Team Documentation

Improve Efficiency, Workflow, and Patient Care

AMA IN PARTNERSHIP WITH

SGIM
Society of General Internal Medicine
Creating Value for Patients

CME CREDITS: 0.5

Christine A. Sinsky, MD, FACP
Vice President, Professional Satisfaction, American Medical Association

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

1. Describes eight steps to select a team documentation model, train staff, and continuously improve the process.
2. Provides answers to common questions about team documentation.
3. Shares advice on situations your practice may encounter during implementation.
4. Includes case reports describing how practices are using team documentation.

ⓘ Introduction

Electronic health record (EHR) systems can be beneficial, but the chief complaint for many physicians is that it takes away from their time with the patient. However, implementing team documentation can help to provide better care to patients, reduce physician burnout, and improve practice efficiency.

What is team documentation?

Team documentation, also referred to as "scribing," is a process where other team members assist with documenting visit notes, entering orders and referrals, and preparing prescriptions, during a patient visit. This process improves patient centered care as the physician is less focused on EHR documentation, and can have a more meaningful interaction with the patient.

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?

In both the 2019 Fiscal Year Medicare Physician Fee Schedule and an FAQ dated Nov. 26, 2018, CMS expanded current documentation policy applicable to office/outpatient E/M visits. Starting Jan. 1, 2019, any part of the chief complaint (CC) or history that is recorded in the medical record by ancillary staff or the patient does not need to be re-documented by the billing practitioner.

Instead, when the information is already documented, billing practitioners can review the information, update or supplement it as necessary, and indicate in the medical record that they have done so. This is an optional approach for the billing practitioner, and applies to the chief complaint (CC) and any other part of the history (HPI, Past Family Social History (PFSH), or Review of Systems (ROS)) for new and established office/outpatient E/M visits.

CMS notes that it has never addressed who can independently take/perform histories or what part(s) of history they can take, but rather addresses who can document information included in a history and what supplemental documentation should be provided by the billing practitioner if someone else has already recorded the information in the medical record.

The physician must still personally perform the physical exam and medical decision-making activities of the E/M service being billed.

For additional information, please visit AMA's **Debunking Regulatory Myths** site, which discusses this topic in depth.

Interactive Calculator: Team Documentation

Use this calculator to estimate the amount of time and money you could save by implementing pre-visit laboratory testing in your practice. *Results should be verified for your specific practice and workflows.*
Enter the amount of time per day spent by physicians on documentation activities that could be eliminated by hiring a documentation specialist. The result will be the savings of implementing team documentation in your practice. *Results may vary by practice.*

Interactive
Calculate your savings

Eight STEPS to implememnt team documentation:

1. Create a change team.

   ----

2. Decide who will help with team 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.

You can't make a big change in your practice without help. A change team is a small group of team members who will identify barriers and determine the best manner to implement changes designed to improve the new process, such as team documentation.

When creating a change team, select a high-level champion – such as the medical director, division head, or chair of the department— and develop a multi-disciplinary team, including representatives from administration, nurses, medical assistants (MAs), information technology personnel, 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.

Decide if the individuals performing the documentation will be an MA, a nurse, a pre-med student, pre-physical therapy or pre-pharmacy student, a former transcriptionist or a dedicated scribe. The type of assistant will determine the 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 Medicare Administrative Contractor (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.

The clerical documentation assistant CDA Model:
The clerical documentation assistant accompanies the physician during each patient visit and assists only with record-keeping. Separate team members, such as nurses, MAs, or the physicians are responsible for the clinical aspects of care. This includes obtaining vital signs, performing medication reconciliation, or providing patient education. There is typically one CDA per physician. In addition, the practice employs MAs and nurses to perform the clinical support functions.

