

Team Documentation



Spend more time caring for patients by sharing responsibilities with staff.

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How will this module help me successfully put team documentation in place?

- 1 Eight steps to select a model, train staff and continue evolving the approach
- 2 Answers to questions and concerns
- 3 Advice on situations your practice may encounter during implementation
- 4 Case studies describing how practices are using team documentation

Increasing administrative responsibilities—due to regulatory pressures and evolving payment and care delivery models—reduce the amount of time physicians spend delivering care. By implementing a team documentation process, physicians can delegate medical recordkeeping tasks that will allow them to focus more on the patient and deliver quality care during patient visits.

Team Documentation

Release Date: October 2014

End Date: October 2018

Objectives

At the end of this activity, participants will be able to:

1. Learn how to effectively implement the team documentation process
2. Assess their current documentation process
3. Design an efficient documentation workflow
4. Appropriately delegate administrative tasks to various staff
5. Manage process improvements after implementing the team documentation process

Target Audience

This activity is designed to meet the educational needs of practicing physicians.

Statement of Need

Electronic health record (EHR) requirements have altered the documentation process in physician practices. Tasks previously performed by staff, such as data gathering, organization and entry have been shifting to physicians. This increased the amount of time physicians spend performing administrative tasks and decreased their time spent delivering direct patient care. This team documentation module is one of several practice transformation strategies aimed at reducing or eliminating onerous administrative tasks associated with documenting patient visits.

Statement of Competency

This activity is designed to address the following ABMS/ACGME competencies: practice-based learning and improvement, interpersonal and communications skills, professionalism, systems-based practice, interdisciplinary teamwork, quality improvement and informatics.

Accreditation Statement

The American Medical Association is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

Credit Designation Statement

The American Medical Association designates this enduring material for a maximum of 0.5 *AMA PRA Category 1 Credit™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Claiming Your CME Credit

In order to claim *AMA PRA Category 1 Credit™*, you must; 1) view the module content in its entirety, 2) successfully complete the quiz answering 4 out of 5 questions correctly and 3) complete the evaluation.

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About the Professional Satisfaction, Practice Sustainability Group

The AMA Professional Satisfaction and Practice Sustainability group has been tasked with developing and promoting innovative strategies that create sustainable practices. Leveraging findings from the 2013 AMA/RAND Health study, “Factors affecting physician professional satisfaction and their implications for patient care, health systems and health policy,” and other research sources, the group developed a series of practice transformation strategies. Each has the potential to reduce or eliminate inefficiency in broader office-based physician practices and improve health outcomes, increase operational productivity and reduce health care costs.

Disclosure Statement

The content of this activity does not relate to any product of a commercial interest as defined by the ACGME; therefore, neither the planners nor the faculty have relevant financial relationships to disclose.

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Introduction

What is team documentation?

Team documentation, also referred to as “scribing,” is a process where staff assist with documenting visit notes, entering orders and referrals and queuing up prescriptions in real-time while in the exam room with the physician and the patient. This frees the physician to focus on the patient.



Why team documentation?

Electronic health records (EHRs) have altered the documentation process in physician practices. Tasks previously performed by staff (e.g., receptionists, medical transcriptionists, medical assistants, pharmacists and/or nurses) such as data gathering, organization and entry, have shifted to physicians.

