Potential Roles for Clinical Assistants in the Office
(In addition to the traditional "rooming" of the patient)

Pre-visit:
- Pre-visit planning – being sure labs are drawn, necessary test results and consults are back; in future, forms sent ahead of visit to patient on Patient Portal
- Chart prep – opening note, checking needed preventive care

At visit
- Scribe/note completion function
- Visit completion – ie filling out lab and imaging orders, referral in Centricity, reviewing plan of care with patient – including new medications, f/u appointments, , printing patient instructions to give to patient
- Specific patient education (ex. how to use asthma inhalers, blood glucose testing, low sodium diet)

After visit
- Recalls – routing to appropriate desktop
- Notification of lab results (following physician direction)

Paperwork
- Prescription refills (with standing orders)
- Completing prescription prior authorizations
- DME forms (home oxygen, etc)
- Nursing home/assisted living communications
Preparing all of above for physician signature, filling out as directed

Care Coordination
- Referral tracking
- F/U phone calls when appropriate

Clinical Assistant/
Nurse Training Manual

Family Health Associates

Practice Redesign

Family Care Network
Family Health Associates
We Take Care

2-WEEK NURSE TRAINING SCHEDULE

WEEK 1
Goal: be functioning mostly independently by the end of the week.

Before Tuesday:
- Read article: "A new approach to making your doctor-nurse team more productive".

Tuesday: **(morning session with patients – afternoon teaching sessions)**
- Arrive at 8:30am
- Morning shadowing with Stephanie and Dr. Anderson - watch and ask questions.
- After lunch meeting with Dr. Anderson and Stephanie to discuss the article and overall visit flow, documentation, coding/billing, introduce chronic disease management, introduce routine care.
- Afternoon meeting with Stephanie on chart preparation, visit check-in form, and overall chart navigation.
- Provide article "Structure and synchronicity for better charting" – read before Wednesday.
- Depart by 3:00pm

Wednesday: **(morning chart preparation – afternoon session with patients)**
- Arrive at 9:00am
- Practice opening visit notes with Stephanie – refer to documentation requirements, chronic disease outline and routine care outline, practice creating visit check-in forms.
- Afternoon shadowing with Stephanie and Dr. Anderson – as involved as desired.
- Brief late afternoon meeting with Dr. Anderson and Stephanie to discuss article, CPOE (including quicktexts), and note completion.
- Depart by 5:30pm

Thursday: **(morning and afternoon sessions with patients)**
- Arrive at 8:00am
- Practice opening visit notes with Stephanie.
- Morning shadowing with Stephanie and Dr. Anderson – practice documentation.
- Afternoon shadowing with Stephanie and Dr. Anderson – attempt complete documentation.

Friday: **(morning and afternoon sessions with patients)**
- Arrive 8:00am
- Attempt to work independently for morning and afternoon session with Stephanie and Dr. Anderson.
- Lunch meeting (Lunch provided) for feedback and additional teaching as needed.
- Depart at 5:00pm

WEEK 2 (schedule will depend on provider)
Goal: Be fully independent by the end of the week.

- Physician's clinic schedule adjusted by Stephanie.
- Stephanie to work with nurse and her regular provider for the entire week.
- Dr. Anderson to check-in with provider about progress, issues.
- Meeting with training nurse, provider, Stephanie and Dr. Anderson (if possible) towards the end of the week – what is working, what isn't working?

Monday:
- Opening visit notes and seeing patients

Tuesday:
- Opening visit notes and seeing patients

Wednesday:
- Provider out of office

Thursday:
- Opening visit notes and seeing patients
- Dr. Anderson to elicit feedback from provider on progress, issues, etc.

Friday:
- Opening visit notes and seeing patients
- Lunch meeting with provider, nurse, Stephanie and Dr. Anderson (if possible) to discuss overall progress with new system, specific issues and areas for improvement, documentation feedback, schedule time for weekly meetings.

Peter Anderson, MD, and Marc D. Halley, MBA

A NEW APPROACH TO
MAKING YOUR DOCTOR-NURSE TEAM MORE PRODUCTIVE

With proper training and delegation, your team can see more patients, deliver better care and feel more satisfied at work.

Myriad factors are challenging the financial viability of physician practices in general and primary care practices in particular. Downward pressure on reimbursement combined with increasing costs have ratcheted up the pressure on physicians to see more patients each day just to stay even. The increasing administrative burden on physicians and their clinical staff has heightened frustration, reduced productivity and career satisfaction, and increased the potential for clinical errors. None of this is news, of course; the situation has been worsening for years. But new ways of surmounting the problems are continually appearing.

A key part of responding to the current threats to medical practice viability is what we call "highest and best use staffing"; that is, structuring work processes to ensure that 1) the physician does only what he or she is trained to do, with appropriate delegation of all lesser tasks, and 2) clinical staff members do only what *they* are trained to do, with appropriate delegation of all lesser tasks. In a typical practice, the failure to delegate hampers efficiency, which in turn hampers practice finances.

In a new approach to the clinical visit called *family team care*, one of the authors

MARK ELLIOTT

The team care model can improve productivity, staff satisfaction, quality of care and practice finances.

When fully implemented, it involves a physician and two clinical assistants who partner closely to provide patient visits.

(Peter Anderson, MD) has created a practice that epitomizes highest and best use staffing. The results have been extraordinary. The team care approach has improved professional satisfaction with practice, quality of care, documentation and financial performance. It has increased patient visit volume while raising patient satisfaction. It has even increased job satisfaction for the nurses. Here's how it works.