Example: University of California Los Angeles
Non-clinical staff in the geriatric practice at the University of California, Los Angeles, serve as Physician Partners (P^2s). The P^2s 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 P^2s enter all aspects of the patient encounter into the EHR, including the patient history, physical exam findings that are verbalized by the 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 P^2s stays behind to review the after-visit summary with the patient, conduct any needed care coordination with other team members, and provide patient education. If labs are required, the P^2s may also escort the patient to improve patient flow through the clinic. After the P^2s conclude the visit with the patient, they complete the encounter in the EHR, and the documentation is sent to the physician for review. With this approach, the physician only needs to review and sign documentation and queued orders, saving significant time. In this practice, there are three P^2s to every two physicians. This 3:2 ratio minimizes interruptions in the workflow by allowing continuous rotation of P^2s in the clinic.

Advanced team-based care model:
A specially-trained nurse or MA accompanies each patient from the beginning to the end of the appointment to provide team care services, such as health coaching, care coordination, and **in-reach approach** to **panel management**. In addition, the nurse or MA assists with the clinical documentation while the physician conducts his or her portion of the patient visit.

Typically, there are two to three nurses or MAs per physician and they perform all of the clinical support functions in addition to assisting with the documentation.

Example: Cleveland Clinic

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

- **Pre-visit:** The physician and team design protocols and templates for specific patient complaints and chronic conditions common to the practice. The MA uses these tools to guide the initial history recorded 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. The MA then exits the room and huddles with the physician to share what was discussed.
- **Visit:** The MA and physician enter the exam room together. The physician confirms and expands on the preliminary history and examines the patient, which the MA documents in real-time. The physician then makes a diagnosis and crafts a treatment plan with the patient. 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 and the physician moves on to the next patient.
- **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. The MA then assists with appointment and referral scheduling.

Learn more about the expanded nurse and 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.

- 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.

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.

Sometimes, people express concern that another person in the room interferes with the patient-physician relationship. However, we find that the extra person actually improves the patient-physician relationship because the physician is able to provide full attention to the patient and is not distracted by data entry.

Q&A

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 of the patient. 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 beside the patient and the nurse is at the desk. There is subtle choreography and the providers switch places automatically, 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.

5 Select the pilot personnel based on commitment.

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

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 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.

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.

6 Define your workflow.

Identify who will perform which responsibilities during each patient visit.

Don't forget to consider your EHR features and functionality as well. 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.

Other items for consideration:
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?

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, the team 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.

Figure 1. Sample Team Documentation Workflow
This workflow shows how team documentation can work in your practice

Patient check-in

Areas where staff could assist in the team documentation process while they are with the physician and patient in the exam room

Patient rooming
Take vital signs, determine chief complaint, update past family and/or social history, update immunizations, etc.

Patient interview and examination
During the physician's discussion with the patient, the documentation assistant records the history and exam as directed by the physician.

Plan of care and clinical documentation
While the physician and the patient discuss the plan of care and next steps, the documentation assistant records the plan and fills in the details for the after-visit summary.

Prescription, order and referral processing
Throughout the visit, the documentation assistant can place orders, ensuring that any orders are prepared for the physician's signature as appropriate.

Patient education and care coordination
Reinforce next steps of care as well as provide immunizations, patient education and health coaching, order and schedule laboratory tests, screenings, etc.

Patient check-out

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.

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. Weekly meetings allow the physician and team to remain up-to-date with what is going on in the practice, any barriers to care, and updates to the process.

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.

> ❝
>
> 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 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 as your practice continues to grow.

STEPS in practice

1   Team Documentation Case Report: The Vancouver Clinic

Physicians at The Vancouver Clinic (TVC) in Vancouver, WA, noticed that they were struggling to keep up with their increasing charting burden. 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. 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 workday, which covered the additional cost of the scribe. The clinic also found that adding a scribe and the corresponding clinic-hour per day for seven physicians is equivalent to adding one more full-time physician and extends the care that The Vancouver Clinic doctors can provide.

