How to write a note: Development of a resident documentation curriculum

Needs and objectives: In most academic health care systems, residents provide the majority of patient care documentation. In addition to acquiring clinical skills, residents are now expected to provide notes that meets billing and regulatory requirements. We created an innovative resident education curriculum in electronic health record documentation to meet the critical need for training residents in these important skills.

Setting and participants: Our curriculum was developed in an academic center, partnered with a large county hospital, and provides resident education in EHR requirements in a lecture- and case-based format. It is a multi-disciplinary approach with team-based involvement from clinical documentation specialists, coders, and faculty.

Description: Approximately 100 residents rotate in a 4+1 system. After 4 weeks of inpatient clinical care, they have one week of outpatient clinics and didactic lectures. Every 5 weeks, the lectures change topics. We start with an "Introduction to Documentation" to the interns. Then all residents participate in an interactive case-based practice session. Residents review an admission note and progress note from a simulated case to identify areas for improvement, such as lack of specificity required by ICD-10. Third-year residents act as near peer mentors for second and first year residents. In addition to scheduled didactics, there are meetings with the residents the day prior to the ward rotation. Residents review de-identified inpatient medicine notes to "fix" unclear documentation. For all sessions, the multi-disciplinary team reviews changes the residents propose and provides immediate verbal feedback.

Evaluation: At least 90% of the residents participated in the dedicated didactic time. Qualitative feedback from residents via post-class surveys and small focus groups has led to more case-based, interactive presentations and helped target topics for the simulated cases (for example, GI bleed). We will measure the success of the curriculum by comparing the case-mix index and length of stay at the beginning and end of the academic year and add knowledge-based pre- and post-tests for the residents attending the scheduled lectures.

Discussion / reflection / lessons learned: The curriculum has been well received by the residents. We have outside rotators on our teams and they comment on the challenges of writing notes without formal teaching in documentation at their institution. The most common feedback was the benefit in reviewing actual notes. These sessions give residents an opportunity for direct interprofessional interaction with the clinical documentation improvement team and coders that would otherwise not occur. It is also an opportunity for the upper level residents to further develop mentoring skills such as feedback to the interns during these sessions. In addition, a critical part of the success of the curriculum is that the sessions occurred during a time already dedicated to didactics.

Impact: - IME: A documentation curriculum meets the ACGME core competencies of interpersonal and communication skills, professionalism, and system-based practice. In the literature, studies have primarily focused on the transition from paper to electronic charts, perceptions of the quality of electronic notes, and challenges of the EHR system. However, there is a lack of research on how to deliver education on this skill which is critical for success post-residency.

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