What is team care?

The team care concept is relatively simple. It involves a physician and a well-trained clinical assistant – or, ideally, two assistants – working closely together to provide a high-quality patient encounter. Most patient visits can be broken down into four distinct components:

Part 1: Data gathering,
Part 2: Analysis of data and pertinent physical exam,

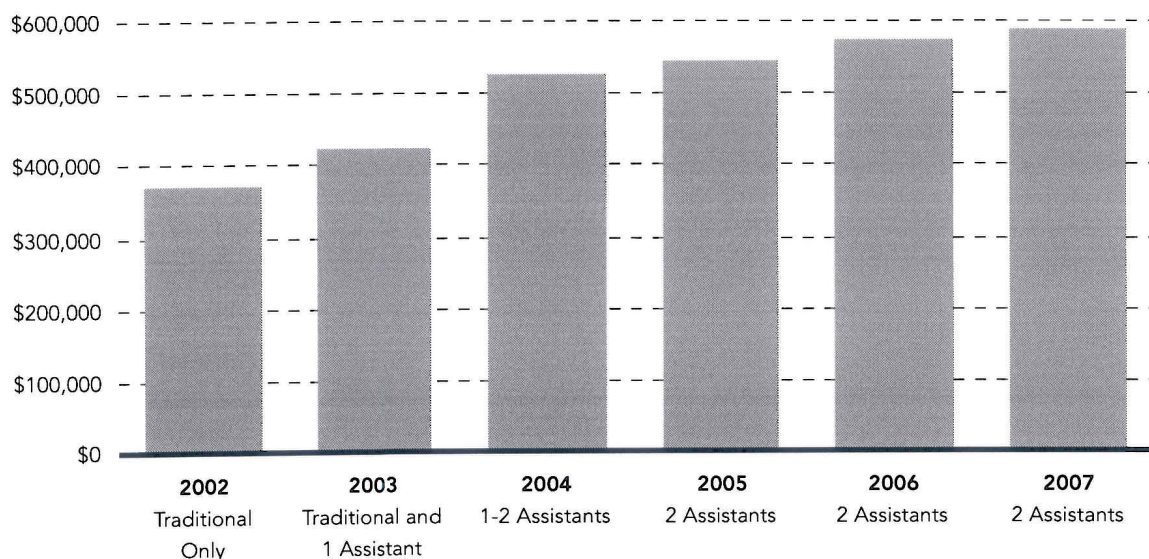Part 3: Decision making and development of a plan,
Part 4: Implementation of the plan and patient education.

During a traditional office visit, the physician completes the majority of all four components. By contrast, in a fully implemented team care model the clinical assistant gathers data according to specific protocols and communicates that information to the physician, in the presence of the patient, when the physician enters the exam room (Part 1). The physician then analyzes the data, conducts the exam, determines the diagnosis and develops the treatment plan (Parts 2 and 3). The clinical assistant documents the findings and additional information elicited by the doctor during the exam. The physician discusses the treatment plan with the patient and the clinical assistant and exits the room. The clinical assistant then closes the visit with the patient, reiterating the physician's

IMPROVED FINANCES

Dr. Anderson's collections have increased from $370,000 in 2002, before he implemented team care, to $590,000 in 2007, with a fully implemented team care model. His income and benefits equal approximately 40 percent of his collections. He sees 540 patients per month, on average, and spends 40 to 44 hours in practice per week, with five weeks paid time off per year.

Collections 2002-2007

Year	Staffing	Collections
2002	Traditional Only	~$370,000
2003	Traditional and 1 Assistant	~$425,000
2004	1-2 Assistants	~$525,000
2005	2 Assistants	~$550,000
2006	2 Assistants	~$575,000
2007	2 Assistants	~$590,000

IMPROVED QUALITY OF CARE

Based on measures used for the National Committee for Quality Assurance (NCQA) Heart Stroke Recognition Program, Dr. Anderson's quality of care, as well as his documentation, has improved since his implementation of team care in 2003. He made improvements in all measures except smoking cessation, where a 4 percent decrease resulted from one chart lacking documentation of smoking cessation counseling. The vast difference in the use of anti-platelet medications is due in part to poor documentation in 2002. While Dr. Anderson would have fallen far short of the NCQA criteria in 2002, he received 50 out of 50 points in 2007. This is just one example of his improved quality of care.

Percentage of patients receiving appropriate care

Legend:
- BP control
- Lipid measurement
- LDL control
- Anti-platelet med
- Smoking cessation