Q&A

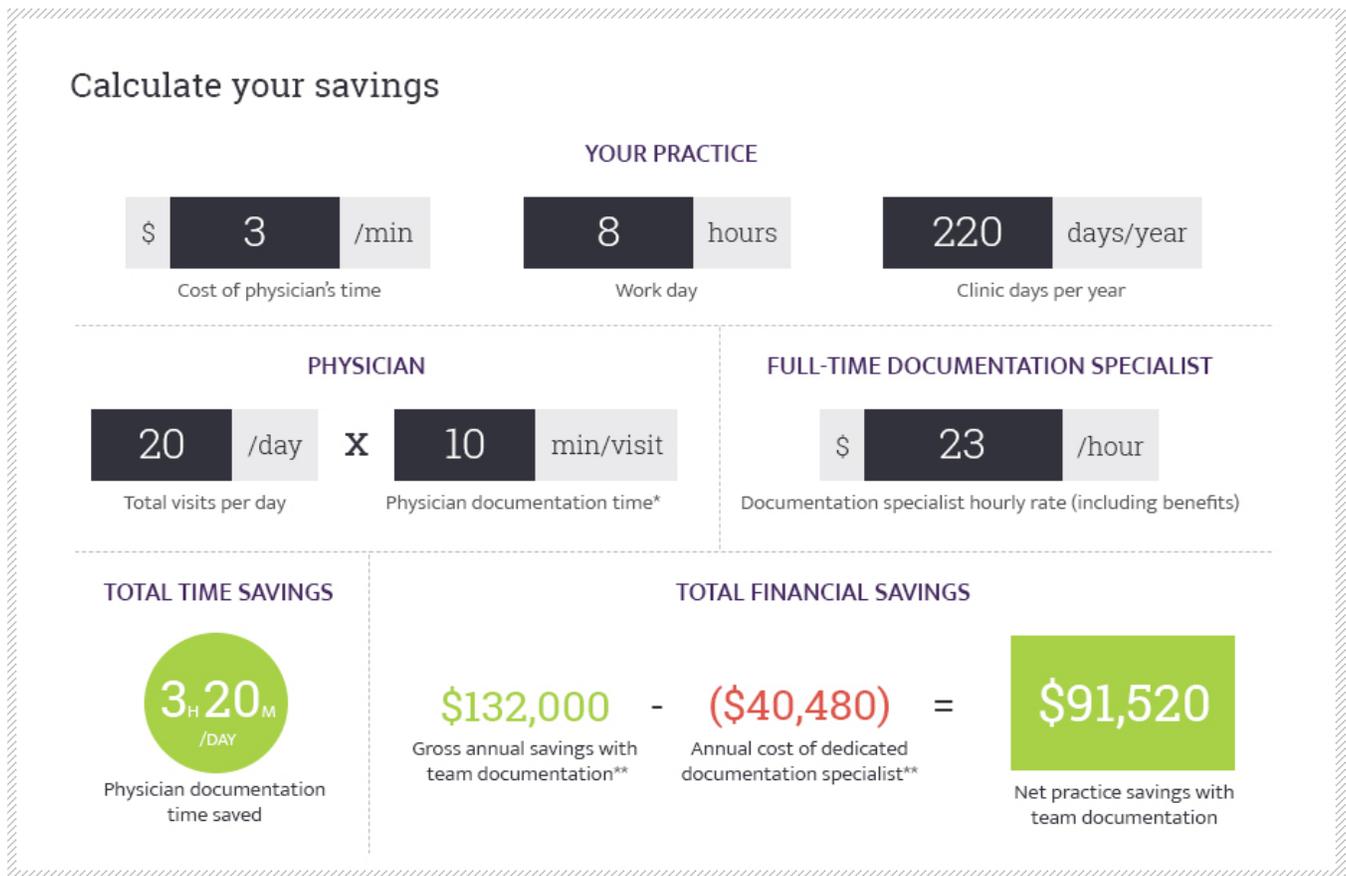
Under Medicare payment rules, can non-physician staff, such as a registered nurse (RN), licensed practical nurse (LPN) or medical assistant (MA), enter elements of an evaluation and management (E/M) visit without the physician present?

Yes, certain elements, like the Review of Systems (ROS) and Past, Family, and/or Social History (PFSH), may be recorded in the EHR by non-physician staff. Medicare guidance specifically allows ancillary staff to enter information derived from the patient for the ROS and/or PFSH. However, the physician must provide a notation in the medical record supplementing or confirming the information recorded by others to document that the physician reviewed the information. For other elements of a visit, like the History of Present Illness (HPI) or Chief Complaint (CC), Medicare rules do not explicitly indicate who may enter documentation. However, several Medicare Administrative Contractors (MACs) currently interpret Center for Medicare & Medicaid Services (CMS) regulations to prohibit the physician (or non-physician practitioner (NPP), if billing for the service) from delegating these elements of the service. Practitioners should check with their respective MACs before allowing individuals other than the treating physician to document an HPI or CC. If the non-physician is entering information about an HPI or CC on behalf of the physician while the physician is present in the room with the patient, some MAC guidance suggests that this practice is allowable as long as the physician actually performed the E/M service billed, the scribe simply served to transcribe the service provided by the physician, and the scribe’s entry is authenticated by the physician. Other MACs, however, restrict this practice. Providers should consult with their MAC before using a scribe to complete entry of an HPI or CC.

What will the net savings of implementing team documentation be for my practice?

Visit <https://www.stepsforward.org/modules/team-documentation> to calculate the cost-benefit of implementing team documentation in your practice.