To be eligible to hire a scribe at The Vancouver Clinic, physicians must have worked at the clinic for at least six months learning the electronic health record (EHR) and must be busy enough to fill their added contact-

hour each day to offset the cost of the scribe. Even with the added contact-hour, the reduced charting burden saves the physicians time each day—data showed that by using a scribe, physicians added one contact-hour but removed two charting-hours, resulting in physicians needing to work one fewer hour each 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, while the other half felt neutral about the scribe. Only rarely did the survey show 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 there is something he or she would prefer to discuss without the scribe present if physician senses the patient may be uncomfortable; the physician may also ask the scribe to leave if he or she believes this is what the patient will prefer.

Scribing is used successfully at The Vancouver Clinic by a wide range of specialties, including primary care providers, urologists, ENTs, rheumatologists, and orthopedic surgeons. 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, physicians are able to take on last-minute patients without feeling burned out and overwhelmed by a heavy charting workload. Practitioners have remarked, "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 Team Documentation Case Report: Cleveland Clinic

At the Cleveland Clinic, Kevin Hopkins, MD, 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, Dr. 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 upon finishing his residency. "My training program didn't have an electronic health record, so after my first two weeks here I wanted to dump the computers. It was so frustrating." Even later, when the electronic health record (EHR) turned from obstacle to 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 was one of the biggest complaints we got from patients," Dr. Hopkins remarks.

"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 a medical assistant (MA) visited another physician who was using a team care model in his practice. Returning to the Cleveland Clinic, 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. The team made modifications to their workspace to better suit their new team approach, including installing curtains to offer privacy to patients while the MA remains in the examining room and adding 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." Through working together, the MAs have developed their multi-tasking skills so they can type, listen to the doctor and patient, and watch what parts of the exam the physician is doing—all at the same time. Shadowing and repetition are integral parts of this training.

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 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 Team Documentation Case Report: Dr. Jim Ingram

Model
In his current model, Dr. Jim Ingram, a family physician in Auburn, IN, works with two certified medical assistants (CMAs). One of CMA rooms the patient and 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 finished, both the physician and CMA leave the room. Together they finish the note, and Dr. Ingram clarifies anything the CMA did not understand. Dr. Ingram 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 patient 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."

Reflecting on what the team and their patients have gained from the change to this team documentation model, Dr. Ingram remarks, "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."

Dr. Ingram adds, "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 Team Documentation Case Report: Via Christi Health

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, such as recording history, review of systems, scribing, and order entry. 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 positive. 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 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 other 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.

Learning Objectives:
At the end of this activity, you will be able to:
1. List steps to effectively implement the team documentation process;
2. Explain how to design an efficient documentation workflow;
3. Identify methods to appropriately delegate administrative tasks to various staff;
4. Describe ways to manage process improvements after implementing the team documentation process.

Article Information

AMA CME Accreditation Information

Credit Designation Statement: The American Medical Association designates this enduring material activity for a maximum of .50 *AMA PRA Category 1 Credit™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Target Audience: This activity is designed to meet the educational needs of practicing physicians,

*****Disclaimer:** Reprinted with permission from the *journal Family Practice Management* (2014). 21(6):23-29.

Those individuals marked with an asterisk below contributed towards Version 1 of this learning activity.

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.

Planning Committee:

Christine A. Sinsky, MD, FACP, Vice President, Professional Satisfaction, American Medical Association*
Marie Brown, MD, MACP, Senior Physician Advisor, Professional Satisfaction and Practice Sustainability, American Medical Association & Associate Professor, Rush Medical College, Rush University Medical Center
Renee DuBois, MPH, Senior Practice Transformation Advisor, Professional Satisfaction and Practice Sustainability, American Medical Association
Brittany Thele, MS, Program Administrator, Professional Satisfaction and Practice Sustainability, American Medical Association
Ashley C. Cummings, MBA, CRCR, CME Program Committee, American Medical Association
Kevin Heffernan, MA, CME Program Committee, American Medical Association*
Ellie Rajcevich, MPA, Practice Development Advisor, Professional Satisfaction and Practice Sustainability, American Medical Association*
Sam Reynolds, MBA, Director, Professional Satisfaction and Practice Sustainability, American Medical Association*
Rhoby Tio, MPPA, Senior Policy Analyst, Professional Satisfaction and Practice Sustainability, American Medical Association*