x-axis: 2002, 2007
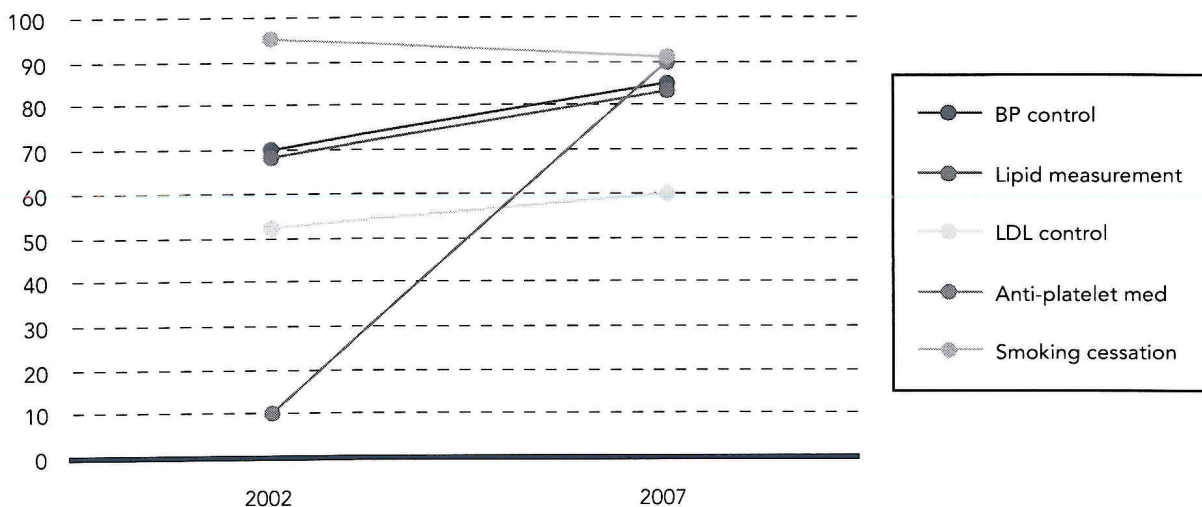
instructions and providing prescriptions, referral information and patient education materials as directed by the physician (Part 4). When fully implemented, the team care model partners two well-trained clinical assistants with one physician and requires three to five exam rooms. As the physician exits one exam room, he enters the next room where the second clinical assistant has gathered information and is prepared to start the communication process again.

The heart of the team care innovation is having an assistant who is trained and capable of soliciting and documenting a complete patient history for the visit. Taking a thorough history and updating medication lists and other important details is often the most time-consuming part of the visit. However,

because this initial gathering of information requires little medical decision making, it is not essential that the physician participate in it. Once the physician enters the exam room, he or she can hear the clinical assistant's summary of pertinent facts, with the potential for clarification by the patient, and can solicit additional information as needed. This step allows the physician to confirm and become owner of the HPI, in a sense, which ensures compliance with documentation guidelines.

Implementing team care

Implementing team care requires starting with at least one clinical assistant, whether part time or full time. This person would gener-

The assistants, usually RNs or LPNs, are trained to solicit and document a complete patient history, among other duties.

Upon entering the exam room, the physician is briefed on the patient and gathers additional data as needed.

About the Authors

Dr. Anderson, a family physician, practices at Hilton Family Practice in Newport News, Va. The practice is part of Riverside Medical Group, one of the largest multispecialty groups in the state of Virginia. He is also a visiting assistant professor of family medicine at the University of Virginia Medical School. Marc Halley is president and CEO of The Halley Consulting Group in Columbus, Ohio. He has provided practice management and consulting services to medical practices for more than 20 years. Author disclosure: nothing to disclose.

With a few hours of training, a clinical assistant can learn to gather the majority of information needed.

While the model can work with just one assistant, involving two assistants maximizes the benefits of the team care model.

ally be an RN or LPN (or a capable MA) who has exhibited dependability, has the skill and capacity to accommodate a changing role, and can commit the time for training. The physician must be able to work closely with the selected clinical assistant since the overlap of functions depends on effective interaction.

The training is primarily focused on Part 1 of the patient encounter and usually requires a few hours of discussion between the physician and the clinical assistant after both have reviewed and studied the training tools (see the resource on page 39; a detailed handbook[1] and training DVD are also available at http://www.familyteamcare.org). The assistant must be taught the different areas of information needed for a high-quality patient visit, including key questions the clinical assistant can use to uncover symptoms or illnesses.

After the initial training, the physician should continue to meet weekly with the clinical assistant to review questions on selected

disease states, discuss specific medical problems, improve their communication skills and streamline the team care process. This ongoing training enhances the working relationship between the physician and the assistant, which is essential to the success of team care.

A physician may choose to implement the team care approach with one clinical assistant or two. If only one assistant is involved, the assistant leaves the first exam room after finishing Part 1 and moves to the next patient, leaving the physician to review the first patient's chart and complete the remainder of the visit on his or her own.

Although having one assistant working on Part 1 of the patient encounter is sufficient to enhance productivity, two full-time assistants are required to maximize the benefits of the team care approach. Once a second assistant is available and trained, the assistants can effectively manage parts 1 and 4 of the encounter, allowing the physician to focus on parts 2

IMPROVED SATISFACTION

Satisfied employees contribute to satisfied patients. In Dr. Anderson's practice, employee satisfaction is consistently above the 75-percent range and higher than the overall rate achieved within their parent organization.