Cost-benefit calculator example:



* Physician minutes spent on documenting patient care and administrative tasks, such as computerized order entry or electronic billing
 **Assumes value of physician time is \$3/minute, staff time value is \$1/ minute, and 220 clinic days / year
 Source: AMA. Practice transformation series: team documentation. 2014.

Eight steps to team documentation

1. Create a change team

2. Decide who will help with documentation

3. Determine the model: Clerical Documentation Assistant (CDA) or Advanced Team-based Care

4. Start with a pilot

5. Select the pilot personnel based on commitment

6. Define your workflow

7. Start small

8. Meet weekly

1

Create a change team

Select a high-level champion and a multi-disciplinary team, including representatives from administration, nurses, MAs, information technology, compliance and physicians. It is helpful if all representatives agree on the goals, such as improved patient and provider satisfaction, better quality and improved productivity.

2

Decide who will help with team documentation

Will it be an MA, a nurse, a pre-med student, a former transcriptionist or a dedicated scribe? The type of assistant will determine their scope of work.

Q&A

[Under Medicare payment rules, can an RN document a patient's medication list in the EHR as part of medication reconciliation \(MR\) during E/M visit?](#)

Yes, where MR is part of the ROS or PFSH for the E/M service, under Medicare payment rules, the medication list may be recorded by any ancillary staff, and then signed by the physician. MR is included in the Advancing Care Information performance category in the Merit-Based Incentive Payment System (MIPS) as well as the Meaningful Use (MU) program.

[Can licensed staff enter electronic orders, such as laboratory or x-ray requests?](#)

Yes, certain credentialed individuals may enter orders for diagnostic tests in an office (non- facility) setting. Medicare generally requires that services provided/ordered be authenticated by the author. A physician's failure to properly authenticate an order could lead to denial of payment by a MAC. However, there are circumstances where Medicare does not require a physician signature, such as for diagnostic tests (e.g., clinical diagnostic laboratory tests and diagnostic x-rays), when ordered in an office setting. While these orders need not be signed by the physician, he or she must clearly document in the medical record his or her intent that the test be performed. Providers should also check state, local, and professional guidelines.

3

Determine the model: clerical documentation assistant (CDA) or advanced team-based care

Clerical Documentation Assistant (CDA) Model: The CDA accompanies the physician during each patient visit and assists only with record-keeping. Separate staff (nurses, medical assistants [MAs] or other clinical staff) or the physicians are responsible for the clinical aspects of care, such as obtaining vital signs, performing medication reconciliation or providing patient education. Typically there is one CDA per physician. In addition, the practice employs MAs and nurses to perform the clinical support functions.

Example: Non-clinical staff in the geriatric practice at the University of California, Los Angeles, serve as Physician Partners (P²s). The P²s document aspects of the office visit, facilitate the flow of patients through the office and improve the efficiency of ordering and/or scheduling tests and medications. Under the direction of the physician, the P²s enter all aspects of the patient encounter into the electronic health record (EHR), including the patient history, physical exam findings that are verbalized by the

In-reach approach: Planning in advance so that gaps in care are closed at the time of each face-to-face visit.

Panel Management: *Panel* refers to the patient panel, or the patient population of the individual physician or practice. Panel management is managing the patient population by monitoring it for important preventive and chronic care based on guidelines set by the practice.

physician, procedures and clinic charges. They also queue orders that were discussed during the visit for the physician to sign. At the close of the visit when the physician leaves the room to see the next patient, the P² stays behind to review the after-visit summary with the patient, conduct any needed care coordination with other support staff and provide patient education. If labs are required, the P² may also escort the patient there to improve patient flow through the clinic. After the P² concludes the visit with the patient, they complete the encounter in the EHR and send the documentation to the physician for review. With this approach, the physician ultimately saves time because s/he only needs to review and sign documentation and queued orders.

In this practice, there are three P²s to every two physicians. This 3:2 ratio minimizes interruptions in the workflow by allowing continuous rotation of P²s in the clinic.

Advanced Team-based Care Model: A specially-trained nurse or MA accompanies each patient from the beginning to the end of their appointment to provide team care services, such as health coaching, care coordination and **in-reach panel management**. In addition, the nurse/MA assists with the clinical documentation while the physician conducts his/her portion of the patient visit. Typically there are two to three nurses/MAs per physician and they perform all of the clinical support functions in addition to assisting with the documentation.

Example: In Dr. Kevin Hopkins’ family medicine practice at the Cleveland Clinic, trained nurses and/or medical assistants follow a three-step process. There are two MAs per physician.

