Competency	Patient Care
Sub Domain	Documentation and Presentation
Learning Objective	1. Accurately documents subjective and objective findings, assessments, plans, and treatments in paper-based and electronic health records in accordance with established guidelines 2. Clearly and efficiently presents patients to attending and resident physicians, consultants, peers, and allied health professionals

Milestones							
Year II				Year III		Year IV	
Mid	End	Mid	End	Mid	End	Mid	End
• Explains the professional obligations of health care providers for patient health information (1,2) * • Lists the elements and sequence of the history, physical exam, other clinical data, assessment, and plan (1,2) • Classifies the types of medical documentation (1) **	• Retrieves clinical information from paper and electronic health records in assigned clinical settings (1,2) • Documents patient data into a SOAP note format (1) • Presents patient data organized into a SOAP note format with focus on accuracy of subjective, objective data gathering and with simple assessment and basic plan (2)	• Documents a comprehensive history and physical in a clinical setting with guidance (1)	• Documents a history and physical without guidance, addressing the complexities present in the patient's care(1) • Explains basic documentation requirements for billing (1) • Presents a comprehensive history focused on clinical problems with minimal reliance on notes (2) • Demonstrates understanding that documentation and oral presentations vary based on clinical setting and situation (1,2)	• Presents relevant patient-centered clinical information appropriate to the clinical setting and situation to the clinical care team and allied health professionals (2) • Incorporates relevant literature into documentation and presentation (1, 2) • Demonstrates compliance with billing and documentation requirements (1)	• Documents using a patient-centered, problem-focused approach addressing complex issues † and incorporating evidence-based medicine (1) • Incorporates history, physical, assessment, and treatment plan into presentation appropriate to practice setting (2) • Presents the patient history at bedside and modifies the language, style, and tone as appropriate (2)	• Demonstrates understanding of effective hand-off when transferring care (1,2) • Performs appropriate documentation and presentation around transitions of care including discharge plans and needs (1,2)	• Demonstrates effective and efficient communication of information needed for hand-offs (1,2) • Demonstrates succinctness and selection of key elements in documentation and presentation (1,2)

APPENDIX

***** ***Health Information Professional obligations*** include an understanding of HIPPA and the terms Privacy, Confidentiality, Plagiarism, as well as professional behaviors that include gathering of a competent history and physical, documenting and presenting in a clear and timely manner, and avoiding the perpetuation of erroneous information (Chart Lore).

*******Examples of different documentation based on Health Provider role or patient's transition through the health system:* Full History, Physical, Consultation, Progress Note, Allied Health Note, Documentation of preventative health services, Transfer Summaries. Different charting systems include paper based formats and the electronic health record.

† ***Examples of complex issues:*** multiple patient care issues including acute and chronic care needs, multiple pathophysiological processes and treatment effects; significant complexities in care systems including setting, ancillary needs