Percentage of employees who are satisfied

Legend:
- Hilton Family Practice
- Riverside Medical Group
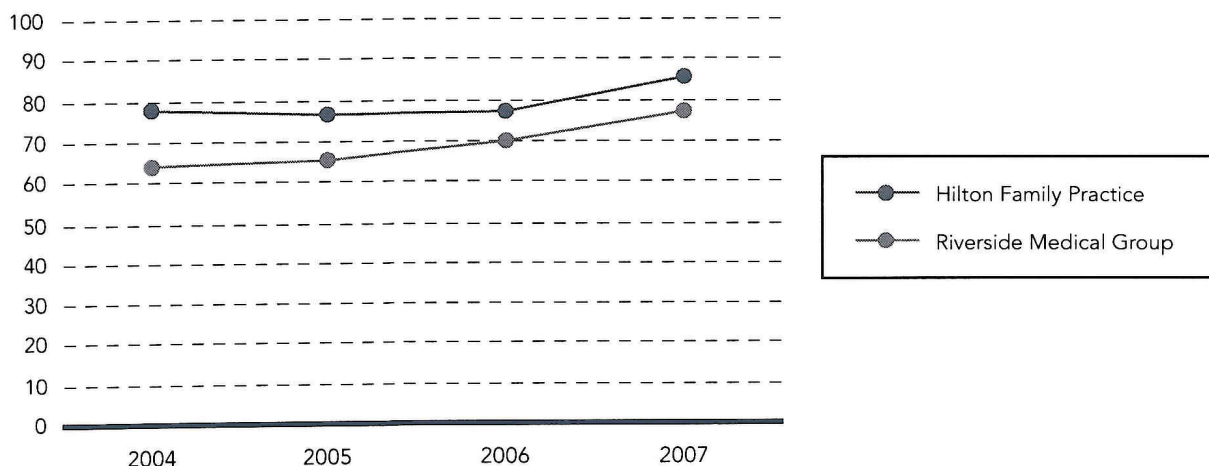
CLINICAL ASSISTANT RESPONSIBILITIES IN A ROUTINE VISIT

The following description of responsibilities relates to routine follow-up visits, such as a routine diabetes check up. The responsibilities vary for other visit types. For example, physicals include greater emphasis on preventive services, while responsibilities for follow-up visits for minor illnesses and acute visits are much more abbreviated.

PART I. ASSISTANT ONLY

A. HPI

Welcome patient and confirm patient's statement of current problems or symptoms.

Ask appropriate questions for the problems or symptoms, using the "ODD IF HAPPY" mnemonic. (Note: The handbook[1] provides specific questions in this format for 116 symptoms and diseases.)

O: Onset of symptoms – When did this episode start?

D: Description of symptoms – Constant vs. intermittent, detail of the sensation, character of the pain, location of the pain, radiation of the pain, etc.

D: Duration – How long does the symptom last?

I: Intensity – Is it mild, moderate, severe, etc.?

F: Frequency – Does it occur daily, weekly, etc.?

H: History – Is this the first episode, or has it occurred before?

A: Accompanying signs and symptoms – Do any other symptoms/signs accompany this symptom?

P: Precipitating/alleviating factors – What makes it better or worse?

P: Progression of the symptom – Is it getting better or worse?

Y: You have finished the questions for this symptom.

Review "plan" from previous two visits.

Review any appended notes or recent phone notes since previous two visits.

Collect the results of any recently completed diagnostic tests, lab results or emergency department visits.

Review problem list and get patient's update on recent problems.

Update the problem list with dates of important completed tests (colonoscopy, mammogram, etc.).

B. PAST MEDICAL HISTORY

Review and update medication list, removing completed medications.

Determine if patient is compliant with medication schedule.

Determine if patient needs refills.

Ask about side effects from medications.

Encourage patient to bring all current medications to each visit.

C. FAMILY HISTORY, SOCIAL HISTORY AND ALLERGIES

Review and update family history and social history.

Review and update allergy list.

D. REVIEW OF SYSTEMS

Review all appropriate systems. (Note: The handbook[1] can serve as a guide about which system to review depending on the problems or symptoms that necessitated the visit.)

E. PREVENTIVE CARE UPDATE

Ask briefly about last physical, well-woman exam, mammogram, lipids, etc.

Recommend and document appropriate preventive care plan.

F. POSSIBLE PROCEDURES AND QUESTIONNAIRES

Administer pulse ox, peak flow, UA, etc., when appropriate.

Administer MMSE, Epworth sleepiness scale, Zung scale, bipolar questionnaire, etc., when necessary.

PART II. ASSISTANT AND PHYSICIAN

Physician enters room, greets patient and, in the presence of the patient, obtains verbally from the assistant all the information already gathered.

Physician adds to information as necessary, and assistant records this additional information.

Physician performs pertinent physical exam and communicates findings for documentation by the assistant.

PART III. ASSISTANT AND PHYSICIAN

Physician writes down impressions and plan.

Physician updates problem list if paper charts are used or communicates to assistant, in writing, problem list changes, which the assistant records in the electronic medical record. The problem list must contain information about pertinent tests and when they are needed.

Physician reviews the impressions and plans with the patient and then politely exits, leaving the hard copy of the impressions and plan with the assistant.

PART IV. ASSISTANT ONLY

Document the impressions and plan of the physician. The plan includes tests and labs ordered, referrals initiated, new medications added, medications discontinued, suggested lifestyle changes, work notes with dates given and date expected to return to clinic.

Document any treatments or tests refused by the patient, along with the patient's acknowledgement of possible poor outcome.

Provide patient education concerning disease process, medications, tests ordered or lifestyle changes.

Explain matters of referral process or obtaining further tests at other facilities.

Provide all scripts and review them with patient.

Obtain medication samples and review dosage schedule.

Remind patient to call if necessary and to schedule any recommended return visits.

Close the visit kindly or take the patient to appropriate area of the practice for further in-office testing.

and 3. Here's how the process works: The first assistant completes Part 1 of the encounter and then is joined by the physician, who completes parts 2 and 3. When the physician exits, the assistant remains in the exam room to implement the care plan, which is Part 4. When the physician enters the next room, the second clinical assistant has completed Part 1. After completing parts 2 and 3 and leaving the assistant to complete Part 4, the physician rejoins the first assistant, who has finished with the first patient, completed Part 1 of another encounter and is ready to share the information he or she has just gathered.