Step 1 (Pre-visit): The physician and team design protocols and templates for specific patient complaints and chronic conditions common to their practice. The MA uses these tools to guide the initial history they record during rooming. During this step the MA also updates the past medical, social and family histories, reviews and sets up orders for any health maintenance items that are due and reviews the patient’s medication list and refills. She then exits the room and huddles with the physician to share what she has learned.

Step 2 (Visit): The MA and physician enter the exam room together. The physician confirms and expands upon the preliminary history and examines the patient, which the MA records in real-time. The physician then makes a diagnosis and crafts a treatment plan with the patient and MA. The MA continues to record the assessment and treatment plan and queues any orders for the physician’s signature. The patient asks any further questions he or she may have and then the physician moves on to the next patient.

Step 3 (Post-visit): The MA remains with the patient to reinforce the treatment plan, provides an updated medication list and visit summary, engages in motivational interviewing and provides self-management support. She will then assist with appointment and referral scheduling.

Learn more about the expanded nurse/MA role in the [expanded rooming and discharge protocols](#) module.

“

So the cost of the additional personnel will always be somewhat of an issue, but, get this - we are actually making a profit (!) the first three months, despite the increased cost.

”



James Jerzak, MD
Family Medicine, Bellin Health System
Green Bay, WI

Q&A

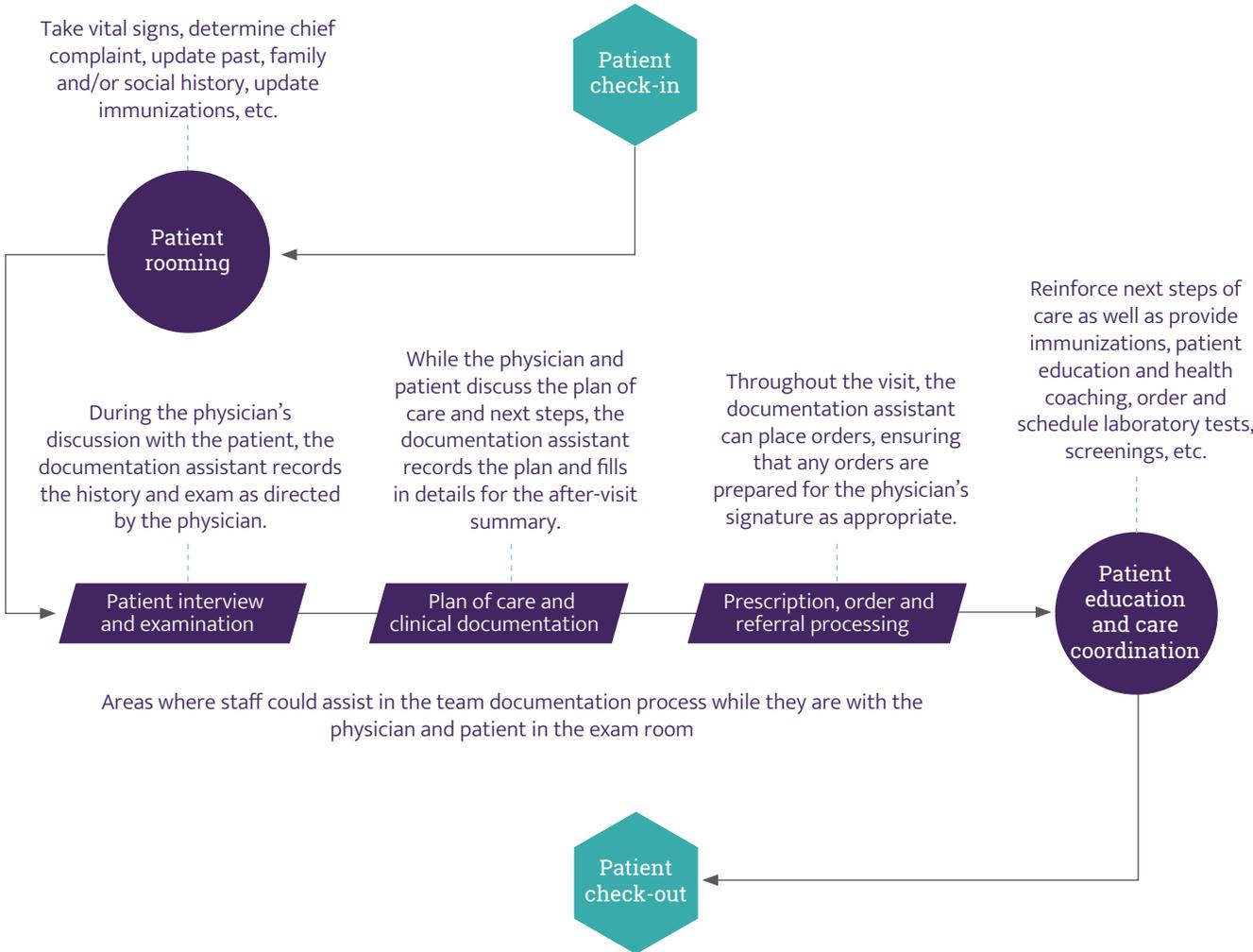
Who should assist with documentation?

