BEST PRACTICES

SEEING OPPORTUNITY WHERE THERE ONCE WAS CHALLENGE: UNIFYING THE PURPOSE OF DOCUMENTATION FOR EDUCATION AND REIMBURSEMENT

Mary E. Lacy, MD, FACP; Lida Fatemi, MD, MPH; Justin Roesch, MD, FACP

Dr. Lacy (melacy@salud.unm.edu) is an assistant professor of internal medicine at the University of New Mexico and is the associate director for the Internal Medicine Clerkship. Dr. Fatemi (lfatemi@salud.unm.edu) is an assistant professor of internal medicine at the University of New Mexico and Clinical Operations faculty leader and director of clinical documentation for the Department of Internal Medicine. Dr. Roesch (jroesch@salud.unm.edu) is an assistant professor of internal medicine at the University of New Mexico, assistant director for Assessment and Learning at the School of Medicine, cochair for SGIM Educators of Medical Students Interest Group, and an associate editor for the SGIM Forum.

With the advent of retroactive reimbursement and its necessary dependence upon provider documentation, clinician educators have often found themselves at an awkward crossroads during rounds. Students may present cogent and sensical problems, like bacterial meningitis presenting with altered mental status, only to have the attending retort, "Well, technically we have to document it as metabolic encephalopathy due to meningitis..." Much to the chagrin of students and residents, this dialogue is a microcosm illustrating the convoluted dynamic between documentation and practice. Larry Weed's creation of the SOAP format in the 1970s was meant to serve as a scientific document and memory aid to help the clinician organize data and reflect their critical thinking. Simultaneously, the SOAP format afforded the clinician a concise way of portraying the illness trajectory and management over time. Eventually, insurance companies and Centers for Medicare and Medicaid Service (CMS) started using the SOAP note as a tool for generating reimbursements, thus subtly but irrevocably transmuting the purpose and content of the medical record. In conjunction with the advent of electronic health records (EHRs), documentation requirements for billing have substantially increased the physician's time spent on the computer rather than with the patient, leaving even less time for education and ultimately contributing to physician burnout and suboptimal patient experience.[1] It is not surprising then that a palpable tension has resulted from the dichotomous roles documentation is presently felt to serve.

Clinical documentation supports effective communication and provider collaboration, can act as an aid to facilitate processing of information, and is used for coding and reimbursement.[2] Despite this importance, it is often relegated to the absent curriculum of undergraduate medical education and most post-graduate training programs. Within this void, trainees are expected to develop a secondary lexicon for medical documentation, which at times is seemingly at odds with or even antithetical to terminology described in texts or medical literature. Until recently, this bore little consequence for most students, as notes were often exercises in documentation but held little practical relevance. This was in part due to prior CMS guidelines that led to a misalignment between billing requirements and the goals of the educational system to engage students in the documentation process. In February 2018, CMS changed its policy, allowing medical student notes to count for billing.[3] This change did not occur in a vacuum. For many years, multiple national medical entities, including the Alliance for Clinical Education (ACE), the American College of Physicians (ACP), and the Society of Teachers of Family Medicine have strongly advocated for medical students to be granted access to the EHR and subsequently to have the ability to document clinical encounters which may be used for billing purposes.[4-6] New CMS guidelines no longer require clinicians to re-document large portions of a note which will reduce the burden on clinicians and improve preceptor recruitment. In many regions and settings, the onerous nature of redoubling documentation contributed to a shortage of high-quality clerkship preceptors. In fact, a summit held in 2016 to address a shortage of family medicine preceptors identi-

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fied a primary tactic to address this problem should be working with CMS to revise student documentation guidelines.[6] The 2018 CMS updates are expected to significantly decrease the administrative workload on faculty which will increase the number of physicians accepting medical students. A pilot study at the University of New Mexico (UNM) implemented new documentation requirements allowing for billing of student notes within both clinic and inpatient ward encounters during the Family & Community Medicine Clerkship.