Developing a fully functioning team care process can take several months. The transition is greatly facilitated by breaking the process into a series of small, sequential changes. Team care can work well with either paper charts or an EMR, but it dramatically enhances productivity of an EMR system.

The benefits of team care

The team care approach offers a variety of important benefits for family medicine offices:

1. Improved productivity and finances. In our experience, one assistant managing Part 1 of the patient encounter can increase visit volumes by 30 percent or more over the traditional approach. Two assistants can increase visit volumes by 60 percent or more. This results in increased income as well. The higher patient volume more than offsets the cost of an additional assistant. In Dr. Anderson's practice, collections increased from $370,000 in 2002 (prior to implementation of team care) to $590,000 in 2007. (See the graph on page 36.)

2. Improved documentation and quality of care. With a well-trained RN or LPN doing most of parts 1 and 4, data can be collected and recorded with less pressure and fewer time restrictions. The clinical assistant continues the documentation process while the physician performs the exam. With most of the documentation completed during the visit, the physician does not have to take time between patients or after hours to dictate. The improved documentation greatly reduces liability risk and makes it easier for physicians to demonstrate their quality of care. In Dr. Anderson's practice, performance on key quality of care measures improved greatly between 2002 and 2007 (see the graph on page 37).

3. Improved patient and staff satisfaction. Patients are delighted by the additional attention to detail and the opportunity to hear the clinical assistant reiterate their issues to the physician (and to contribute to that communication, if necessary). In Dr. Anderson's practice, 96 percent of patients say they are likely to return to the practice and 94.5 percent say they are satisfied with the manner of treatment by their physician. The fact that the practice provides same-day service for all acute visits plays a big part in patient satisfaction. The practice starts every day with 10 to 14 acute slots open for patients' medical needs that day.

Staff members who are trained to do more than move patients and take vital signs also express greater satisfaction with team care.

An approach worth trying

From a business perspective, the success of a medical practice is driven by the revenue side of the income statement. Many medical groups have had to extend their hours and reduce the time they spend with patients to remain viable. These changes have sometimes strained patient relationships and have added to physicians' frustrations. The team care approach dramatically enhances a family physician's ability to see additional patients while improving quality of care, increasing patient satisfaction, enhancing clinical documentation and improving the quality of work life for both physicians and their clinical assistants. **FPM**

Send comments to **fpmedit@aafp.org.**

1. Anderson PB. *Liberating the Family Physician: The Handbook of Team Care for 21st Century Family Medicine.* Newport News, Va: Riverside Health System; 2005 (http://www.familyteamcare.org).

After finishing with one patient, the physician leaves the first assistant to close the visit and joins the second, who has gathered the history on a second patient.

It can take several months to transition to a fully functioning team care process.

This approach allows the clinical team to see more patients each day, which boosts collections, among other benefits.

Visit Flow
(page 1 of 2)

Patient Check-in

Check weight and vitals
  Must click "calc BMI %ile" button for adults and "Growth Chart" button for children.
  Repeat BP in 5 minutes if initial reading >140/90 (repeat if >130/80 for diabetes, heart disease)

Ask about changes from the Patient Check-In Form – record changes into chart

Discuss HPI
  Detailed review of current complaint
  Please also briefly touch on chronic conditions – mentioning if pt is due for routine labs or other

Complete ROS
  Need at least two elements from two different groups

If time allows, discuss routine preventive care and administer needed vaccines

Provider in Room

Enter appropriate additional info into HPI and ROS based on additional questioning from physician

Enter physical exam findings as described by provider

Record CPOE – utilize .cpoec for confirmed diagnoses and .cpoes for symptom based diagnoses

Print labs, imaging, scripts or other needed documents

Administer vaccines or provide other services as indicated

Complete Patient Instructions tab
  Print and review with patient

Visit Flow
(page 2 of 2)

Note Completion

HPI – all CPOE problems are mentioned in the HPI
      Each problem does not need its own paragraph

PMH/PSH, FH, SH, ROS – Include as appropriate in the note, minimum of one item reviewed.

ROS – at least two elements from two systems are marked

PE – as described by provider

CPOE – utilize .cpoec and .cpoes quicktexts

Complete any needed recalls including diabetes recalls

Be sure that referrals are entered with appropriate diagnosis code attached

Record and code all injections, tests (EKG, spirometry, etc) and procedures (cerumen removal)

Place note on hold for provider and to Recall Desktop or Diabetes Desktop if relevant

Minimum Documentation Requirements
(page 1 of 2)

Problem Visit – Established Patient (has been seen in the last 3 years)
- Detailed HPI – at least 4 elements or 3 chronic diseases
- One of the following – PMH/PSH/FH/SH/Habits & Risk Factors
- ROS – 1 element from 2 different system categories (i.e. CV and Respiratory)
- Physical Exam – per physician
- CPOE – as is addressed in visit, but would aim for 3 diagnoses
    - Document which diagnoses are new
    - Document what additional workup is indicated
    - Document which medications are prescribed
    - If old records were reviewed, include "old records reviewed and summarized".

Problem Visit – New Patient (has NOT been seen in the last 3 years)
- Detailed HPI – at least 4 elements or 3 chronic diseases
- Past Medical History/Past Surgical History
- Family History
- Social History
- Habits and Risk Factors
- ROS – must be complete (every item reviewed)
- Physical Exam – per physician, will be more detailed than
- CPOE
    - Be sure that every diagnosis is noted as new
    - Document what additional workup is indicated
    - Document which medications are prescribed
    - If old records were reviewed or requested, be sure to document this.