The team member who assists with medical documentation varies across practices and specialties. The model may include clinically trained staff (e.g., MAs, LPNs, RNs, physical trainers, ophthalmology technicians, PAs and NPs) who can conduct elements of the patient visit themselves. The degree of task-sharing varies according to state and local scope of practice regulations, which may include taking visit notes, submitting prescription requests and/or renewals, entering laboratory test orders, administering immunizations and providing patients with supplemental health coaching. Alternatively, the model may include non-clinically trained staff, for whom the term “clerical documentation assistant” (CDA) can be used rather than “scribe.”

Will I need more space in the exam room to implement this process?

The size of the exam room is important. There needs to be enough space for the patient, one or more caregivers or family members, the physician and the CDA, nurse or MA. However, most practices may find they do not need to alter the size or configuration of existing exam rooms.

Modified Team Documentation Interactive Workflow Diagram



4

Start with a pilot

Developing collaborative care is hard work. It is best to start small. We suggest a pilot of one or two physicians. As institutional knowledge grows and bugs are worked out, the process can be spread to more physicians. Many practices report a three- to six-month learning curve.

Q&A

Does the extra person interfere with the physician-patient relationship?*

We find that the extra person actually improves the physician-patient relationship because the physician is able to provide his or her full attention to the patient and is not distracted by data entry.

*Reprinted with permission from the journal *Family Practice Management (Fam Pract Manag)*, 2014;21(6):23-29.

How do you position assistants in the exam room so they aren't intrusive?*

In an advanced team-based care model, the assistant helps interact with the patient during the visit and does not need to “disappear.” In one practice, the nurse and physician position themselves according to the care needs. When the patient is seated at the desk, the physician is also at the desk, and the nurse stands at the counter. When the patient is on the exam table, the physician stands at his or her side at the counter, and the nurse is at the desk. There is subtle choreography and the providers switch places automatically now depending on how they need to interact with the patient. Positioning also depends on the available technology infrastructure and hardware. Some practices use tablets for better mobility, but this can certainly be done with laptops or desktop computers as well.

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5

Select the pilot personnel based on commitment

The physician should be willing to invest in training the staff and learning a new model. Staff should be enthusiastic about assuming new responsibilities and being trailblazers within the organization. They should also be eager to help shape the new process.

Q&A

What qualities or skills should I look for in an assistant in the team care model?*

The most important skills are being personable, putting the patient at ease, and eliciting the preliminary history. It is also important to have good keyboarding skills and EHR-navigating skills. A minimum typing competency and timed typing test may be a good idea. An understanding of billing requirements also helps individuals document accurately.

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Does the assistant perform all of the medical recordkeeping duties or do physicians still play a role?

This varies according to specialty and physician preference. In some practices, the assistant records the majority of the patient’s medical history, exam, diagnoses and plan of care as indicated by the physician. In others, the assistant records portions of the patient’s medical history, exam and administrative data. The physician may document key elements of the patient’s medical history and medical decisions. In each example, the physician reviews and signs off on the medical record before the patient’s visit is closed.

Can licensed staff enter electronic orders, such as laboratory or x-ray requests?

Yes, certain credentialed individuals may enter orders for diagnostic tests in an office (non- facility) setting. Medicare generally requires that services provided/ordered be authenticated by the author. A physician’s failure to properly authenticate an order could lead to denial of payment by a MAC. However, there are circumstances where Medicare does not require a physician signature, such as for diagnostic tests (e.g., clinical diagnostic laboratory tests and diagnostic x-rays), when ordered in an office setting. While these orders need not be signed by the physician, he or she must clearly document in the medical record his or her intent that the test be performed. Providers should also check state, local, and professional guidelines.

6

Define your workflow

Identify who will perform which responsibilities during each patient visit. Will template notes be used? How will the provider sign the team notes and orders?