Content Reviewers:

J. James Rohack, MD, FACC, FACP, Senior Advisor and former President, American Medical Association
Renee DuBois, MPH, Senior Practice Transformation Advisor, Professional Satisfaction and Practice Sustainability, American Medical Association & Associate Professor, Rush Medical College, Rush University Medical Center
Brittany Thele, MS, Program Administrator, Professional Satisfaction and Practice Sustainability, American Medical Association

David Eltrheim, MD, Family Physician, Mayo Clinic Health System–Red Cedar*
Michael Glasstetter, VP Advocacy Operations, Advocacy Planning & Management, American Medical Association*
Thomas Healy, JD, Vice President and Deputy General Counsel, American Medical Association*
Kevin D. Hopkins, MD, Family Medicine, Cleveland Clinic*
Michelle M. Johnson, RN, BSN, Patient Care Director, Caledonia Clinic, Mayo Clinic Health System*
Anton J. Kuzel, MD, MHPE, Chair, Department of Family Medicine and Population Health, Virginia Commonwealth University*
Jeffrey Panzer, MD, Medical Director, Oak Street Health*
Sara J. Pastoor, MD, MHA, Director, Primary Care Center, University of Texas Health Science Center at San Antonio*
David B. Reuben, MD, Archstone Professor of Medicine, David Geffen School of Medicine, University of California, Los Angeles*
Ellie Rajcevich, MPA, Practice Development Advisor, Professional Satisfaction and Practice Sustainability, American Medical Association*
Sam Reynolds, MBA, Director, Professional Satisfaction and Practice Sustainability, American Medical Association*
Gordon Schectman, MD, MS, Primary Care Chief Consultant, Veterans Affairs Central Office*
Rhoby Tio, MPPA, AMA, Senior Policy Analyst, Professional Satisfaction and Practice Sustainability, American Medical Association*
Rachel Willard-Grace, MPH, Research Manager, Center for Excellence in Primary Care, Department of Family & Community Medicine, University of California, San Francisco*

About the Professional Satisfaction and 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: Unless noted, all individuals in control of content reported no relevant financial relationships.

The project described was supported by Funding Opportunity Number CMS-1L1-15-002 from the U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.

ABMS MOC: Through the American Board of Medical Specialties ("ABMS") ongoing commitment to increase access to practice relevant Maintenance of Certification ("MOC") Activities, this activity has met the requirements as an **MOC Part II CME Activity.** Please review the *ABMS* Continuing Certification Directory to see what ABMS Member Boards have accepted this activity.

Renewal Date: February 2, 2018; April 25, 2019

Glossary

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

References

1. Ammann Howard, K., Helé, K., Salibi, N., Wilcox, S., Cohen, M. (2012). Adapting the EHR scribe model to community health centers: The experience of Shasta Community Health Center's pilot. Blue Foundation of California. Retrieved from https://blueshieldcafoundation.org/sites/default/files/covers/Shasta%20EHR%20Scribes%20Final%20Report.pdf
2. Anderson, P., Halley, M.D. (2008). A new approach to making your doctor-nurse team more productive. Family Practice Management, **15**(7), 35–40. Retrieved from www.aafp.org/fpm/2008/0700/p35.html

3. Anderson, P. (2013). What is team care medicine? [video]. Retrieved from www.youtube.com/watch?v=1dPNn2OUuaA

4. Arya, R., Salovich, D.M., Ohman-Strickland, P., Merlin, M.A. (2010). Impact of scribes on performance indicators in the emergency department, Academic Emergency Medicine, **17**(5):490–494. doi: 10.1111/j.1553-2712.2010.00718.x

5. Bank, A.J., Obetz, C., Konrardy, A., Khan, A., Pillai, K.M., McKinley, B.J., Gage, R.M., Turnbull, M.A. & Kenney W.O. (2013). Impact of scribes on patient interaction, productivity, and revenue in a cardiology clinic: a prospective study. ClinicoEconomics and Outcomes Research, **5**, 399–406. doi: 10.2147/CEOR.S49010