Minimum Documentation Requirements

Well Adult Exam

- HPI can be brief if no patient concerns
- Review all of the following: PMH/PSH/FH/SH/Habits & Risk Factors
- ROS – must be complete (every item reviewed)
- Physical Exam – per physician, should be complete exam
- CPOE
  - First diagnosis should be V70.0
  - Document what preventive tests were ordered (including vaccines)
  - Document what counseling was given (i.e. exercise regularly, eat healthy, etc.)

Well Child Exam

- Utilize Bright Futures forms
- Complete History and Developmental Milestones section
- CPOE
  - First diagnosis should be Well Child Exam or Well Adolescent Exam
  - Document what counseling was done
  - Document if any tests were ordered or vaccines given.
  - Document next WCC

Routine Care

Age	Male	Female
21-39 WAE every 3 years	FLP, CMP every 5 years Td(?ap) every 10 years Flu shot every year Pneumovax x 1 if high risk (diabetes, asthma, COPD)	FLP, CMP every 5 years Pap every 3 yrs until age 30; then every 5 yrs with neg HPV Chlamydia screen once between ages 21-24 Td(?ap) every 10 years Flu shot every year Pneumovax x 1 if high risk (diabetes, asthma, COPD)
40-49 WAE every 1-2 years	FLP, CMP every 2-3 years Td(?ap) every 10 years Flu shot every year Pneumovax x 1 if high risk (diabetes, asthma, COPD)	FLP, CMP every 2-3 years Mammogram every 1-2 years Pap every 5 years with negative HPV test Td(?ap) every 10 years Flu shot every year Pneumovax x 1 if high risk (diabetes, asthma, COPD)
50-64 WAE every year	Colon cancer screening - FOBT vs. colonoscopy FLP, CMP every 2-3 years Td(?ap) every 10 years Flu shot every year Pneumovax x 1 if high risk (diabetes, asthma, COPD) Zostavax x 1 at age 60	Colon cancer screening - FOBT vs. colonoscopy FLP, CMP every 2-3 years Mammogram every 1-2 years Pap every 5 years with negative HPV test Td(?ap) every 10 years Flu shot every year Pneumovax x 1 if high risk (diabetes, asthma, COPD) Zostavax x 1 at age 60
65-75 WAE every year	Annual FOBT or colonoscopy per f/u recs FLP, CMP every 2-3 years Td(?ap) every 10 years Flu shot every year Pneumovax x 1 at age 65 if >5 years since prior Abdominal Aortic Aneurysm screening x 1 for smokers	Annual FOBT or colonoscopy per f/u recs FLP, CMP every 2-3 years Mammogram every 1-2 years Td(?ap) every 10 years Flu shot every year DEXA screening every 5 years Pneumovax x 1 at age 65 if >5 years since prior

Chronic Disease Management

Diabetes
Visits: every 3 months if last Ha1c was >7.0; every 6 months if last Ha1c <7.0
Routine testing: labs q3-6 months, Eye exam - once per year, Foot exam - each visit
Other: pneumovax x 1 prior to age 65, ASA 81mg daily, unless contraindicated
Stable = Ha1c < 7.0

Hypertension
Visit Frequency: once a year if BP stable on anti-hypertensive medication
Routine testing: BP with each visit, CMP once per year
Stable = <140/90 unless DM or CKD (then is <130/80)

Hyperlipidemia
Visit Frequency: once a year if stable on a statin
Routine Testing: FLP once per year
Stable = LDL <130, if DM or CV disease then <100

Hypothyroid
Visit Frequency: once a year if stable on thyroid medication
Routine Testing: TSH with reflex once per year
Stable = TSH in normal range

GERD
Visit Frequency: once a year if symptoms controlled on medication
Routine testing: none
Stable = no active reflux symptoms

Asthma/COPD
Visit Frequency: once a year if symptoms controlled with daily medication
Routine testing: spirometry once per year
Other: pneumovax x 1 prior to age 65
Stable = symptoms are minimal with infrequent albuterol use

Depression
Visit Frequency: once per year if stable
Routine testing: none
Stable = symptoms controlled per patient report

Dementia
Visit Frequency: once per year if stable
Routine testing: none
Other: POLST on file, contact information for DPOA or preferred contact
Stable = no significant recent progression of symptoms

Chronic Pain/ADHD
Visit Frequency: every 3-6 months
Routine testing: UDS once every 6 months (for patients over age 13), CMP once per year
Other: up to date Pain Contract on file
Stable = dontrol of symptoms without evidence of medication abuse

Chart Preparation

Pre-Visit Chart Preparation

1. **Review Problem List**
   a. Remove resolved problems – i.e. prior infections
   b. Transfer family history and past medical history items to appropriate tabs
      i. Leave history of TAH/BSO on the problem list
   c. Prioritize problems as follows:
      i. Anticoagulation
      ii.
   d. Check box "problem list reviewed"

2. Review Medication List
   a. Remove old or complete scripts – i.e. antibiotics
   b. **Update wording of medications – i.e. "BID" to "twice daily"**
   c. Order meds as follows
      i. Anticoagulants at the top (Coumadin, Plavix)
      ii. Narcotics, benzodiazepines, stimulants
      iii. Organize remainder into problem groups
      iv. Place vitamins and supplements at bottom (be sure to indent to right)
   d. Check box "medication list reviewed"