Determine which devices the assistant and physician will use. Will you use one computer or two? Will the computer be a laptop or a desktop? Consider your EHR features and functionality. Some EHRs allow only one user in the record at a time. Others allow the record to be “passed” from one user to another without being closed. Choreograph the work, and expect that it will be refined with experience.



Q&A

How do I train existing staff in my practice to implement the team documentation process?

Some physician practices contract companies that train medical documentation specialists. Others train their own staff. While the second option is a considerable investment of time, staff will learn exactly what is needed as it pertains to the specific practice. In both examples, training is ongoing. For instance, early in the implementation phase, the change team can consider debriefing daily to discuss what went well and identify opportunities for improvement. They can meet weekly for 30 to 60 minutes to review and adjust the workflow of the documentation process. They may also provide educational opportunities to learn more about clinical issues, billing and coding.

7

Start small

For the first few days, you might do team care for only half of your scheduled patients, or for all of your patients only a few days per week. Use the rolling start to refine the process and avoid change fatigue.

Q&A

Do patients mind discussing private issues with the assistant in the room?*

We have found that if the physician explains that the assistant’s role is to ensure accurate documentation and handling the computer so the physician can remain focused on the patient, most patients accept and welcome the additional medical professional helping with their visit. Many patients even see it as an opportunity to have another advocate for their health care. When introducing the team care process, it may be reassuring to let patients know that it is no problem if they want to be alone with their physician. In addition, if the physician or assistant senses that the patient is uncomfortable—such as during certain sensitive parts of the visit—the assistant may leave the room. Exam rooms may also be fitted with curtains or screens that can provide additional patient privacy.

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8

Meet weekly

Training is ongoing. The physician and team should meet at least weekly for 30 to 60 minutes to review and adjust the workflow. The meetings can also be used to continue the educational process about clinical issues, billing and coding.

Q&A

Is using an assistant more likely to result in documentation errors than doing it yourself?*

Accuracy and completeness of the documentation depends on training and a close working relationship between the physician and the assistant. In some ways, the documentation is likely to be more accurate because the assistant is focused on documentation while the physician is focused on providing care. In addition, the documentation is done in real-time, so there are fewer chances for details to be misremembered or confused between different patients. Some teams adopt a hybrid approach where the assistant does most of the documentation, especially those elements that are most suited to structured text entries, while the physician types or dictates a few additional lines explaining the medical thinking and more complicated details of the care plan.

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“

We set aside one hour every Friday morning to go over the week: what worked well, what didn't and what changes we need to make. We edit our note templates during those meetings as well. We do some education, for example, why we do microalbumin testing on diabetic patients and other important clinical items. Learning why we do certain things gains buy-in. The new model has not only been good for patients and the physician, it has also been good for the MAs. The MAs are more fully engaged in patient care than they have ever been and they enjoy their work. They have increased knowledge about medical care in general and about their individual patients in particular.

”



Kevin Hopkins, MD
Family Medicine, Cleveland Clinic, Strongsville, OH

Conclusion

Both the clerical documentation assistant (CDA) model and the advanced team-based care model benefit the practice as a whole. Team documentation instills a sense of cooperation among staff at all levels of your practice, empowering them to take an active role in managing patient visits. Through ongoing training and weekly meetings, team documentation processes can evolve with your practice.



STEPS in practice

1

How's it working in Vancouver, WA?

Physicians at The Vancouver Clinic (TVC) in Vancouver, WA, noticed that they were struggling to keep up with their increasing charting burden. In an effort to help the providers spend more time with patients and less time with charts, the practice decided to give scribes a try.

After testing different team documentation models, the clinic formed an agreement with a local scribing company. The company uses recent college graduates who are pursuing careers in medicine as physicians, nurses or physician assistants. This model worked well and is still in place. TVC has been impressed by the scientific training and vocabulary of these scribes and have found that they require little additional training.

The clinic studied different models to pay for the scribes. Physicians who used a scribe added one contact hour to their seven contact hour work day which covered the additional cost of the scribe. The clinic also found that adding a scribe and the corresponding clinic hour per day for 7 physicians creates the equivalent of one more physician FTE and extends the care that The Vancouver Clinic doctors can provide. Physicians are eligible to hire a scribe after practicing at the clinic for at least six months (to learn the EHR) and have to be busy enough to fill their added contact hours to offset the cost of the scribe. Even with the added contact hour the reduced charting burden saves them time each day. Data showed that one contact hour was added but two charting hours were removed, so the net was still a shorter day.