Faculty were queried about their perceptions of the experience and the overwhelming response was favorable:

- **"I didn't have to re-write SOAP notes! Still had to tweak the notes like I would for an intern, but our Sub-I was pretty good at documentation. Huge time savings."**
- **"Less data entry. More of a teaching opportunity as I reviewed the note with them."**
- **"They seem more directly involved/engaged in patient care as they are the ones writing the actual note."**

The Alliance for Clinical Education's (ACE) charge to allow students to document within the EHR was leveled with the intention of enhancing a student's contribution to the medical team while also promoting skill development through feedback to help focus content and clinical reasoning.[4] In the same pilot study at UNM, a student survey after the experience noted "*I felt being able to send notes and have them used for billing purposes gave me a larger sense of belonging on the team and felt my contributions were more meaningful.* " Another student responded, "*Sending endless notes into space that were never read and never looked at again was fatiguing.* " Ultimately, all surveyed students reported agreement with the statement that "this process change helped me to be integrated into the care delivery team" (A. Rankin, MD, unpublished data, 2018).

The results of this pilot are promising for students and faculty alike. In particular, faculty were still afforded the opportunity to provide feedback on students' clinical reasoning processes, including the prioritization and interpretation of clinical findings to support diagnostic considerations. Understanding this potential value, medical educators should maintain vigilance that billing requirements can be formulaic and offer little room for the ambiguity that exists in practice. Moreover, there is plausible risk of placing educational goals in greater tension with billing, and for the student role to be reduced to scribe, whose primary purpose is to complete billable documentation. It is paramount that we contemplate these dynamic benefits and risks if we are to achieve the goal of integrating medical education and documentation for billing.

Many institutions are trying to figure out how to implement these recent CMS guidelines. While some aspects related to their use remain under debate—such as whether exams by students need to be directly supervised or simply repeated—these guidelines present an opportunity for the medical education system to appraise and revamp the current process on education related to documentation. Medical education is approaching a crossroads wherein institutions will need to contemplate whether teaching documentation standards can be neatly integrated into the standing curriculum, whether it warrants the creation of an entirely new curriculum, or temporarily and perhaps less effectually, whether it should remain unaddressed and within the absent curriculum.

Ultimately, we advocate that national organizations such as SGIM and the AAMC help to develop clear recommendations for best practices related to student education on documentation. In the interim, we entreat each school to carefully 1) engage all stakeholders (students, residents, faculty, community providers, documentation and billing staff, etc.) for input regarding curricular content, structure, outcomes, and assessments, and 2) acknowledge how differences in terminology (e.g. altered mental status and septic metabolic encephalopathy) can be reconciled between documentation needs and clinical practices in a sensical fashion for learners. Appropriate implementation of these guidelines has the potential to reduce documentation duplication, improve physician satisfaction, increase preceptor recruitment, and enhance the student role on the medical team through legitimate participation.

References

1. Christino MA, Matson AP, Fischer SA, et al. Paperwork versus patient care: A nationwide survey of residents' perceptions of clinical documentation requirements and patient care. *J Grad Med Educ*. 2013;5(4):600-604. doi:10.4300/JGME-D-12-00377.1.
2. Rowlands S, Coverdale S, Callen J. Documentation of clinical care in hospital patients' medical records: A qualitative study of medical students' perspectives on clinical documentation education. *Health Inf Manag J Health Inf Manag Assoc Aust*. 2016;45(3):99-106. doi:10.1177/1833358316639448.
3. Centers for Medicare & Medicaid Services. E/M service documentation provided by students (manual update). https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/

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Downloads/MM10412.pdf. Updated June 1, 2018. Accessed January 1, 2019.
4. Hammoud MM, Dalymple JL, Christner JG, et al. Medical student documentation in electronic health records: a collaborative statement from the Alliance for Clinical Education. *Teach Learn Med*. 2012;24(3):257-266. doi:10.1080/10401334.2012.692284.
5. Kuhn T, Basch P, Barr M, et al. Clinical documentation in the 21st century: Executive summary of a policy position paper from the American College of Physicians. *Ann Intern Med*. 2015;162(4):301. doi:10.7326/M14-2128.
6. Society of Teachers of Family Medicine: Preceptor expansion initiative. https://www.stfm.org/about/keyinitiatives/preceptorexpansioninitiative/. Accessed January 1, 2019.

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