to Medicare for Part B services **may be considered by the Federal government to be fraud and abuse and may lead to allegations of False Claims Act violations.**

Medical students as scribes

- Any policy on the use of scribes should consider that scribes may create substantial compliance risks

CMS GUIDELINES ON THE USE OF SCRIBES WITH EVALUATION & MANAGEMENT SERVICES

Many providers of Medicare services utilize scribes to assist with everyday documentation. There are various reasons why a provider may benefit from using a scribe, such as efficiency, legibility and the additional time to focus on patient care.

The Centers for Medicare & Medicaid Services (CMS) offered the following guidance to contractors when reviewing evaluation and management services when documented by scribes in the medical record.

If ancillary staff is present while the provider is gathering further information related to the patient's visit (e.g., the three key components), he/she may document (scribe) what is dictated and performed by the physician or NPP

The provider needs to review the information as it is written, documented, recorded or scribed. The provider also needs to write a notation that they reviewed the documentation for accuracy (add to it if supplemental information is needed) and sign his/her name.

The name of the scribe must be identified in the medical records. Note that although not required, the date of the signature should be noted.

Ancillary staff does not need to be employed by the physician (e.g., hospital employee) in order to fill the 'scribe' role

Scribe policy Washington U St. Louis

- *Can you provide some examples of what is and is not appropriate under this policy?*

Appropriate utilization of scribes:

A medical student who only writes down what the physician says during the assessment, observing and learning, but not touching the patient, and not documenting his/her own findings.

Inappropriate utilization of scribes:

- A medical student evaluates the patient with the attending physician and the medical student documents the service. The physician edits, corrects and signs the note. This does not represent a scribed service. (*Note: this practice is also not allowed under the teaching physician rules, see MCM 15016*)

References:

1. Guidelines for Teaching Physicians, Interns, and Residents, July, 2008, Medicare Learning Network, Center for Medicare and Medicaid Services, Department of Health and Human Services.
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4. Peled JU, PLoS Med 6(5): e1000069.
5. Rouf E, BMC Medical Education 2008, 8:13
6. Keenan CR, Academic Psychiatry 2006; 30:522–527