The scribes are welcomed by most patients. The purpose of the scribe was explained to patients during initial visits. The scribes wear scrubs and name tags like other members of the team. Patients have the option to decline the scribe, but this rarely occurs. An initial patient survey revealed that half of patients thought their visit was substantially better with the scribe in the room, and the other half felt neutrally about the scribe. On occasion the survey showed that the patient would have preferred a private conversation with the physician but was afraid to speak up. It is now at the discretion of the physician to ask the patient if they'd prefer to discuss without the scribe present if they sense the patient may be uncomfortable; they also may ask the scribe to leave if they believe this is what the patient will prefer.

Scribing is used successfully by a wide range of specialties, including primary care providers, urologists, ENTs, rheumatologists and orthopedic surgeons at The Vancouver Clinic. Approximately 60 physicians now use scribes and the number keeps growing. Working with scribes has increased physician satisfaction with their work. With the added support they are able to take on last minute patients without feeling burned out and overwhelmed by a heavy charting workload. They've commented, "I feel like I have my life back" and "I feel like I'm a real doctor again." The improved physician experiences is a selling point for recruiting new providers to TVC.

2

How's it working in Strongsville, OH?

Kevin Hopkins, MD, family physician at the Cleveland Clinic, recalls overhearing triage nurses just outside his office tell patient after patient, "I'm sorry, we can't see you today, you'll have to go to Urgent Care." As a family physician trained in the importance of the ongoing doctor-patient relationship, Hopkins strove for continuity in his practice, yet he was spending so much of his day documenting care that many of his patients were being turned away.

Dr. Hopkins joined the Cleveland Clinic after finishing his residency in 2005. "My training program didn't have an EHR, so after my first two weeks here I wanted to dump the computers. It was so frustrating." Even later, when the EHR "became my friend" and was indispensable, Dr. Hopkins felt he was putting his focus in the wrong place. "I was staring at the computer screen rather than looking at the patient. I was spending more time on documentation than on the patients." He wasn't the only one to notice. "This is one of the biggest complaints we get from patients."

“One day I realized if I didn’t have to do this documentation I would really like my work.” Slowly he resolved to make changes. He and one of his MAs visited another physician who was using a team care model in his practice. Returning home, Dr. Hopkins and his colleague used this physician’s model as a guide to develop templates specific to their practice and patients. Dr. Hopkins taught his staff how to use the health maintenance reminders in the practice’s EHR to place orders for mammography screening, labs and immunizations. Workspace modifications were made, such as installing curtains to offer privacy to patients while the MA remains in the examining room and a computer workstation in the hallway to allow Dr. Hopkins to do minor note editing between patients.

“One of the challenges for me was letting go of some of the control, especially control over the computer. We also had to figure out ways for the MA to pull up information that I wanted on the screen when I wanted it. We have worked with the MAs to develop their multi-tasking skills. They need to be typing, listening to me, and watching what parts of the exam I am doing all at the same time. We trained them with shadowing and repetition.”

Dr. Hopkins and his team are continually refining their processes. “We set aside one hour every Friday morning to go over the week: what worked well, what didn’t and what changes do we need to make. We edit our note templates during those meetings as well. We do some education, for example, why we do microalbumin testing on diabetic patients and other important clinical items. Learning why we do certain things gains buy-in. The new model has not only been good for patients and the physician, it has also been good for the MAs. The MAs are more fully engaged in patient care than they have ever been and they enjoy their work. They have increased knowledge about medical care in general and about their individual patients in particular.”

3

How’s it working in Auburn, IN?



Model

In his current model, Dr. Jim Ingram, a family physician in Auburn, IN, works with two certified medical assistants (CMAs). One of them rooms the patient, updates the problem list, the medication list, allergies, etc. She then uses EHR templates to get as much history as possible. The CMA leaves the room to huddle with Dr. Ingram; they review the history together, and he reviews the note. They enter the room together where he clarifies the history and performs the exam, discussing pertinent normal and abnormal findings. He explains the diagnoses and determines the treatment plan with the patient. The CMA documents those items and enters the orders while Dr. Ingram speaks with the patient. Once he is done, both the physician and CMA leave the room, finish the note, and he clarifies anything the CMA did not understand. He then joins the second CMA with the next patient. By being intentional and complete about follow up on all chronic conditions when patients are seen, much of the team’s phone work has been eliminated.