3. Review Allergies
   a. Clean up list if anything seems odd
   b. Check box "allergies reviewed"

4. Review Family History, Social History and Risk Factors
   a. Adjust wording if needed

5. **Print and review the Patient Check-In Form**
   a. Check formatting, adjust as needed

6. **Prep HPI based on known info about reason for visit**
   a. If it is an existing problem, summarize prior workup including imaging, labs and last assessment.
   b. If a new problem, gather any info that you think might be relevant – i.e. if dizziness is the complaint, hypertension may be contributor

7. **Review other chronic conditions**
   a. Use HPI to enter any other chronic issues that should/could be addressed – i.e. HTN, HLD, DM, CAD, etc

8. **Review routine Preventive Care per spreadsheet**
   a. Check Carecast and old office visit notes for undocumented preventive services

9. **Start CPOE if possible – i.e. visits for diabetes, HTN, HLD can usually have their CPOE started in advance.**

VISIT CHECK-IN FORM

Please Review the Following Information.
Update information that has changed and write-in anything that is missing.

Name: Jason J Fakerson   **DOB**: 05/05/1938

Current Medication (please confirm dosage and dosing instructions):
1) SIMVASTATIN 40 MG TABS (SIMVASTATIN) Take one by mouth every day.
2) LANTUS 100 UNIT/ML SOLN (INSULIN GLARGINE) 45 units every evening
3) METHADONE HCL 10 MG/ML SOLN (METHADONE HCL) ggdghg
4) ASPIRIN 81 MG EC TAB (ASPIRIN) Take 1 tablet by mouth once a day
5) DOCUSATE SODIUM 100 MG CAPS (DOCUSATE SODIUM) Take one tablet by mouth everyday

Allergies:
NIACIN (Critical)
PENICILLIN (Critical)

Family Medical History (significant health problems in your siblings, parents and grandparents):
Father: A&W age 99
Mother:
Siblings:
CVA
Alcoholism
Angina
Hypertension
Depression

Social History:
Marital Status: Married
Children:
Occupation: Retired, Wildcat oil driller

Health Habits:
Tobacco use: never
Alcohol use: Yes
   Drinks per day: <1
   Type: wine only on weekends
Exercise (Type and Times per Week):

Pharmacy of Choice: Fred Meyer - Lakeway

Do you have a new Advanced Directive, Living Will, or End of Life Orders?   [ ] yes   [ ] no
   Directives that we currently have on file:
   1) POLST
   2) PERPETUAL AUTH - ELAINE FAKERSON - SEE SCANNED COPY

STRUCTURE AND SYNCHRONICITY FOR BETTER CHARTING

Two key characteristics will help you to ensure that your notes communicate not only what you did, but also what you were thinking.

How many times have you read a medical note that does not make the selection of the diagnosis or treatment clear? Have you ever read your own notes after receiving notice of a malpractice suit and winced at the inconsistencies?

Poorly constructed medical notes are a widespread problem. I've seen it while reviewing the charts of medical students and residents to ensure that they met the standard of care and avoided malpractice risk. While most physicians document history and physical data with the required number of CPT elements, few clearly convey a line of reasoning that reveals their clinical thought process. A note that documents a detailed history and moderately complex decision making does not necessarily illuminate why certain decisions were reached or why a particular treatment was justified.

I wanted to find out where in the educational process students learned key documentation concepts, so I did some research that included informally querying medical students from multiple medical schools who were rotating at our residency. None of them could describe learning a formal structure for completing assessments and plans, which is consistent with a study that found only 4 percent of standardized encounters were accurately charted by medical students.[1] I also discovered that the 2010 United States Medical Licensing Examination clinical skills exam guide states that students are expected to present a list of differential diagnoses in order of likelihood along with desired evaluations, but no requirements existed for discussing the clinical rationale.[2]

As a result of these and other findings, I developed a formal framework, described in this article, to teach residents and students an appropriate way to construct their notes. The initial feedback has been highly positive.

Documenting a confirmed diagnosis

To begin, let's review what should be included when documenting a confirmed diagnosis. Generally, six elements are needed (see also "The structured note" summary on page 17).

1. New or established diagnosis. The first element overtly communicates to coders whether the diagnosis is new or established, since this helps to determine code selection.

2. Controlled or uncontrolled. The second element should communicate whether the status is controlled or uncontrolled, which also directly affects complexity and reimbursement.

3. Treatment goal. The treatment goal should be

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clearly stated. How can one justify the decision to refill, increase or decrease a medication if the desired benefit is undefined? For example, simply refilling albuterol for asthma may actually hurt the patient if he or she needed a controller medication after reporting daily rescue medicine use.

4. Evaluation or surveillance. Any evaluations or testing, whether for the intrinsic disorder or for comorbidities, must be included in the plan as the fourth element. For instance, ordering an A1C test is beneficial in monitoring diabetes, but the evaluation element also reminds physicians to screen for diabetic retinopathy or hyperlipidemia.

5. Management. Documentation of treatment or management should always be listed, even if only to write, "Continue carvedilol 12.5 mg bid." Using action verbs such as "resume" or "increase" helps communicate the treatment instructions.

6. Disposition. The final element is disposition. This is likely to include instructions for the patient to return to the clinic after a certain period of time, criteria that should prompt him or her to call the office sooner than scheduled and any actions the patient should perform at home, such as keeping a food diary or blood pressure log.