6. Center for Excellence in Primary Care. (2013). Health Coaching. Retrieved from http://cepc.ucsf.edu/health-coaching

7. Yan, C., Rose, S., Rothberg, M.B., Mercer, M.B., Goodman, K. & Misra-Hebert, A.D. (2016). Physician, scribe, and patient perspectives on clinical scribes in primary care. Journal of General Internal Medicine. **31**(9), 990–995. doi: 10.1007/s11606-016-3719-x

8. Funk, K., Davis, M. (2015). Enhancing the role of the nurse in primary care: The RN "co-visit" model. Journal of General Internal Medicine, **30**(12), 1871–1873. doi: 10.1007/s11606-015-3456-6

9. Hafner, K. (2014). A busy doctor's right hand, ever ready to type. The New York Times. Retrieved from www.nytimes.com/2014/01/14/health/a-busy-doctors-right-hand-ever-ready-to-type.html

10. Hopkins, K., Sinsky, C.A. (2014). Team-based care: Saving time and improving efficiency. Family Practice Management, **21**(6), 23–29. Retrieved from www.aafp.org/fpm/2014/1100/p23.html

11. Koshy, S., Feustel, P.J., Hong, M. & Kogan, BA. (2010). Scribes in an ambulatory urology practice: Patient and physician satisfaction. The Journal of Urology, **184**(1), 258–262. doi: 10.1016/j.juro.2010.03.040

12. Miller, N., Howley, I., McGuire, M. (2016). 5 Lessons for working with a scribe. Family Practice Management, **23**(4), 23–27. Retrieved from www.aafp.org/fpm/2016/0700/p23.pdf

13. Misra-Hebert, A.D., Amah, L. & Rabovsky, A. (2016). Medical scribes: How do their notes stack up? Journal of Family Practice. **65**(3), 155–159. Retrieved from www.mdedge.com/familymedicine/article/106833/practice-management/medical-scribes-how-do-their-notes-stack

14. Reuben, D.B., Knudsen, J., Senelick, W., Glazier, E. & Koretz, B.K. (2014). The effect of a physician partner program on physician efficiency and patient satisfaction. JAMA Internal Medicine, **174**(7), 1190–1193. doi: 10.1001/jamainternmed.2014.1315

15. Sinsky, C.A., Sinsky, T.A. (2013). In search of joy in practice: Innovations from 23 high-performing primary care practices [video]. Retrieved from www.youtube.com/watch?v=tKVl74Al_I0

16. Sinsky, C.A., Willard-Grace, R., Schutzbank, A.M., Sinsky, T.A., Margolius, D. & Bodenheimer, T. (2013). In search of joy in practice: A report of 23 high-functioning primary care practices. The Annals of Family Medicine, **11**(3), 272–278. doi: 10.1370/afm.1531

17. Sinsky, C.A. (2011). Care by design. Redstone Clinic Case Study.

18. Sinsky, C.A. (2011). Office of the future. Quincy Family Practice Case Study.

19. Sinsky, T.A. Improving access, quality and satisfaction with "turbo practice". The ABIM Foundation. Retrieved from https://abimfoundation.org/wp-content/uploads/2016/01/Finding-Joy-In-Primary-Practice-Site-Visit-Cleveland-Clinic.pdf

20. Sinsky, T.A. (2011). Reconnecting with patients through scribing. The ABIM Foundation. Retrieved from https://abimfoundation.org/wp-content/uploads/2016/01/Finding-Joy-In-Primary-Practice-Site-Visit-Allina-Clinics.pdf

21. Sinsky, T.A. (2011). The family team care model. The ABIM Foundation. Retrieved from https://abimfoundation.org/wp-content/uploads/2016/01/Finding-Joy-In-Primary-Practice-Site-Visit-Newport-News.pdf

22. Team Care Medicine v1 [video]. (2013), California: Sutter North Medical Foundation.