Training

Dr. Ingram spends a lot of time with his CMAs reviewing the history and exam findings. They have reviewed principles of treatment for chronic conditions commonly seen at the practice. They have also developed refill protocols and are doing some basic pre-visit planning such as printing labs and x-rays for review.



Results

Dr. Ingram has found that his results are great overall. “I never come in on my day off or work in the evenings on notes like I used to. I am much more relaxed during the visits and I am more thorough with my patients. I no longer have to flip through the chart looking for things, or look away from the patient. The patients enjoy more interaction with me and the CMAs. The CMAs are very proud of their role and have observed our increased efficiency as well. My productivity has increased.

“For me, the biggest return on investment was achieving a real sense of teamwork, increased joy in practice and getting rid of extra work at nights and on my days off. Patients are better served by me and the CMAs and patient satisfaction has increased.”

“It hasn’t all been easy. At this stage we have worked successfully through most obstacles, but the inertia of our former documentation process is a powerful thing. On the bright side, our administration is now noticing our efficiencies and seeks to implement these changes in several of the other doctors’ practices.”

****A note about nomenclature:** We prefer the term “team documentation” rather than “scribing” to describe the shared work of medical record-keeping. This nomenclature keeps the focus on the task rather than on the role of the person performing the task.

4

How’s it working in Wichita, KS?

In 2015, in response to worsening physician dissatisfaction, burnout and turnover, Via Christi Health in Wichita, Kansas, began a “Team-based Care” documentation pilot project in seven of its clinics. The pilot project deployed two different approaches to team documentation:

The **Team Care Assistant Model** utilizes highly trained medical assistants (MAs) to provide enhanced team-based patient care services during the ambulatory care office visit. The MAs work at the top of their license by completing tasks that are typically completed by the physician (recording history, review of systems, scribing, order entry, etc.). In this model, the MA becomes the “workflow manager” of the patient visit. This frees the physicians from clerical work and allows them to focus on providing patient care that is person-centered, efficient, high-quality and cost-effective.

The **Scribe Model** utilizes an independent contractor to provide clinical documentation staff. The scribe assists with documenting visit notes in real-time while in the exam room with the physician and the patient. The scribe thus frees the physician to focus on the patient instead of the electronic health record (EHR).

The preliminary results of the pilot project were favorable. After nine months, physician satisfaction increased by 31 percent and staff satisfaction increased by 10 percent over baseline. Daily visits increased 42 percent under the Team Care Assistant Model and overall physician revenue increased with both team documentation models. Although the pilot project lacked the statistical rigor of a true experimental research study, the initial results were favorable, and the organization has chosen to expand its efforts based on both available evidence and anecdotal praise:

- “The team care model has reinvigorated both me and my practice. I feel almost guilty when I look around at my colleagues who are frustrated and burned out with the conventional practice model while I feel energized and excited by my practice.” – Physician
- “The clinic has changed the way they are doing things. The nurse is staying in the room during my visit and I feel the doctor has time to slow down to take care of me, and is not worried about the person in the next room over.” – Patient
- “The program has enhanced my relationship with our patients. I’m able to spend more time with them, in turn providing better care.” – Staff
- “The new model allows me to remember why I went into medicine to begin with: to take care of the patient and not the chart.” – Physician

Although it may be too early to decide which team documentation model works best at Via Christi, one thing seems clear: there may not be a one-size fits all answer. Some of the more “autonomous” providers in the clinic prefer the Scribe Model, while some of the more “team-oriented” providers thrive under the Team Care Assistant Model.

Via Christi also learned some important lessons along the way:

- Bringing the compliance and information technology (IT) departments into new documentation model projects early-on is necessary to address stringent documentation regulations and workflows.

- Open up panels early! Doctors working with mid-level providers saw enhanced access so quickly that their mid-level providers were left seeing significantly fewer patients during the initial stages of the pilot project.
- At minimum, block schedules and conduct regular meetings to discuss the project during the first month. This allows time for continuous process improvement and communication that is vital to the success of either model.
- Both models require consistent, high-functioning support staff, which can be hard to recruit and retain in certain markets.
- Collect and track relevant data and compare to baseline to measure results. Some key metrics to consider include:
 - Provider satisfaction
 - Staff satisfaction
 - Patient satisfaction
 - Work relative value units (WRVUs)
 - Patients seen per day
 - Panel size
 - Specific preventive health metrics

As Via Christi continues to expand team-based care, the lessons learned from the pilot projects will be used to improve team documentation across the system.



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