Following this structure, a note for a confirmed diagnosis might look like this:

• Hypertension: Established, uncontrolled by home blood pressure (BP) log; systolic BP

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in 150s. Treatment goal: systolic BP in 130s. Complete chemistry panel/lipids/urinalysis in one week. Increase lisinopril now to 20 mg every morning, 60 tabs, five refills. Consult nurse education for dietary approaches to stop hypertension (DASH diet). Return to clinic in one month with BP log.

• Asthma: Established, controlled. Treatment goal: albuterol needed less than three times weekly. Complete annual pulmonary function tests at next visit. Refill mometasone 220 mcg one puff daily. Continue albuterol two puffs four times daily as needed. Return to clinic in three months or sooner per asthma action plan.

Documenting an unconfirmed diagnosis

When documenting an unconfirmed or symptom-based diagnosis, two elements borrowed from the five-step "microskills" model can enhance the note and provide a glimpse into the physician's thoughts.[3] It is critically important for the physician to *commit* to a diagnosis and explain *why*, among the various differential options, this suspected diagnosis is most applicable to this particular patient. Testing to confirm or rule in the working diagnosis should be listed along with empiric or symptomatic treatment. Less likely diagnoses should be listed next, along with why they are not as probable and how to rule them out. Finally, parameters for reviewing the evaluation and treatment response should be defined. See also "The structured note" on page 17.

Following this structure, a note describing symptom-based diagnoses might read as follows:

• Abdominal pain: Suspect biliary dyskinesia due to epigastric location, relation to fatty meals, body habitus and negative right-upper-quadrant ultrasound for gallstones. Confirm with cholescintigraphy (HIDA). Treatment: fatty food avoidance. Doubt pancreatitis given nondrinker and negative ultrasound, but rule

out with amylase/lipase. Doubt gastroesophageal reflux disease (GERD) given proton-pump inhibitor use and contrast to usual GERD symptoms. Return to clinic after HIDA scan and consider surgery consult.

• Rash: Suspect allergic photodermatitis given location in sun-exposed areas and onset after use of new sunscreen lotion. Confirm by stopping lotion. Treatment: PABA-free sunscreen. Doubt lupus given no prior history and absence of other complaints. Doubt prescription medications due to no admitted use. Return to clinic if symptoms persist after lotion change.

Synchronicity

Finally, synchronicity should be evident in every note both globally and locally, that is, both within and across the major sections. For example, the past medical history should match the medication list. If it doesn't, a reviewing physician may wonder what other aspects of care were sloppy or incomplete. Here's an abbreviated example of poor *local* synchronization:

• Past medical history: hyperlipidemia, COPD.

• Meds: tiotropium, lisinopril, levothyroxine.

Synchronicity between the subjective/objective (S/O) and the assessment/plan (A/P) sections of the note is also important. For example, if the physician documents three abnormal items in the S/O section, but the A/P only lists two diagnoses, then a mismatch

exists between abnormal data collected and assessments made. Not only might this pattern result in underpayment, but it also puts physicians in indefensible positions if a malpractice case ensues. Most important, it may contribute to patient harm.

Here's an abbreviated example of poor *global* synchronization:

• Subjective/objective abnormal data: Epigastric burning pain at bedtime, non-scarring hair loss three months postpartum, loss of urine with coughing and laughing.

• Assessment: GERD, telogen effluvium.

Summing it up

Structure and synchronicity are part of disciplined note construction, which is critical to effective communication between physicians. Better documentation may also contribute to clearer medical decision making, which is needed for reimbursement and malpractice defense. Instruction in comprehensive note writing should be promoted in early predoctoral education and continued throughout postgraduate medical training. **FPM**

Send comments to **fpmedit@aafp.org.**

1. Szauter KM, Ainsworth MA, Holden MD, Mercado AC. Do students do what they write and write what they do? The match between the patient encounter and patient note. *Acad Med.* 2006;81(Suppl 10):S44-S47.

2. U.S. Medical Licensing Examination. *2010 Step 2 Clinical Skills: Content Description and General Information.* http://download.usmle.org/2010/2010CSinformationmanual.pdf. Accessed May 17, 2011.

3. Parrot S, Dobbie A, Chumley H, Tysinger JW. Evidence-based office teaching – the five-step microskills model of clinical teaching. *Fam Med.* 2006;38(3):164-167.

When documenting an unconfirmed diagnosis, the physician should commit to a diagnosis and explain why the diagnosis is the most likely.

Synchronicity should be evident in every note. For example, the rationale for each drug on the medication list should be implicit in the past medical history.

Better documentation contributes to clearer medical decision making, which is needed for reimbursement and defense against malpractice suits.

THE STRUCTURED NOTE

The table below shows the essential components of a detailed assessment and plan.

Confirmed diagnosis	Symptom-based diagnosis	
New or established diagnosis	Suspected diagnosis	
Stable or uncontrolled	Rationale	
Treatment goal	Evaluation (to confirm)	SYNCHRONIZE LOCALLY AND GLOBALLY
Evaluation/surveillance (including related comorbidities)	Management	
Management	Less likely diagnoses	
Disposition	Rationale	
	Evaluation (to rule out)	
	Disposition	

CPOE Quicktexts

Confirmed diagnosis
Quicktext: .cpoec

New vs. Established Problem
Stable vs. Uncontrolled
Treatment goal:
Additional testing (labs, imaging):
Management plan (medications, therapies):
Follow-up instructions:

Symptom based
Quicktest: .cpoes

Suspected diagnosis:
Reasoning:
Other possible diagnoses:
Diagnostic testing (labs, imaging):
Management plan (medications, therapies):
Follow-up Instructions: