

APPENDIX A

<https://www.congress.gov/115/plaws/publ182/PLAW-115publ182.pdf>

APPENDIX B

MISSION Act Section 507: Medical Scribe Pilot Program

Training Manual

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- Katherine Williams, MPH, Health Systems Specialist
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MISSION 507: Medical Scribe Pilot

I. Purpose

The purpose of the MISSION Act Section 507: Medical Scribe Pilot Program Training Manual is to provide a comprehensive reference document for both Medical Scribes and their respective facility's teams in order to facilitate a smooth implementation of the medical scribe pilot at their facility.

II. Background

Medical scribes are intended to take the burden of interacting with the computer off the shoulders of the physician or Licensed Independent Practitioner (LIP) so these clinicians can focus on diagnosis and treatment during the visit. Scribes are popular with some non-VA practices in part because they allow clinicians to see more patients during their day. Congress is asking VA to pilot scribes in VA to study the potential benefits and costs. The results of this pilot will inform future VA policy.

The main role of scribes is to provide documentation assistance to a physician or LIP. The scribe listens and records relevant information from the discussion between the clinician and patient per the direction of the clinician. This information, while documented by the scribe, is the clinician record for all medical purposes. The clinician is ultimately responsible and must review, edit, and ultimately verify the record.

The Medical Scribe Pilot is authorized by law as documented in Section 507 of the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act. Section 507 states "The Secretary of Veterans Affairs shall carry out a 2-year pilot program under which the Secretary shall increase the use of medical scribes at Department of Veterans Affairs (VA) medical centers". The scribe program will be implemented at 12 medical centers of the Department with the following criteria:

1. At least four such medical centers located in rural areas
2. At least four such medical centers located in urban areas
3. Two such medical centers located in areas with need for increased access or increased efficiency, as determined by the Secretary

The following sites have been chosen to participate in the MISSION 507 Medical Scribe Pilot:

1. Oklahoma City Healthcare System (Oklahoma City, OK)
2. VA New Jersey Healthcare System (East Orange, NJ)
3. Fargo VA Hospital (Fargo, ND)
4. Clarksburg VA Medical Center (Clarksburg, WV)
5. Southern Arizona VA Healthcare System (Tucson, AZ)
6. Louisville VA Medical Center (Louisville, KY)
7. Hampton VA Medical Center (Hampton, VA)
8. South Texas Veterans Healthcare System (San Antonio, TX)
9. Togus VA Medical Center (Augusta, ME)
10. Montana VA Healthcare System (Fort Harrison, MT)
11. Department of Veterans Affairs Manchester Medical Center (Manchester, NH)
12. Olin E. Teague Veterans Medical Center (Temple, TX)

A. Medical Scribes

As part of the pilot program, four scribes will be assigned to each of the 12 pilot sites. Two of the medical scribes will be hired as Department of Veterans Affairs term employees and the remaining two will be provided by a VA Contract. Thus, each site will have two VA employee scribes and two contract scribes. Two medical scribes will be assigned to one physician, and/or LIP at each facility. According to the MISSION Act Section 507, thirty percent of the medical scribes shall be employed in the provision of emergency care and seventy percent of medical scribes shall be employed in the provision of specialty care in specialties with the longest patient wait times or lowest efficiency ratings, as determined by the Secretary. For this pilot, sites will have their scribes assigned to either the Emergency Department (ED), or Cardiology and/or Orthopedic clinic

Medical Scribes (both VA employee and contract) will work directly with their assigned physician and/or LIP to assist in medical documentation and any of the below duties:

1. Transcribing information into the electronic health record, as directed by physician and/or LIP, during the patient visit
2. Record diagnostic results such as radiology interpretations and lab values, enter medication orders, physical therapy orders, home exercises, educational handouts, work restrictions and other orders per LIP instruction

3. Assisting the physician and/or LIP in navigating the health record and gathering necessary information when directed
4. Researching additional information, as directed by the physician and/or LIP, for use in coordinating referrals
5. Preparing reports, responding to messages, and other clerical tasks as directed by the physician and/or LIP
6. Ensuring records are accurate, complete and reviewed for spelling, grammar, and sequential order before review by the Treatment Team
7. Ensuring up-to-date record movement control and accountability through record tracking in the health record
8. Ensuring forms are accurate and signed by appropriate individuals for request and release. Requesting records from VA and non-VA facilities as directed by the Treatment Team
9. Ensuring medical documentation complies with Joint Commission and other accreditation body requirements
10. Using knowledge of qualitative and quantitative data collection methods to improve the health records system by ensuring proper workload credit and statistical information is maintained

III. Definitions

Scribes must know the meaning of a variety of medical terms in order to perform their duties. Some of these terms include:

Adjunct Condition: although not service connected, is medically determined to be associated with or is aggravating a disease or condition, which is service connected.

Agent Orange: is an herbicide that was used in Vietnam between 1962 and 1971 to remove unwanted plant life that provided cover for enemy forces.

Chief Complaint: is a concise statement describing the symptom, problem, condition, diagnosis, or other factor that is the reason for the encounter, usually stated in the patient's words.

Combat Veterans: served on active duty in a theater of combat operations during a period of war after the Persian Gulf War or in combat against a hostile force during a period of hostilities after November 11, 1998.

Consultation: is a type of service provided by a physician and/or LIP whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source.

Diagnosis: is the identity of a medical condition, cause or disease.

Encounter: is a professional contact between a patient and a clinician vested with primary responsibility for diagnosing, evaluating, and/or treating the patient's condition.

Encounter documents contain information needed for workload reporting (workload ultimately funds the facility) and patient or insurance billing.

Family History: Record of health information about a person and his or her close relatives. A complete record includes information from three generations of relatives, including children, brothers and sisters, parents, aunts and uncles, nieces and nephews, grandparents, and cousins.¹ A review of medical events in the patient's family, including diseases that may be hereditary or place the patient at risk.

History of Present Illness (HPI): is a chronological description of the development of the patient's present illness from the first signs and/or symptom or from the previous encounter to the present. It includes the following elements:

- Location
- Quality
- Severity
- Timing
- Duration
- Context
- Modifying Factors
- Associated Signs and Symptoms

Medical Decision Making: Evaluation and Management (E/M) service levels are documented on the encounter form and include four types of medical decision-making services: straight-forward, low complexity, moderate complexity and high complexity. Medical decision is one component involved in picking and E/M code which considers the

¹ "Why Is It Important to Know My Family Medical History? - Genetics Home Reference - NIH." U.S. National Library of Medicine, National Institutes of Health, ghr.nlm.nih.gov/primer/inheritance/familyhistory.

complexity of establishing a diagnosis and/or selecting a management option as measured by:

- The number of possible diagnoses and/or the number of management options that must be considered.
- The amount and/or complexity of health records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed; and
- The risk of significant complications, morbidity and/or mortality, as well as comorbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

Medical Necessity: is defined as tests and services that are determined to be reasonable and necessary. Documentation supporting diagnosis codes assigned for procedures performed must be maintained in the record and be legible. Physicians must provide the specific symptom, sign or diagnosis at the time the service is ordered.

Military Sexual Trauma (MST): Sexual trauma experienced while on active duty in the military or while in active duty for training status. Sexual trauma is defined as sexual harassment, sexual assault, rape and/or other acts of violence. Sexual harassment is further defined as repeated unsolicited, verbal or physical contact of a sexual nature, which is threatening in nature.

Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF): The Global War on Terror (GWOT) includes Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF); these have been ongoing conflicts since October 2001.

Outpatient Visit: Any visit made to a hospital outpatient department, or hospital unit providing health and medical services to individuals who receive services but do not require hospitalization overnight. (Note: definition adapted from reference 2 below)²

Past, Family and/or Social History (PFSH): consists of a review of three areas:

- Past History
- Family History
- Social History

² Healthcare Research. Medical Expenditure Panel Survey Topics, meps.ahrq.gov/mepsweb/data_stats/MEPS_topics.jsp?topicid=38Z-1.

Past History: The patient's past major illnesses, injuries, operations, hospitalizations, current medications, allergies, age appropriate immunizations status, and age appropriate dietary status.

Provider: is a person or organization that furnishes health care to a consumer and bills or is paid for the health care in the normal course of business. This includes a professionally licensed practitioner who is authorized to operate in a health care delivery facility.

Review of Systems (ROS): is an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms which the patient may be experiencing or has experienced. For purposes of ROS, the following systems are recognized:

- Constitutional (fever, weight loss)
- Eyes
- Ears, Nose, Mouth, Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin, breast)
- Neurological
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/Immunologic

Shipboard Hazard and Defense (SHAD)/Project 112: Program for both shipboard and land-based biological and chemical testing that was conducted by the United States (U.S.) military between 1962 and 1973.

Service Connected: VBA determination (rating) that a Veteran's illness or injury was incurred in or aggravated by military service.

Social History: An age appropriate review of past and current activities (such as marriage or living arrangements, employment history, use of drugs, alcohol and tobacco, education, sexual history and other related relevant social factors).

VA Video Connect (VVC): VA Video Connect allows Veterans and their caregivers to quickly and easily meet with VA health care providers through live video on any computer, tablet, or mobile device with an internet connection.

IV. Scribe Pilot Process

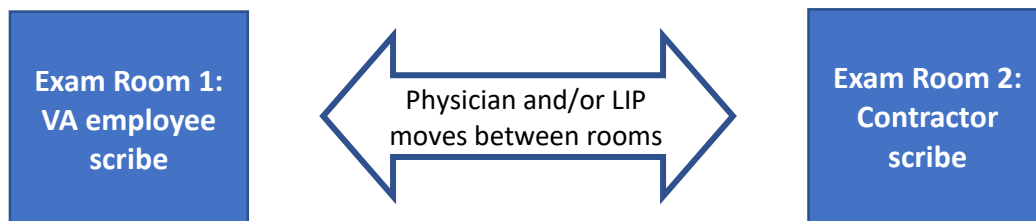
A. Scribe Pilot Process

For MISSION 507, each facility will employ in total, four scribes with two physicians and/or LIPs participating in the pilot. Each physician and/or LIP will be assigned two scribes, one VA employee scribe and one Contractor scribe. Effective incorporation of scribes into clinic processes requires a clear understanding of the roles, processes, and tasks. The best resulting system has the clinician (the most expensive resource) as the “constraint” or rate-limiting step for clinic flow. This means the clinician must be maximally used in performing patient care working at the top of their licensure and competency for as much of the day as possible. Below is a potential clinic process flow for one physician and/or LIP, one VA or contractor scribe.

Two Rooms:

1. It is ideal for each practice (defined as 1 physician and/or LIP, 1 VA employee scribe, and 1 Contractor scribe) to use two exam rooms for maximal efficiency. In this model, one scribe is assigned to each exam room.
2. The physician and/or LIP will alternate between the two exam rooms seeing patients.

While the physician and/or LIP is with VA employee scribe and patient in exam room 1, Contractor scribe will finish notes in exam room 2 from previous patient. As physician and/or LIP is with Contractor scribe and patient in exam room 2, VA employee scribe will finish notes in exam room 1 from previous patient.



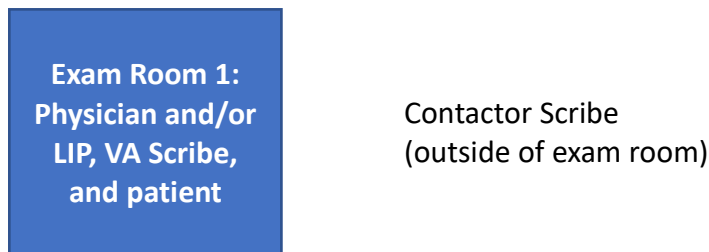
3. At the next break, physician and/or LIP reviews the scribes' notes with the scribes. Physician and/or LIP approves and signs.

One Room

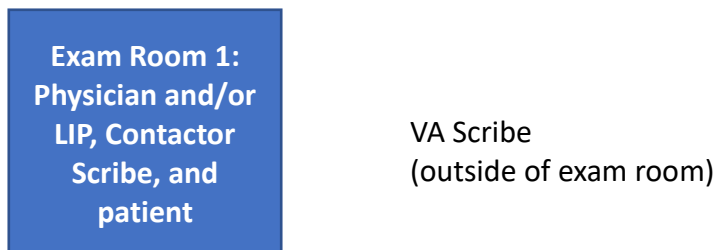
If the practice (1 physician and/or LIP, 1 VA employee scribe, 1 Contractor scribe) only has one room in which to work, it is possible that the room (not the clinician) could become the constraint, or rate-limiting step in the clinic. Teams will have to be creative in designing the clinic flow in this case and use the exam room for "only" things that need an exam room and move as much of the other workflow outside the room. This scribe model will still improve efficiency.

Below describes the process for one group (1 physician and/or LIP, 1 VA employee scribe, and 1 Contractor scribe) using one room. Essentially, scribes (VA scribe and Contractor scribe) will alternate between patients as the physician and/or LIP sees patients in one exam room.

1. Physician and/or LIP and VA scribe will be with a patient in the exam room. Meanwhile, the Contractor scribe will be outside of exam room finishing notes from the previous patient.



2. When the physician and/or LIP is completed with the appointment, the VA employee scribe, physician and/or LIP and patient will leave the room.
3. Follow regular procedures for prepping room and bringing in a new patient for their appointment.
4. When exam room is ready and new patient is in the room, physician and/or LIP and Contractor scribe enter room and complete appointment. Meanwhile, VA employee



scribe will finish notes from previous patient outside of exam room.

5. Continue steps 1-4 (scribes alternating between patients) until physician has break in clinic schedule.
6. At the next break, physician and/or LIP reviews the encounter notes with the scribes. Physician and/or LIP approves and signs the note.

Virtual Scribe

There are several instances where the utilization of a virtual scribe could be accomplished. Facilities with space constraints, provider/practice location and remote Veteran care are all ideal situations where virtual scribing can be utilized.

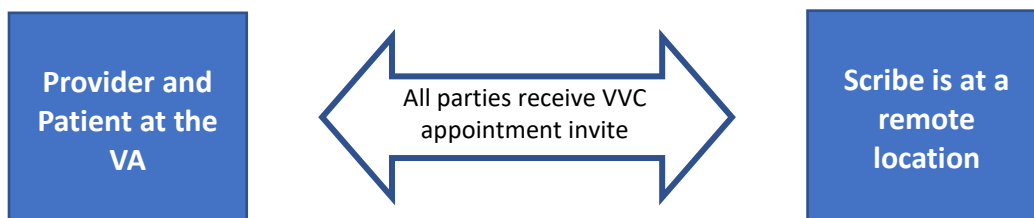
Scenario 1: Provider and scribe together in the exam room at VA location and Patient is at a remote location connecting via VVC on a computer or IOS app capable device.



Scenario 2: Patient and scribe are in an exam room at VA location and provider is at another VA location.



Scenario 3: Provider and patient are in an exam room at a VA location and scribe is at a remote location.



Scenario 4: Provider, patient, and scribe are in different locations.



Emergency Room

Each facility will have some scribes available in the Emergency Room (ER). Consistent with the principles above, ER teams must use the scribes to maximize the physician or LIP’s time.

B. Example Ramp Up Schedule for MISSION 507 Medical Scribes:

Medical Scribes will need some time to gain confidence in their new position so it is expected there will be ramp up period for them in terms of the number of patients seen per day. Please do what works best for your facility, scribes and providers but below offers an example of a schedule for a beginner medical scribe.

MISSION 507 Medical Scribe Beginner Schedule (Week 1)					
	Monday	Tuesday	Wednesday	Thursday	Friday
1 Provider Patient #	14	14	14	14	14
VA Employee Scribe # of Patients/day	3	4	5	6	7
Contract Scribe # of Patients/day	3	4	5	6	7

*** Please remember, this is just an example. Please adapt to whatever is best for your facility and provider schedules

C. Pilot Site Program Implementation Checklist

The below checklist can be used by scribe pilot site administrators to ensure they have completed all the necessary tasks prior to the arrival of their medical scribes for a successful implementation of the medical scribe pilot:

- Ensure all administrators and physicians/LIPs completed review and understand all topics in Medical Scribe Training Manual

- Connected with local Systems Redesign Coordinator to develop current state and future state process maps for facilitation of scribe into clinic flow
- Ensure local facility CACs and local facility CPRS trainers completed quick order trainings and are prepared to train scribes on how to enter notes and orders in CPRS

D. Medical Scribe Onboarding Checklist

The below checklist can be used by all medical scribes throughout their first weeks in the position to ensure they have completed all onboarding tasks:

- Completed VA New Hire Orientation (for VA medical scribes only)
- Completed and understood concepts in Medical Scribe Training Manual
- Completed CPRS training at the facility as a new employee
- Met with facility CAC or CPRS trainer to learn how to enter notes and orders on CPRS
- Obtained facility CAC or CPRS trainer contact information in case have further questions on CPRS
- Met with assigned Physician and/or LIP to discuss progress note template and other general preferences
- Received orientation of workspace and available equipment by scribe administrator or Physician and/or LIP
- Ensure understand ramp up schedule and number of patients seeing each day

V. Scribe Trainings and Orientation

Trainings to be offered by VA Central Office:

Trainings will be available on the [MISSION 507 SharePoint](#):

Training Manual

The training manual developed by the OVAC MISSION 507 Medical Scribe Pilot team will cover information on the overall pilot as well as documentation guidelines and tips for the medical scribes.

Clinic Flow

Local Systems Redesign Coordinators will provide training on clinic flow and assist pilot sites with developing current and future state flow maps to facilitate implementation of scribes into clinic flow.

CPRS Order and Progress Note Trainings (Cardiology, Orthopedics and Emergency Department)

Training/Guide will be provided for Clinical Application Coordinators (CACs) to set up the process in Vista/CPRS

Pilot sites' Computerized Patient Record System (CPRS) trainers, CACs/Health Information Management Service (HIMS), or other appropriate personnel will need to meet with the scribes to train on entering the orders, notes, etc.

Trainings that should be conducted at Pilot Sites:

New Employee Orientation

All scribes will attend the mandatory New Employee Orientation conducted at their facility and

Training with facility CACs/CPRS trainers

Facility CACs/CPRS trainers are expected to meet with all scribes at pilot sites to discuss CPRS and order entry and will act as a POC for scribes in the event they have further questions about the Electronic Health Record (EHR).

Training with facility Systems Redesign or Improvement staff

Facilities should arrange time with the Systems Redesign staff to review the current state of clinic flow and make adjustments to the new state, if possible.

Training with assigned Physicians and/or LIPs

Physicians and/or LIPs should review training manual and attend training manual presentation to understand scribe pilot processes. It is also critical to remember that medical scribes (VA or contract) cannot release orders. Providers and/or LIPs should work with their assigned scribes through the clinic and documentation flow during their 1:1 training. Also, Physicians and/or LIPs need to ensure there is time throughout their day to meet with the scribes, especially during their first few weeks together, to review notes and help to build the scribe/provider relationship. Physicians and/or LIPs should work together with their scribes during patient visits such that the physician and/or LIP should organize the visit by following an agreed upon documentation template so that the scribe knows where to input information.

Medical Record Documentation Guide for Scribing

VI. Policies and Procedures

A. Policies and Procedures

Each facility should have a policy/procedure regarding processes associated with scribes. Per guidance from The Joint Commission, (reference: Perspectives Newsletter, August 2018, Volume 38, Issue 8 – The Official Newsletter of The Joint Commission.)

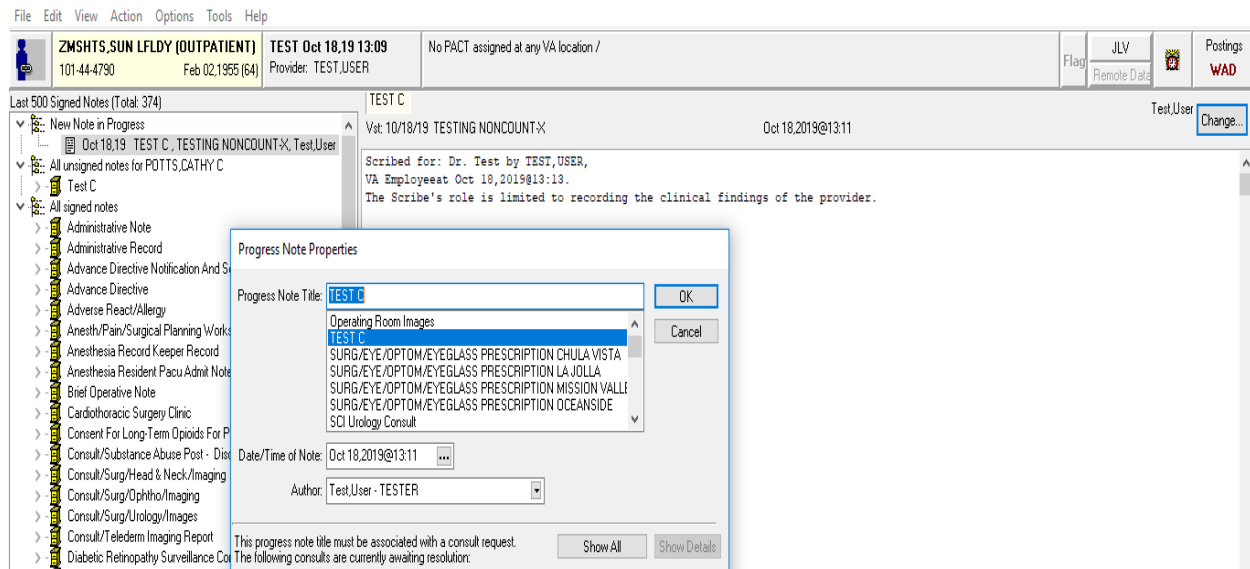
The documentation should include:

- Support the use of scribes and performance of scribing actions
- Scribes enter information in the electronic health record (EHR) or chart, as directed by a physician or Licensed Independent Practitioner (LIP).
- All documentation must be reviewed, edited, and submitted by the LIPs who will be responsible for the content of the progress notes, orders, and other documentation.
- Progress notes will not be viewable in CPRS prior to review, verification, editing, and signature by the provider.
- All orders entered by personnel who are not authorized to submit orders should be entered in CPRS entering the ordering provider's name and held for signature by the provider. The provider will review and submit the orders only after verification.
- Transcribing orders in CPRS is NOT considered a verbal order.
- Scribes must use proper log-in procedures – such as prohibition of documentation assistants from using the physician or LIP's log-in
- An example policy is located on the MISSION Act Pilot SharePoint: <https://vaww.vha.vaco.portal.va.gov/sites/DUSHOM/10NA/ACAO/MISSION507/Hiring%20Resources/Policy>

B. Progress Notes

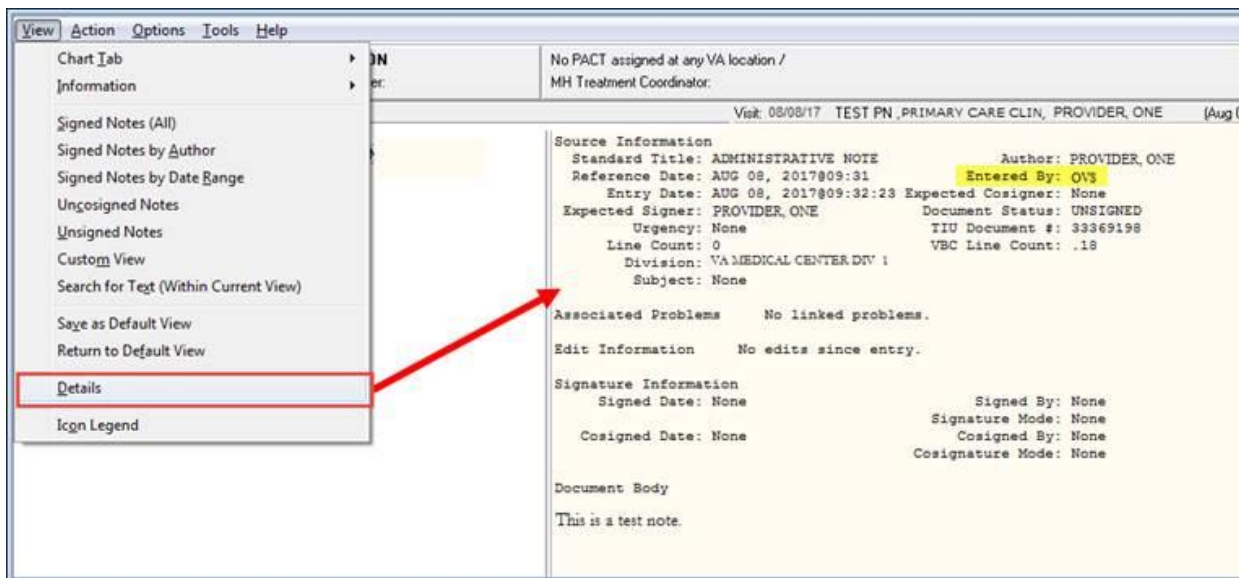
When writing a progress note, once the scribe has entered all information in the note, the scribe is to change the author's name from the scribe's own name to the physician or LIP for this patient visit. This is performed on the CPRS notes Tab, as shown in Figure 1 below. The LIP will then be displayed as the Author of the note.

Figure 1:



To serve as an audit trail, the scribe's initials will appear in the "Entered by" field of the document when displaying the details of the document as shown below in Figure 2.

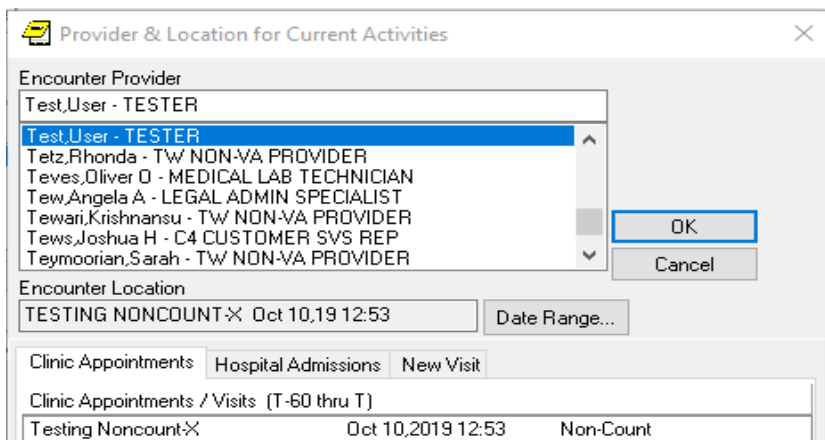
Figure 2:



It is crucial that the scribe utilizes a templated progress note provided by the provider so that the communications during the patient visit will be easier to document in the note. The note may also contain data objects that automatically pull in laboratory or radiology results, medications, etc. that will simplify the documentation.

C. Orders

Orders for non-clinical scribes should be set up to automatically accept orders to avoid clinical decisions. The scribe should enter the order by entering the provider's name in the Encounter Provider. When the scribe clicks on the Orders Tab, and selects an order on a menu, the provider name will need to be selected on the Provider & Location for Current Activities and then click OK.



As a result, the Provider's name will appear in the box next to the patient's name at the top of the screen.

ZZTEST, TRY AGAIN (OUTPATIENT)	TEST Oct 10, 19 12:53
000-00-4790 Feb 02, 1955 (64)	Provider: TEST,USER

The Imaging order below shows that the status of the order is Unreleased and the Provider's name Test,User is listed, not the Scribe's name. Scribes cannot release any orders.

Service	Order	Start / Stop	Provider	Nurse	Cl..	Status	Location
Imaging	KNEE 3 VIEWS RIGHT (Modifier), Weight Bearing, Right (mod, Merchant View, Right (modifier), LEFT (Modifier) *UNSIGNED*	Start: TODAY	Test,User			unreleased	Testing Noncount-X

It is a best practice for the scribe to use the same or a similar menu as their provider so that they are consistent. The scribe orders should be "auto accept" orders.

Please see recommended orders for each of the 3 scribe pilot specialties below. Each site can review the suggested orders and set up orders for scribes if needed, based on the facility's needs.

Definition

Quick orders consist of a standard template of common orders scribes can choose from to limit scribes from making clinical decisions.

D. Orthopedics Orders Recommended

Ortho Scribe Menu			Done
RETURN TO CLINIC Return to Clinic Order	PHARMACY Non-VA Meds Dalteparin Procrit 40K SQ QwK x 3wKS Outpatient Meds/Supplies/IV Order Menu	REQUEST SURGERY ORTHOPEDIC Orthopedic Surgery Request	
LABS Basic Hepatic Panel Basic Metabolic Panel BMP Carboxy Hgb (venous) CBC with Diff Cell Count-Synovial Synovial Fluid Exam Diabetes Panel Fungal Culture Nicotine & Cotinine Metabolite Ostopaenia Order Set PT/PTT/INR Sedimentation Rate	RADIOLOGY/NUCMED Nuclear Medicine Menu Bone Density Whole Body Bone Scan Limited Area Bone Scan Three Phase Bone Densitometry (Dexascan) Bone Densitometry for Hyper	PREOP Pre-Invasive Procedure orders	
	Imaging/X-Ray/CT Common Imaging orders	CONSULTS/PROCEDURES Consults PT/OT	
		MISC Discharge from Clinic Request for Surgery Allergy/Adverse Reaction	

E. Emergency Department Orders Recommended

Emergency Room Scribe Menu			Done
<p>Anaphylaxis</p> <ul style="list-style-type: none"> Order Set PT/INR PTT Hold extra blood tubes 	<p>Shortness of breath</p> <ul style="list-style-type: none"> Order Set CXR 2 view VBG STAT ABG STAT Lactate STAT Troponin Blood Culture X 2 Sputum Culture and Gram Stain Albuterol/pratropium(Duoneb) 3m NebulizerX1 Solumedrol 125 mg IV X 1 Prednisone 60 mg PO X 1 NS 1L Bolus over 1 hour Albuterol 3m Nebulizer X 1 	<p>Nursing Orders</p> <ul style="list-style-type: none"> Click here for nursing orders 	
<p>Chest Pain</p> <ul style="list-style-type: none"> Order Set Chest X-RAY PA & Lateral 		<p>Medications</p> <ul style="list-style-type: none"> Non IV Medications IV Push-IVPB IV Drips & IV Fluids 	
<p>Flank Pain</p> <ul style="list-style-type: none"> Order Set X-RAY, MRI, CT, US 		<p>Lab Orders</p> <ul style="list-style-type: none"> Click here for lab menu 	
<p>Hematuria</p> <ul style="list-style-type: none"> Order Set CBC & Diff (Stat) PT/INR 	<p>Stemi</p> <ul style="list-style-type: none"> Order Set Nitro Drip Morphine 4 mg IVP Heparin Bolus NS 1L at 20 mL/hr 	<p>Imaging Orders</p> <ul style="list-style-type: none"> X-RAY,CT,MRI,US orders 	
<p>Hyperglycemia</p> <ul style="list-style-type: none"> Order Set VBG STAT Chest X-Ray PA & Lateral 	<p>Stroke</p> <ul style="list-style-type: none"> Order Set 	<p>Consults</p> <ul style="list-style-type: none"> Cards-Output-STAT Cards Outpt Mental Health-Output-STAT Mental Health-Output Neuro-Output Neuro Surg-Output Plastics-Output Stroke-Output Surgery-Output Transfer Coordinator Urology Output-STAT Urology Output 	
<p>Hyperkalemia</p> <ul style="list-style-type: none"> Order Set VBG STAT Uric Acid Digoxin Potassium 	<p>Suspect Overdose</p> <ul style="list-style-type: none"> Order Set B12/Folate Valproic Acid Level Carbamazepine Level Lithium Level Flumazenil 0.2 mg IV Nalozone 0.4 mg IV x 1 Activated Charcoal 100grams PO/NGT x 1 Haloperidol 5 mg IVP x 1 Diphenhydramine 50 mg PO x 1 Lorazepam 2mg IVP x 1 		
<p>Sepsis</p> <ul style="list-style-type: none"> Order Set Blood Cultures X 2 Troponin 1 Phosphorus Type & Screen only 	<p>Syncope</p> <ul style="list-style-type: none"> Order Set 		

F. Cardiology Orders Recommended

Scribe Cardiology Orders			Done
<p>PROCEDURES</p> <ul style="list-style-type: none"> ECG Event monitor Holter monitor Cardioversion <p>Cath Lab</p> <ul style="list-style-type: none"> Left heart cardiac catheterization Right heart cardiac catheterization Pacemaker or ICD insertion <p>Stress Tests</p> <ul style="list-style-type: none"> Exercise stress test Exercise MPI Pharmacologic MPI Echocardiography-Dobutamine <p>Echocardiography</p> <ul style="list-style-type: none"> Echocardiogram- Transesophageal Echocardiogram- Transthoracic <p>EP Lab Procedures</p> <ul style="list-style-type: none"> Afib ablation Generator change Pacemaker implantation ICD implantation Bi-V ICD implantation Bi-V upgrade VT/PVC ablation SVT ablation Diagnostic EP study Tilt table testing DFT testing Lead reposition Lead replacement Lead removal/extraction 	<p>NURSING</p> <ul style="list-style-type: none"> Cardiac monitoring Clean and dress wound Discharge patient EKG Foley placement IV saline lock IV NS bolus NGT placement to suction Nasal Canula O2 via mask Peak Flow Post Void Residual Pulse Ox placement Restraints Straight Cath <p>LABORATORY</p> <ul style="list-style-type: none"> Basic metabolic panel (BMP) Blood Gas (arterial) BNP CBC with diff CK, CK-MB D Dimer Digoxin Level Fe/TIBC Ferritin Free T4 H&H Hemoglobin A1C HIV Antibody Influenza (Flu) swab Lipid panel Liver panel (SGPT, SGOT, Bili, Alk Phos) Magnesium Potassium PT/INR, PTT Retic count Sed Rate Troponin Level TSH UA with WC Urine C & S 	<p>CONSULTS</p> <ul style="list-style-type: none"> Cardiac Surgery Outpt Electrophysiology Outpt Mental Health - Outpt Neurology-Outpt <p>IMAGING</p> <p>X-Ray</p> <ul style="list-style-type: none"> Abdominal series CXR single view CXR - 2 view - PA/LAT CXR-Decubitus <p>CT</p> <ul style="list-style-type: none"> Head w/o contrast - stroke Angio head and neck Angio PE Angio Aorta Angio Abdominal Abd/Pelvis with contrast Abd/Pelvis CAC Score Cardiac CT <p>MRI</p> <ul style="list-style-type: none"> Brain - Stroke Cardiac <p>US</p> <ul style="list-style-type: none"> Abd complete Abd RUQ Carotid US Echocardiogram- Transesophageal Echocardiogram- Transthoracic Extremity for DVT <p>Nuclear Medicine</p> <ul style="list-style-type: none"> Exercise MPI Pharmacologic MPI MUGA Cardiac Viability 	

VII. Documentation

A. Tips and Guidelines for Excellent Clinic Notes

1. The health record is complete and legible.

2. Documentation includes the reason for the visit and is timely, accurate and authenticated.
3. Use key terms that have unambiguous meaning.
4. The final diagnosis is reflective of care documented.
5. If not specifically documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred by an independent reviewer. An example is documenting in a progress note that a blood glucose level was ordered for a diabetic patient.
6. Past and present diagnoses documented are accessible to the treating and/or consulting physician.
7. Appropriate health risk factors are identified.
8. CPT, HCPCS and ICD-9-CM codes reported on the encounter form are supported by the documentation in the health record.
9. Visit (Evaluation and Management) codes are based on:
 - a. History
 - b. Exam
 - c. Complexity of Medical Decision-making
10. Time can be used as an indicator if:
 - a. Counseling or coordination of care took >50% of the total visit time
 - b. Documentation includes what patient was counseled about
 - c. Documentation includes total time of visit
 - d. Documentation includes total time counseling
11. Medication reconciliation across the continuum of care is accurate and complete.
<http://www.jointcommission.org/patientsafety/nationalpatientsafetygoals/>
12. Use appropriate note titles and templates.
13. All clinical treatments and procedures require the prior, voluntary informed consent of the patient, or if the patient lacks decision-making capacity, the patient's authorized surrogate using iMedConsent™.
14. Ensure all documentation is professional and defensible.

B. Copy and Paste Guidelines

1. There is limited use of copy and paste in the electronic health record.

2. Documentation should only include information or data specific and pertinent to the care provided for the particular date of service.
3. Copying unnecessary information from other documents in CPRS is redundant and makes it difficult to read the progress note and quickly elicit pertinent facts.
4. Do not copy entire laboratory findings, radiology reports, entire problem lists, and other information verbatim into a note. Refer to this information without copying verbatim.
5. Documentation should not be a mirror image of previous notes.
6. Appropriate use of templates can reduce time spent documenting while providing pertinent information. If templates are used, the wording is changed from visit to visit to reflect the care provided for that episode of care. Note: templates should not include pre-populated history or exam findings.
7. It is acceptable to refer to current documentation in CPRS that was reviewed rather than repeating or inserting the information into the note. This can be accomplished by a statement that the documentation was reviewed, e.g., nurse's note from 12/1/09 reviewed.
8. Do not copy the signature block into another note.
9. Providers are responsible for the content of their authenticated notes, including copied items and information pulled into templates via object codes. Plagiarized (copied) data, without attribution, in the patient record is prohibited.
10. Additional information may be added in an addendum once a note has been signed.

C. Progress Note Critical Components

1. Chief Complaint(s)

Concise statements describing the main reason for the visit. This includes symptoms, problems, conditions, diagnoses, or other factors that are the reasons for the encounter. At least a portion of the statement should include the patient's own words.

Examples of a typical Chief Complaint include:

- "Tightness in my chest" for the past 4 days
- "I can't pass my water" for the last day.
- "I just haven't been feeling good all summer"

Things to avoid in writing a chief complaint statement are “Routine Visit”, “Here for meds” or “Here because I had an appointment”. Remember to record the main reason for the visit in this statement.

2. History

History of Present Illness (HPI) and interval history for chronic problems being followed. The HPI should include as much as possible the time of onset of the complaint, the duration, character and course, precipitating, alleviating and aggravating factors associated symptoms, medications and pertinent negative questions from the surrounding organ systems.

- ROS Entry
- Other History as Pertinent:
 - Past History
 - Social History
 - Family History
 - Military History

An example of the HPI might be this: Mr. Green is a 78-year-old man who comes in complaining of chest pain for 4 days. This started Saturday evening after chopping a chord of wood. He says the pain is in the chest and left shoulder. It is worse with “putting on my shirt” and better when he rests. He has not taking any meds for it. Mr. Green denies nausea, vomiting, shortness of breath, sweats, or palpitations. He has never had heart problems and he believes it is tendonitis.

3. Physical Examination (PE) and Test Results

- Vital Signs
- Exam (Problem Related)
- Pertinent Test Results

4. Assessment for each problem evaluated/treated

An assessment of each problem being addressed during the visit. For example:

- Diabetes mellitus – Excellent glycemic control. No evidence of end organ disease.

5. Treatment Plan

Diagnostic

- Labs: with reasons for ordering
- Imaging
- Consults treatment

Treatment

- Medications
- Rx Changes
- Other treatments (operations, therapy, exercises, diet, over the counter medications, etc.)
- Follow up:
 - Follow-up treatment
 - Patient Instructions

VIII. Consultation Guidelines

CPT defines a consultation as “a type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source.”

Key factors that define a consultation:

- A physician and/or LIP requests the opinion and/or advice of another physician and/or LIP regarding the evaluation and/or management of a specific problem.
- A consultant may initiate diagnostic and/or therapeutic services and the initial service will still be considered a consultative visit.
- A “consultation” initiated by the patient and/or family, and not by another physician or other appropriate source, is not reported using the consultation codes but may be reported using the office visit, home visit, or domiciliary/ community living center care codes.
- A referral to take over the care for a condition is not reported using the consultation codes but office visit codes, i.e., new patient code when seeing the patient for the first time or established patient code when the specialty or clinic has seen the patient within three years.
- The request and need for a consultation from the requesting clinician is documented in the health record.
- The consultant’s opinion and any services that were ordered or performed must also be documented in the health record. After the consulting provider completes the initial consultation, if that provider

assumes responsibility for managing all or a portion of a patient's condition(s), the follow-up visits will be classified as Established Patient visits.

- If an additional request for an opinion or advice regarding the same or a new problem is received from the attending provider and documented in the record, the provider consultant may report the office consultation codes again.

IX. Data Capture Tips

- The most important skill to cultivate is to be prepared when the clinician walks into the room, listen carefully and record accurately.
- Seek feedback from the clinician on your notes so you can continually work to record the information in the way the clinician requests.
- Remember you are recording information in an interaction between the patient and their provider. Don't be afraid to ask questions, however, also don't interfere with the visit. Some questions may be best left for time with the clinician outside the exam room.
- Always be professional, appropriate, and pleasant in your attitude.
- Time spent training and re-training on how CPRS works is invaluable and can help you navigate the record and make the work easier.
- In addition to progress notes, you will likely interact with encounter forms. Remember that an encounter is defined as a professional contact between a patient and a practitioner vested with primary responsibility for diagnosing, evaluating and/or treating the patient's condition.
- An encounter can include face-to-face interactions or those accomplished via telemedicine.
- Telephone contact is only considered an encounter if the contact is documented and includes appropriate elements of a face-to-face encounter, namely history and medical decision making. Telephone encounters are associated with a telephone clinic.
- Telemedicine encounter uses communication equipment to link health care practitioners and patients in different locations.
- When there is a need to document an important note in the patient's record without patient contact, such as reviewing a record, leaving a message, documenting a no show, or calling to cancel an appointment, enter a "historical" progress note. Historical notes do not require encounter data, i.e., diagnosis or CPT code, as these notes do not generate workload.

- Only one provider can be designated as PRIMARY for each encounter. If both the Attending and Resident see the patient, then the Attending is selected as the primary provider. If the provider you selected is the primary provider for the encounter, click on the Primary button. If you are not listed as a provider and should be, you should enter your name and add your name to the list of providers.
- When selecting a diagnosis, you may utilize the PROBLEM LIST. However, do not utilize diagnoses associated with code 799.9 as this is an inaccurate code.
- The first diagnosis you select will always be listed as the primary diagnosis. When another diagnosis is selected that should really be primary, highlight the correct diagnosis, then click on the PRIMARY button located to the right. Diagnoses can also be added to the problem list when highlighted and selected.
- Any incorrect information can be deleted before the note is signed by clicking the encounter button and everything that was selected will appear. Click on the incorrect item and then click on the remove button to delete the incorrect information.
- Nurse services without care by a physician or LIP, use CPT code 99211 or appropriate procedure code for services ordered by a physician.

X. Reference Materials

A. Evaluation and Management (E/M)

Medical progress notes document the care provided to patients. Both new and established patient notes are graded using an Evaluation and Management (E/M) scale, with visits coded at level 1 being the least complex and those at level 5 the most complex. This system is used for determining charges to insurance companies and for vesting patients in the VA system.

History, exam and medical decision-making are considered the 3 **KEY** components that must be performed when selecting a visit code.

The complexity of medical decision-making is dependent upon:

- The number of diagnoses or management options
- The amount and/or complexity of data to be reviewed, and
- The risk of complications and/or morbidity or mortality

Time becomes a key factor in selecting a level of service only when counseling or coordinating care accounts for over 50% of the time spent with the patient.

B. Examples of E/M Services Documentation Requirements

Level 1

- Chief Complaint – history of present illness
- One body system/area examined, 1-5 elements (New Patient)
- One minor problem identified (e.g., common cold, insect bites, influenza) or being seen for previously diagnosed problem that is stable or improving
- Minimal treatment required (i.e. injection, bed rest, and chest x-ray/lab tests)

Many Veterans have multiple chronic conditions, which may increase the level of care to:

Level 2

- Chief Complaint – history of present illness; minimum 1 element for either New or Established Patient. One ROS taken from patient (New Patient)
- At least six bullets (New Patient)

Or

One to five bullets (Established Patient)

- One minor problem identified (i.e. cold, insect bites, influenza, etc.) or being seen for a previously diagnosed problem that is stable or improving
- Minimal treatment required (i.e. injection, bed rest, and chest x-ray/lab tests)

Level 3

- Chief Complaint – history of present illness (must include 4 of 8 elements at a minimum or 3 chronic conditions for a New Patient or 1 for an Established Patient)
 - ROS (verbal) (i.e. any problems such as weight loss, dizziness, etc.)
 - Past medical history (patients)
 - Family history
 - Social history, 1-2 PFSH New Patient, None Established Patient
- At least 2 bullets from 6 areas or 12 bullets in 2+ areas (New Patient)

Or

At least 6 bullets (Established Patient)

- Conditions found – self-limiting or minor conditions (at a minimum) such as a chronic condition – patient stable, and/or new problem to the physician or LIP with no additional work-up planned

- Treatment recommendation usually an over the counter drug, minor surgery with no identified risk factors, OR invasive diagnostic test

Level 4

- Chief Complaint – history of present illness (must include 4 of 8 elements at a minimum or 3 chronic conditions)
 - ROS (verbal) (10 ROS New Patient, minimum 2 ROS Established Patient)
 - Past medical history
 - Social or family history, all 3 PFSH New Patient, 1 PFSH Established Patient
- At least 2 bullets from 9 systems (New Patient)

Or

At least 2 bullets from 6 areas or 12 bullets in 2+ areas (Established Patient)

- New problem to the physician or LIP – additional workup planned; one or more chronic problems with mild exacerbation; two or more stable chronic illnesses; acute complicated injury. Normally three or more diagnoses are documented.
- Order/review tests; prescription drug therapy; elective major surgery; invasive diagnostic tests (i.e. scopes)

Level 5

- Chief Complaint – history of present illness (must include 4 of 8 elements at a minimum or 3 chronic conditions).
 - ROS (verbal) (10 or more systems reviewed with patient)
 - Past medical history
 - Social history
 - Family history, all 3 PFSH New Patient, minimum 2 PFSH Established Patient
- At least 2 bullets from 9 systems
- New problem to the physician or LIP with additional work-up planned; two or more chronic illnesses with severe exacerbation; acute injuries, illnesses that pose a threat to life or bodily function; abrupt change in neurologic status (i.e. seizure, TIA, sensory loss, etc.)
- Emergency or elective major surgery: drug therapy requiring intensive monitoring for toxicity

XI. Service Connected and Treatment Factors

Veterans are eligible for cost-free (not charged co-pays nor have their billable health insurance plan billed) medical care for conditions that have been adjudicated as a service connected (SC) condition or for special treatment authorities related to exposures or experiences. The special treatment authorities as of 2011 include:

- Combat Veterans. Care of conditions potentially related to combat service for enrolled Veterans who were discharged from active duty on or after January 28, 2003 for 5 years post discharge
- Agent Orange (AO) exposure for Veterans who served in the Republic of Vietnam from January 9, 1962 through May 7, 1975
- Ionizing Radiation (IR) Exposure for Veterans exposed during atmospheric testing or during the occupation of Hiroshima and Nagasaki
- Southwest Asia conditions for Gulf War Veterans who served in Southwest Asia from August 2, 1990 through November 11, 1998
- Shipboard Hazard and Defense (SHAD)/Project 112
- Military Sexual Trauma (MST)
- Head and/or Neck Cancer (HNC) related to nose or throat radium treatments

The provider must make a clinical decision to determine if an encounter is for a SC condition or one of the special treatment authorities. If the Veteran is being treated during the encounter for a condition that the provider believes is for a SC or a special treatment authority, the provider will check “Yes” next to the appropriate category on the encounter form. Neither the Veteran, nor the Veteran’s health plan will be billed for the encounter if “yes” is checked. Clinical documentation must support the provider marking the “Yes” box for SC or special treatment authority conditions.

Medication(s) related to a SC condition or special treatment authority condition must be indicated during the outpatient medication ordering process. The Veteran will not be charged a co-payment nor have his/her billable health insurance plan billed, for a medication that is for SC condition or a special treatment authority.

Visit Related To	
Yes	No
<input type="checkbox"/>	<input checked="" type="checkbox"/> Service Connected Condition
<input type="checkbox"/>	<input type="checkbox"/> Combat Vet (Combat Related)
<input type="checkbox"/>	<input checked="" type="checkbox"/> Agent Orange Exposure
<input type="checkbox"/>	<input type="checkbox"/> Ionizing Radiation Exposure
<input type="checkbox"/>	<input type="checkbox"/> Southwest Asia Conditions
<input type="checkbox"/>	<input type="checkbox"/> Shipboard Hazard and Defense
<input type="checkbox"/>	<input type="checkbox"/> MST
<input type="checkbox"/>	<input type="checkbox"/> Head and/or Neck Cancer

A. Service Connected (SC) Determinations

Adjudicated service connection means that the facts, shown by evidence, establish that a particular injury or disease resulting in disability was incurred coincident with service in the Armed Forces, or if preexisting such service, was aggravated therein. The assignment of SC percentage and disability code is based on the degree of disability as determined by the rating board decision following the submission of a claim that a Veteran's illness or injury was incurred in or aggravated by military service. The very nature of some disabilities is to increase in severity as time passes, regardless of the activities of the individual concerned. These later manifestations of injury/disease in themselves that were not included in an original adjudicated rating are not routinely service connected. Over a period of many years, a Veteran's disability claim may require evaluation for re-rating in accordance with changes in laws, medical knowledge and his or her physical or mental condition to include such proportionate addition and/or increase in percentage.

An adjunct condition, although not service connected, is medically determined to be associated with or is aggravating a disease or condition, which is service connected. A Veteran is eligible to receive treatment for an adjunct condition; however, because the adjunct is not a condition that is specifically rated, VA can bill the insurance carrier as well as those Veterans responsible for co-payments for treatment provided for the adjunct condition. Veterans should be encouraged to file a compensation claim.

A secondary condition is defined as a condition that has been caused or is the result of a service-connected condition. A Veteran is eligible to receive treatment for a secondary condition. However, because the secondary issue is not a condition that is specifically rated, VA can bill the insurance carrier, as well as those Veterans responsible for co-payments for treatment provided for the secondary condition. Veterans should be encouraged to file a compensation claim.

It is important that the provider be aware of the patient's service-connected conditions. This information is available by clicking the patient's name in the square in the upper left corner in

CPRS. It is also found on the encounter form. If a patient is being treated for a service-connected condition during a visit, the provider should check “yes” in the service-connected box on the encounter form.

NOTE: Mentioning the service-connected condition does not constitute active treatment of a SC condition. In order for the encounter to be marked as SC the provider must actually provide treatment to include, but not limited to changing medications, ordering diagnostic services, etc.

Example of SC encounter: The provider ordered HCTZ for the Veterans SC hypertensive condition. This will constitute active treatment and the visit must be marked as SC.

Example of Non-Service-Connected (NSC) encounter: Provider documents that the Hypertension is stable. Mentioning the SC condition in the note does not constitute active treatment.

Utilization Review (UR) nurses have the responsibility to validate SC determinations made by providers. If a determination is made without proper documentation, etc. the UR nurse will contact the provider by various means to ensure the proper designation of the encounter. Ultimately, it is the provider’s responsibility to make appropriate service connected and special authority determination. Documentation must support the determination of the encounter.

Compensable Service-connected Veterans are not charged an outpatient co-payment. They may be charged a medication co-payment if the medication is for a non-service-connected condition and the Veteran is not rated greater than 50% service connected, not a former Prisoner of War, in Priority Group 4 or exempt by virtue of low income. If the Veteran has health insurance, a claim will be submitted to the insurance carrier for the treatment of non-service-connected conditions.

B. Combat Veteran

A Veteran who served on active duty in combat operations during a period of war after the Gulf War, or in combat against a hostile force during a period of hostilities after November 11, 1998, is eligible for hospital care, medical services, and nursing home care for any illness, even if there is insufficient medical evidence to conclude that such condition is attributable to such service. Treatment provided under this authority is not subject to copayment requirements.

The law provides:

- Combat Veterans who were discharged or released from active service on or after January 28, 2003, are to receive care and services at no cost for any illness or condition possibly related to their combat service for five years beginning from the date of their discharge.

Veterans Health Administration (VHA) providers have wide latitude in determining if a Veteran's condition may be possibly related to the Veteran's combat service. This clinical determination does not require the same rigor or standards used for adjudication of a service-connected claim. It is a determination solely within the medical judgment of the treating clinician. In general, VHA providers need to conclude that illnesses and conditions requiring treatment or monitoring during the combat Veteran's enhanced enrollment period (i.e., 5 year-period post-discharge or release) are possibly related to combat service. Physical or mental health evaluations needed to rule out combat-related health concerns are to be provided at no cost to the enrolled combat Veterans.

However, the Under Secretary for Health has determined that certain conditions will invariably be deemed to be due to causes other than combat service. These include, but are not limited to:

- Congenital or developmental conditions, (e.g., scoliosis)
- Conditions which are known to have existed before military service unless there is an indication that the condition has been aggravated or exacerbated by combat service
- Conditions having a specific and well-established etiology that began after military combat service, (e.g., bone fractures occurring after separation from military service, a common cold)

Contrary to the other special treatment authorities, the "Combat Vet" (CV) status on the encounter form is defaulted to Yes. This means that the provider must make a clinical decision to determine if a visit or medication is not related to CV. If the Veteran is being treated for conditions during this episode of care that the provider believes is NOT related to CV, the visit should be un-checked and the "NO" box must be marked on the encounter form and the medication should be designated as not related to CV.

On-line information on the intranet:

<http://www.va.gov/healtheligibility/eligibility/CombatVets.asp>

C. Agent Orange

Agent Orange (AO) is an herbicide that was used in Vietnam between 1962 and 1971 to remove unwanted plant life that provided cover for enemy forces. VA has recognized the following conditions as associated with but not necessarily caused by exposure to Agent Orange. These are called "presumptive diseases":

- a. Diabetes (type 2)

- b. Chloracne or other acneform disease consistent with chloracne (must occur within one year of exposure to AO)
- c. Porphyria cutanea tarda (must occur within one year of exposure to AO). Acute and subacute peripheral neuropathy developed within one year of exposure
- d. Parkinson's disease (effective October 31, 2010)
- e. Ischemic heart disease (effective October 31, 2010)
- f. Chronic B-cell leukemias (effective October 31, 2010)
- g. Numerous cancers:
 - i. Prostate cancer
 - ii. Hodgkin's disease
 - iii. Multiple myeloma
 - iv. Non-Hodgkin's lymphoma
 - v. Respiratory cancers (cancer of the lung, bronchus, larynx, or trachea) (Must occur within 30 years of exposure to Agent Orange)
 - vi. Soft-tissue sarcoma (other than osteosarcoma, chondrosarcoma, Kaposi's sarcoma, or mesothelioma)
 - vii. Chronic lymphocytic leukemia

The conditions above represent the presumptive service-connected approved list by the Veterans Benefits Administration (VBA). For VHA and medical care purposes, this list is used as guidance for the provider, but is not an all-inclusive list for the Veteran to receive care under the Agent Orange program. The provider may determine that a visit is potentially related to AO without the condition being located on the VBA list. Again, documentation must support the claim.

The VBA presumptive SC conditions are for SC adjudication purposes only. The presumptive conditions allow a more rapid adjudication process without the need for the Veteran to prove actual exposure to Agent Orange.

Note: Agent Orange was also used in Korea in 1968 and 1969 in an area from the Civilian Control Line to the southern boundary of the Demilitarized Zone (DMZ). U.S. service members in the area near spraying operations may have been exposed to Agent Orange during this

period. While Veterans who were exposed to AO in DMZ have no special eligibility for medical care, they are eligible for Agent Orange registry examinations.

Check the following website for on-line training and updated information:

<http://www.publichealth.va.gov/exposures/index.asp>

D. Ionizing Radiation

Atomic veterans may have been exposed to ionizing radiation in a variety of ways at various locations. Veterans exposed at a nuclear device testing site (the Pacific Islands, e.g., Bikini, NM, NV, etc.) or in Hiroshima and/or Nagasaki, Japan, may be included. Atomic Veterans with exposure to Ionizing Radiation (IR) are eligible to receive treatment for conditions related to this exposure. VA has recognized the following conditions by statute or regulation as being associated with radiation exposure; these are called “presumptive diseases.”

Conditions Associated with Ionizing Radiation	
Leukemia, Lymphoid (except chronic lymphatic leukemia)	Multiple myeloma
Leukemia, Myeloid	Posterior subcapsular cataracts
Leukemia, Monocytic	Non-malignant Thyroid Nodular Disease
Leukemia, Hairy Cell	Ovarian Cancer
Leukemia, other Leukemia, unspecified cell type	Parathyroid Adenoma
Thyroid Cancer	Malignant tumors of the brain and central nervous system
Breast Cancer	Lymphomas other than Hodgkin’s Disease
Lung Cancer (malignant neoplasm of trachea, bronchus, and lung)	Cancer of the rectum
Bone Cancer	Cancer of the small intestine
Primary Liver Cancer	Cancer of the pharynx
Skin Cancer	Cancer of the bile duct
Esophageal Cancer	Cancer of the gall bladder
Stomach Cancer	Cancer of the renal pelvis, ureters, and urethra
Colon Cancer	Cancer of the prostate
Pancreatic Cancer	Broncho-alveolar carcinoma (a rare lung disease)
Kidney Cancer	Benign neoplasms of the brain and central nervous system
Urinary Bladder Cancer	Other malignancy/malignancies not listed in the preceding diagnoses
Salivary Gland Cancer (malignant neoplasm of major salivary gland)	

The conditions above represent the presumptive service-connected approved list by the VBA. For VHA and medical care purposes, this list is used as guidance for the provider but is not an all-inclusive list for the Veteran to receive care under the Ionizing Radiation special authority. The provider may determine that a visit is potentially related to IR without the condition being located on the VBA list.

The VBA presumptive SC conditions are for SC adjudication purposes only. The presumptive conditions allow a more rapid adjudication process without the need for the Veteran to prove actual exposure to IR.

Note: Atomic Veterans do not have to receive an IR Registry Exam to qualify for this special treatment authority. This is also true of Agent Orange.

The visit should be checked as related on the encounter form and the medication should be designated as related to IR Exposure. This will mean that the Veteran does not have to pay a co-payment for the visit or the medication nor will the Veteran's health insurance be billed.

On-line training and updated information on website:

<http://www.publichealth.va.gov/exposures/index.asp>

E. Southwest Asia Conditions

Veterans who served in Southwest Asia between August 2, 1990 and November 11, 1998 were also exposed to a wide variety of environmental hazards and potentially harmful substances during their service in Southwest Asia. These include depleted uranium, pesticides, the anti-nerve gas pill pyridostigmine bromide, infectious diseases, chemical and biological warfare agents, and vaccinations (including anthrax and botulinum toxoid), and oil well free smoke and petroleum products. VA recognizes that there are other health risk factors encountered by these Gulf War Veterans. Treatment provided during the encounter that is for any disability that may possibly be associated with service in the Southwest Asia Theater of operations during the Gulf War should be indicated on the encounter form or medication order. This will mean that the Veteran does not have to pay a co-payment for the visit or the medication, nor will the Veteran's health insurance be billed. The encounter must be marked as related to Southwest Asia Conditions.

VA recognizes the following presumptive diseases:

- a. Brucellosis
- b. Campylobacter jejuni
- c. Coxiella Burnetii (Q fever)

- d. Malaria
- e. Mycobacterium tuberculosis
- f. Nontyphoid Salmonella
- g. Shigella
- h. Visceral leishmaniasis
- i. West Nile virus
- j. Amyotrophic Lateral Sclerosis

Illnesses include medically unexplained clusters of symptoms that have existed for six months or more, such as:

- Chronic fatigue syndrome
- Fibromyalgia
- Irritable bowel syndrome
- Any diagnosed or undiagnosed illness that VA's Secretary determines should be presumed to be associated with Gulf War Service

Signs and symptoms of an undiagnosed illness may include:

- Abnormal weight loss
- Cardiovascular signs and symptoms
- Fatigue
- Gastrointestinal signs or symptoms
- Headache
- Joint Pain
- Menstrual disorder
- Muscle pain
- Neurological signs or symptoms
- Signs or symptoms involving the skin
- Signs or symptoms involving the upper and lower respiratory system
- Sleep disturbances

The conditions above represent the presumptive service-connected approved list by the VBA. For VHA and medical care purposes, this list is used as guidance for the provider, but is not an all-inclusive list for the Veteran to receive care under the Southwest Asia special authority. The provider may determine that a visit is potentially related to SW Asia without the condition being located on the VBA list.

The VBA presumptive SC conditions are for SC adjudication purposes only. The presumptive conditions allow a more rapid adjudication process without the need for the Veteran to prove actual SW Asia conditions.

NOTE: The VA provider must determine and document if the conditions are related to the Veteran's Gulf War service. If treatment is related to Gulf War Service, the Veteran will be exempt from first party copay and third-party billing for that date of service.

On-line training and updated information on website:

<http://www.publichealth.va.gov/exposures/index.asp/>

F. Shipboard Hazard and Defense (SHAD)/Project 112

Project Shipboard Hazard and Defense (SHAD) was part of a larger effort called Project 112 which was the overall program for both shipboard and land-based biological and chemical testing that was conducted by the United States military between 1962 and 1973. Project SHAD was the shipboard portion of these tests, which were conducted to determine:

- a. The effectiveness of shipboard detection of chemical and biological warfare agents
- b. The effectiveness of protective measures against these agents, and;
- c. The potential risk to American forces posed by the weapons

SHAD Veterans are to receive hospital care, medical services, and nursing home care at no cost for any illness possibly related to their participation in these tests. However, these Veterans may be charged a co-payment for care of conditions found to have resulted from a cause(s) other than their participation in Project 112 tests.

Conditions Associated with Project SHAD/112:

- a. Congenital or developmental conditions, e.g., scoliosis
- b. Conditions which are known to have existed before military service
- c. Conditions having a specific and well-established etiology and that began after military service ceased (e.g., bone fractures occurring after separation from military service, common cold)

Although the preceding types of conditions are not ordinarily considered to be due to military service, if the staff physician finds that a Veteran requires care under this provision for one or more of those conditions, the physician is to seek guidance from the facility Chief of Staff (COS) and the Registry Physician (RP) regarding the authorization for such treatment. The decision and its basis must be clearly documented in the medical record and charted by the RP.

VA facilities are responsible for ensuring that Project 112/SHAD Veterans who request either an examination or enrollment in the VA health care system, whether or not they have previously received health care from VA, are offered a complete "Primary Care New Patient History and

Physical Examination,” using the standardized template for this examination, and that the results of the examination are documented in the patient’s health record.

The provider must make a clinical decision to determine if a visit or medication is related to SHAD. If the Veteran is being treated for any condition during this episode of care that the provider believes is related to SHAD, the visit should be checked as related on the encounter form and the medication should be designated as related to SHAD. Clinical documentation must support determination. This will mean that the Veteran does not have to pay a co-payment for the visit or the medication nor will the Veteran’s health insurance be billed.

On-line information on the intranet:

<http://www.publichealth.va.gov/exposures/shad/index.asp>

G. Military Sexual Trauma (MST)

VA is authorized by law to provide counseling services to women and men Veterans who experienced incidents of sexual trauma while they served on active duty in the military. Note: This authority was extended to those whose service was only active duty for training. The Law defines a sexual trauma as sexual harassment, sexual assault, rape and other acts of violence. It further defines sexual harassment as repeated unsolicited, verbal or physical contact of a sexual nature, which is threatening in nature.

The provider must make a clinical decision to determine if a visit or medication is related to MST. If the Veteran is being treated for any condition during this episode of care that the provider believes is related to MST; the visit should be checked as related on the encounter form and the medication should be designated as related to MST. Clinical documentation must support the determination. This will mean that the Veteran does not have to pay a co-payment for the visit or the medication nor will the Veteran’s health insurance be billed.

On-line information on the intranet: <http://vaww.mst.va.gov>

Sexual Trauma Counseling Information website:

<http://www.publichealth.va.gov/womenshealth/trauma.asp>

H. Head and Neck Cancer

Veterans with cancer of the head and neck and a history of receipt of Nasopharyngeal (NP) radium therapy are eligible for treatment. There are very specific dates and locations where this activity occurred. Eligibility for this special class needs to be verified by the local Business

Office (not all Veterans receiving head and neck cancer treatment fall into this treatment category).

During the 1920s, nasopharyngeal (NP) radium therapy was developed to treat hearing loss caused by repeated ear infections. Radium-tipped rods were inserted into the nostrils and left in place for several minutes. Military physicians used NP radium to treat aerotitis media (barotrauma) in submariners, aviators, and divers. It is estimated that between 8,000 and 20,000 military personnel received NP radium treatments during World War II and into the 1960s. Veterans also included are those with documentation of NP radium treatment in active military, naval or air service; those who served as an aviator in the active military, naval or air service before the end of the Korean conflict; or underwent submarine training in active naval service before January 1, 1965. Veterans with exposure to NP radium treatments are entitled to receive treatment for conditions related to this exposure, including head and neck cancer.

If the Veteran is being treated for any condition during this episode of care that is related to Head and Neck Cancer; the visit should be checked as related on the encounter form and the medication should be designated as related to Head and Neck Cancer. Clinical documentation must support the determination. This will mean that the Veteran does not have to pay a copayment for the visit or the medication nor will the Veteran's health insurance be billed.

On-line training and updated information on website:
<http://www.publichealth.va.gov/exposures/index.asp>

Appendix A: Scribe Weekly Deliverable Report

Medical Scribes should utilize the below form to track the name and type of providers worked with throughout the week, the number of appointments attended, their mode (in-person, telehealth, telephone, or other) and whether any patients refused having a scribe in the exam room. Scribes will be asked to submit this information on a weekly basis on the [MISSION 507 SharePoint](#).

VISN: _____

Facility: _____

Report for Week of: _____

1. Scribe Type: VA or Contract
2. Name and Type (Physician or LIP) of Provider(s) worked with this week:
 - a. Name: _____ and Type: _____
 - b. Name: _____ and Type: _____
 - c. Name: _____ and Type: _____
 - d. Name: _____ and Type: _____
3. How many appointments did you attend each day and their mode (telehealth, in-person, telephone, and other)?
 - a. Monday Total Appointments:
 - i. Number of Telehealth Appointments: _____
 - ii. Number of Telephone Appointments: _____
 - iii. Number of In-person Appointments: _____
 - iv. Number of Other Appointments: _____
 - b. Tuesday Total Appointments:
 - i. Number of Telehealth Appointments: _____
 - ii. Number of Telephone Appointments: _____
 - iii. Number of In-person Appointments: _____
 - iv. Number of Other Appointments: _____
 - c. Wednesday Total Appointments:
 - i. Number of Telehealth Appointments: _____
 - ii. Number of Telephone Appointments: _____
 - iii. Number of In-person Appointments: _____

- iv. Number of Other Appointments: _____
 - d. Thursday Total Appointments:
 - i. Number of Telehealth Appointments: _____
 - ii. Number of Telephone Appointments: _____
 - iii. Number of In-person Appointments: _____
 - iv. Number of Other Appointments: _____
 - e. Friday Appointments:
 - i. Number of Telehealth Appointments: _____
 - ii. Number of Telephone Appointments: _____
 - iii. Number of In-person Appointments: _____
 - iv. Number of Other Appointments: _____
- 4. Did any patients refuse the use of scribes in their appointments?
 - a. If yes, how many refused? _____
 - b. What was their reason for refusal?

APPENDIX C

DOCUMENTATION ASSISTANCE PROVIDED BY SCRIBES

1. PURPOSE

The Purpose of this Standard Operating Procedure (SOP) is to establish documentation assistance procedures for Medical Scribe Progress Note and Order Entry Policy for the MISSION 507 Medical Scribe Pilot at the following sites: Manchester, NH; Togus, ME; East Orange, NJ; Clarksburg, WV; Hampton, VA; Louisville, KY; San Antonio, TX; Temple TX; Helena, MT; Oklahoma City, OK; Tucson, AZ; and Fargo, ND.

2. BACKGROUND

- a.** The Medical scribes in this pilot will be placed in the Emergency Department and/or Specialty Care Clinics (Orthopedics and Cardiology).
- b.** Scribe Role versus Documentation Assistance by Licensed Staff
 1. A scribe enters information into the Electronic Health Record (EHR), or chart as directed by a physician or Licensed Independent Practitioner (LIP). The scribe may not act independently and is not permitted to interject any documentation or opinion that is not specifically dictated by the physician or LIP performing the physician examination.
 2. The Joint Commission recently relaxed restrictions on order entry, allowing (non-licensed) Scribes to enter orders, which should benefit sites participating in the MISSION 507 Medical Scribe Pilot.
 3. The Joint Commission has previously defined scribes as unlicensed personnel and prohibited them from entering orders. However, due to the widespread emergence of scribe models (including both licensed and unlicensed personnel of varying levels of skill and clinical knowledge performing scribe duties), that previous definition has changed. There are individuals with the official title of “scribe” for whom documentation assistance is their only role, and there are individuals who perform dual roles that include clinical responsibilities as well as documentation assistance. To clarify, the scribes in this pilot

will not have any clinical responsibilities and documentation assistance is their main role.

4. The provider and or LIPs are ultimately responsible for the review, approval, and signing of the scribe entries.

3. PROCEDURES/DOCUMENTATION

a. Orders

1. The Acting Assistant Deputy Under Secretary for Health for Access for the Office of Veterans Access to Care (OVAC) has made the decision that Medical Scribes at the MISSION 507 Medical Scribe Pilot Sites can enter orders, including medication orders. Pilot Sites have the option to not allow nonclinical scribes to enter orders, if they prefer.
2. All types of personnel functioning as a medical scribe at sites in this pilot may, at the direction of a physician or another LIP, enter orders into the electronic health record. The use of “read-back, repeat-back” of the order by the scribe is encouraged, especially for new medication orders. Scribes who are not authorized to submit orders must leave the entered order in a pending status until a certified or licensed personnel activates or submits the orders after verification.
3. The process of a scribe’s entry of orders into the electronic health record is not considered a verbal order. Verbal orders are orders received from a LIP and are acted upon immediately by individuals practicing within the scope of their licensure, certification, or practice in accordance with law and regulation as well as with organizational policy.

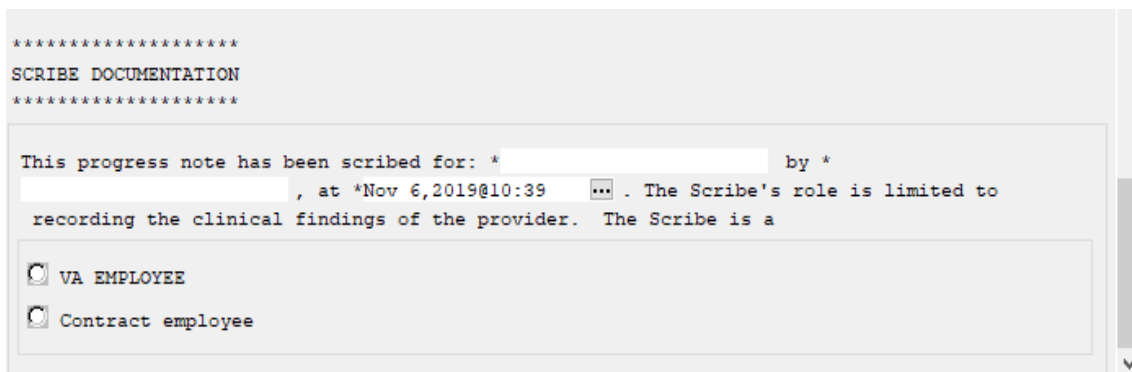
b. Order Entry Process

1. Scribes, as with all employees, will have their own log in information and are prohibited from using any other log in credentials including the physician or LIP’s log in information.
2. All non-clinical scribes should be provided with OREMAS key only, never the ORELSE key.

3. Upon the direction of the provider, the scribe will enter medication orders under the providers name. The use of “read-back, repeat-back” of the order by the scribe is encouraged, especially for new medication orders.
4. After verification, the scribe will hold the order for signature.
5. The provider or LIP is responsible for verifying all documentation, including orders, entered by a scribe prior to signing and releasing the order.

c. Progress Notes

1. Each progress note must use the below reminder dialog and health factors in order to capture workload for the scribe. The reminder dialog consists of scribe documentation in the progress note indicating “the progress note has been scribed for Dr. X by Y at time and date. The Scribe’s role is limited to recording the clinical findings of the provider. The scribe is a VA Employee or Contract Employee.” A screenshot of the reminder dialog can be found below:



d. Progress Note Process

1. Scribes, as with all employees, will have their own log in information and are prohibited from using any other log in credentials including the physician or LIP’s log in information.
2. Scribe will document only what is dictated by the physician or LIP performing the examination in the progress note.
3. Once the scribe is finished writing the note, they will change the author to the provider.
4. Providers will review, edit, update, and sign the note.

5. The note will not be viewable to others prior to the provider's signature and CPRS/VistA progress note business rules must ensure that this is followed.
6. Providers are responsible for the note content.

4. RESPONSIBILITY:

- a. The Chief of Staff is responsible for the implementation of this policy with all clinical staff and ensuring their compliance with this and all related facility policies.
- b. The Service Chiefs of those staff whose roles and responsibilities are defined within this policy are responsible for ensuring their compliance with the process and parameters outlined
- c. Providers are responsible for:
 - (1) Functioning within the parameters outlined within their individual approved clinical privileges/scope of practice.
 - (2) Assuring the appropriateness and completeness of all documentation including orders entered into the patient's medical record.
 - (3) Providing clarification to those staff responsible for the implementation of these orders as needed or requested.

5. Dr. Michael Davies, Senior Medical Advisor in the Office of Veterans Access to Care (OVAC), is the executive lead of the MISSION 507 Medical Scribe Pilot. Katherine Williams is the project lead of the MISSION 507 Medical Scribe Pilot and is the primary contact for all discussions regarding this agreement or conditions of this SOP. She can be reached via email at Katherine.williams10@va.gov.

APPENDIX D

**DEPARTMENT OF
VETERANS AFFAIRS**

Memorandum

Date: October 4, 2018; *revised October 10, 2019*

From: Austin Frakt, PhD, Director, Partnered Evidence-Based Policy Resource Center (PEPReC)

Subj: National Access and Clinic Administration Evaluation

To: Susan Kirsh, MD, MPH, Acting Deputy ADUSH for Access to Care, Office of Veterans Access to Care

1. The purpose of this letter is to confirm that the VA Quality Enhancement Research Initiative (QUERI) project entitled “National Access and Clinic Administration Evaluation” meets the criteria for classification as non-research. This project is being conducted at the VA Boston Healthcare System and is led by **Steven Pizer**. The project is designed to inform quality improvement efforts, as part of the agreed-upon protocol established with QUERI and OVAC.
2. The purpose of this project is to support internal implementation and evaluation efforts to develop and validate access metrics, such as return-to-clinic dates in primary and mental health care. PEPReC is working with OVAC to measure the impact of a pilot program using new scheduling software that has the potential to have profound effects on access and productivity in VA clinics nationwide. Additionally, PEPReC is tasked with completing a quantitative analysis of MISSION Act Section 507, a national two-year pilot of the use of medical scribes in emergency and specialty care. These projects use secondary data collected using assessments that are part of routine care and/or clinical management. The project will be collecting information that is designed for quality improvement initiatives, as described in VHA Handbook 1058.05, for the purposes of program implementation/evaluation.
3. These activities are designed and implemented for internal VA purposes and findings are intended to be used to better inform care in the VA. This project is not designed to inform activities beyond VA, produce information that expands the knowledge base of a scientific discipline or other scholarly field, and does not involve collecting additional data or performing analyses that are not needed for the purposes of this internal implementation.

Susan Kirsh

Signature _____

Susan Kirsh, MD, MPH, Acting Deputy ADUSH for Access to Care, Office of Veterans Access to Care

APPENDIX E

COVID-19 is an emerging, rapidly evolving situation.

Get the latest public health information from CDC: <https://www.coronavirus.gov>.


Get the latest research information from NIH: <https://www.nih.gov/coronavirus>.

 U.S. National Library of Medicine

ClinicalTrials.gov

[Find Studies](#) ▼
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[Submit Studies](#) ▼
[Resources](#) ▼
[About Site](#) ▼

Evaluation of the Use of Medical Scribes in VAMC Emergency Departments and Specialty Care Clinics

 The safety and scientific validity of this study is the responsibility of the study sponsor and investigators. Listing a study does not mean it has been evaluated by the U.S. Federal Government. [Know the risks and potential benefits](#) of clinical studies and talk to your health care provider before participating. Read our [disclaimer](#) for details.

ClinicalTrials.gov Identifier: NCT04154462

[Recruitment Status](#)  : Recruiting

[First Posted](#)  : November 6, 2019

[Last Update Posted](#)  : March 17, 2020

See [Contacts and Locations](#)

Sponsor:

VA Boston Healthcare System

Collaborator:

US Department of Veterans Affairs

Information provided by (Responsible Party):

Melissa Garrido, VA Boston Healthcare System

[Study Details](#)[Tabular View](#)[No Results Posted](#)[Disclaimer](#)[How to Read a Study Record](#)

Study Description

Go to

Brief Summary:

Background and study aims: Medical scribes are trained paraprofessionals that assist providers with documenting patient encounters. Prior evidence suggests that scribes may be effective in increasing provider productivity and satisfaction, and decreasing provider time spent on documentation without negatively affecting patient satisfaction. Section 507 of the MISSION Act of 2018 mandated a two-year pilot of medical scribes, which will begin in March 2020 in specialty clinics and emergency departments (EDs) of twelve VA Medical Centers (VAMCs) across the country. The aims of this study are to understand how the introduction of scribes and scribe training affect provider efficiency, patient and provider satisfaction, wait times, and daily patient volume in the VA context.

Who can participate? Urban and rural VAMCs willing to be assigned medical scribes for use in EDs or selected high wait time specialty clinics (cardiology, orthopedics).

What does the study involve? Four medical scribes will be assigned to each of the 12 VAMC sites randomized into treatment with the VA hiring half as new employees and contracting out for the remaining half. 30% of the scribes will be assigned to emergency departments and the other 70% will be assigned to specialty care. Remaining sites that expressed interest in the pilot but were not randomized treatment will be used as comparators. Provider productivity, patient volume, wait times, and patient satisfaction from the treated sites will be compared to baseline (pre-scribe) data as well as data from comparison sites.

What are the possible benefits and risks of participating? VAMCs where medical scribes are introduced may see gains in provider efficiency, reduced wait times, and increased patient satisfaction due to the shifting of administrative burdens associated with documenting patient encounters in electronic health records from providers to these trained professionals. The introduction of medical scribes could complicate patient encounters by making some patients and/or providers uncomfortable.

Where is the study run from? This study is being coordinated by the Partnered Evidence-based Policy Resource Center (PEPRc) at the VA Boston Healthcare System in collaboration with the VA Office of Veterans Access to Care (OVAC).

When is the study starting and how long is it expected to run for? March 2020 to February 2022

Who is funding the study? U.S. Veterans Health Administration

Condition or disease ⓘ	Intervention/treatment ⓘ	Phase ⓘ
Medical Scribes	Other: Scribes	Not Applicable

Study Design

Go to

[Study Type](#) ⓘ : Interventional (Clinical Trial)

Estimated [Enrollment](#) ⓘ : 12 participants

Allocation: Randomized

Intervention Model: Parallel Assignment

Intervention Model Description: A two-arm randomized field experiment is being used to assess the effect of medical scribes on productivity, wait times, and patient satisfaction. OVAC will work with participating VAMCs to identify providers to participate in the pilot. A varied provider pool will limit selection bias but must be balanced with recruitment and retention of providers. The goal is to keep the provider-scribe pairs consistent throughout the pilot.

Each VAMC site randomized to treatment will have two VA employee scribes and two contract scribes. Two medical scribes, ideally one employee and one contract, will be assigned to one physician, with two physicians and/or Licensed Independent Practitioners (LIP) participating at each facility. Scribes will work with others if the provider partner is not available during a scheduled shift. Power analyses have been conducted to determine the minimum effect size for each outcome with 80% power, which will be useful for putting the final results into context.

Masking: None (Open Label)

Primary Purpose: Other

Official Title: Evaluation of the Use of Medical Scribes on Provider Efficiency, Patient Satisfaction, and Wait Times in VAMC Emergency Departments and Specialty Care Clinics



Actual Study Start Date  : March 1, 2019

Estimated Primary Completion Date  : February 28, 2022

Estimated Study Completion Date  : May 31, 2022

Arms and Interventions

Go to 

Arm 	Intervention/treatment 
<p>No Intervention: No intervention</p> <p>The VAMC sites randomized to the comparison arm will not have medical scribes introduced into emergency departments or specialty clinics.</p>	
<p>Experimental: Treatment</p> <p>The VAMC sites randomized to the treatment arm are each expected to have four medical scribes, with two being VA employees and two being contractors, introduced into emergency departments or specialty clinics to assist providers during patient encounters.</p>	<p>Other: Scribes</p> <p>Section 507 of the MISSION Act of 2018 mandates a two-year pilot of medical scribes in VA specialty clinics and emergency departments. Medical scribes assist health care providers by helping to administratively expedite an episode of care through the recording of patient information and updating patient records. Scribes are trained but non-licensed professionals, often deployed in emergency departments and outpatient clinic settings, that observe and document patient encounters but do not participate in clinical care.</p>

Outcome Measures

Go to

Primary Outcome Measures :

1. Pay period work relative value-based provider efficiency [Time Frame: Approximately 42 months]

Pay period work relative value-based provider efficiency is measured using administrative data collected by the VA Corporate Data Warehouse in pay period increments

2. Pay period visit-based provider efficiency [Time Frame: Approximately 42 months]

Pay period visit-based provider efficiency is measured using administrative data collected by the VA Corporate Data Warehouse in pay period increments

3. Daily visit-based provider efficiency [Time Frame: Approximately 42 months]

Daily visit-based provider efficiency is measured using monthly-based provider efficiency, scaled by full-time-equivalent days; this is based on administrative data collected by the VA Corporate Data Warehouse in pay period increments

4. Days to completed consult [Time Frame: Approximately 42 months]

Days to completed consult is measured using administrative data collected by the VA Corporate Data Warehouse in pay period increments

5. Days to scheduled consult [Time Frame: Approximately 42 months]

Days to scheduled consult is measured using administrative data collected by the VA Corporate Data Warehouse in pay period increments

6. Unique patient volume [Time Frame: Approximately 42 months]

Unique patient volume is measured using administrative data collected by the VA Corporate Data Warehouse in pay period increments

7. Patient satisfaction [Time Frame: Approximately 42 months]

Patient satisfaction is measured using V-Signals survey data collected by the VA Office of

Veterans Experience in pay period increments

Eligibility Criteria

Go to 

Information from the National Library of Medicine



Choosing to participate in a study is an important personal decision. Talk with your doctor and family members or friends about deciding to join a study. To learn more about this study, you or your doctor may contact the study research staff using the contacts provided below. For general information, [Learn About Clinical Studies](#).

Ages Eligible for Study: Child, Adult, Older Adult

Sexes Eligible for Study: All

Accepts Healthy Volunteers: Yes

Criteria

Inclusion Criteria:


- Expression of interest by VAMC

Exclusion Criteria:

- Lack of appropriate site capabilities

The VA Office of Veterans Access to Care developed a list of 32 interested VAMCs based on email surveying, which were categorized based on location (urban, rural), desired scribe deployment (ED, specialty care), and underserved (based on high new patient specialty care wait times). 12 VAMCs were then randomly selected for the treatment, accounting for the requirements of the law, OVAC preferences, and site capabilities, with the remainder used as comparison sites.

Contacts and Locations

Go to 

Information from the National Library of Medicine

To learn more about this study, you or your doctor may contact the study research staff using the contact information provided by the sponsor.

Please refer to this study by its ClinicalTrials.gov identifier (NCT number):

NCT04154462

Contacts

Contact: Steven Pizer, PhD (857) 364-6061 peprec@va.gov

Locations**United States, Arizona**

Southern Arizona VA Health Care System **Recruiting**
Tucson, Arizona, United States, 85723

United States, Kentucky

Robley Rex VA Medical Center **Recruiting**
Louisville, Kentucky, United States, 40206

United States, Maine

Togus VA Medical Center **Recruiting**
Augusta, Maine, United States, 04330

United States, Montana

Fort Harrison VA Medical Center **Recruiting**
Helena, Montana, United States, 59636

United States, New Hampshire

Manchester VA Medical Center **Recruiting**
Manchester, New Hampshire, United States, 03104

United States, New Jersey

Recruiting

East Orange VA Medical Center
East Orange, New Jersey, United States, 07018

United States, North Dakota

Fargo VA Medical Center **Recruiting**
Fargo, North Dakota, United States, 58102

United States, Oklahoma

Oklahoma City VA Medical Center **Recruiting**
Oklahoma City, Oklahoma, United States, 73104

United States, Texas

Audie L. Murphy VA Hospital **Recruiting**
San Antonio, Texas, United States, 78229

Olin E. Teague Veterans' Medical Center **Recruiting**
Temple, Texas, United States, 76504

United States, Virginia

Hampton VA Medical Center **Recruiting**
Hampton, Virginia, United States, 23667

United States, West Virginia

Louis A. Johnson VA Medical Center **Recruiting**
Clarksburg, West Virginia, United States, 26301

Sponsors and Collaborators

VA Boston Healthcare System
US Department of Veterans Affairs

Investigators

Principal Investigator: Steven Pizer, PhD Boston VA Healthcare System

More Information

Go to

Additional Information:

[S.2372 - VA MISSION Act of 2018](#) [EXIT](#)**Publications:**

Pearson, E., Frakt, A., & Pizer, S. (2018, December). Medical Scribes, Productivity, and Satisfaction. Partnered Evidence-based Policy Resource Center Policy Brief, 3(2).

Responsible Party: Melissa Garrido, Associate Director, VA Boston Healthcare System
ClinicalTrials.gov Identifier: [NCT04154462](#) [History of Changes](#)
Other Study ID Numbers: PEPRc Protocol #2019-001
VA QUERI PEC #16-001 (Other Grant/Funding Number: VA QUERI)
First Posted: November 6, 2019 [Key Record Dates](#)
Last Update Posted: March 17, 2020
Last Verified: March 2020

Individual Participant Data (IPD) Sharing Statement:

Plan to Share IPD: No

Studies a U.S. FDA-regulated Drug Product: No

Studies a U.S. FDA-regulated Device Product: No

Keywords provided by Melissa Garrido, VA Boston Healthcare System:

workforce
medical records
documentation
efficiency
patient satisfaction

Additional relevant MeSH terms:

Emergencies
Disease Attributes
Pathologic Processes

APPENDIX F

Measures

We will evaluate the impact of medical scribes on outcomes in several domains, including provider efficiency, wait times, patient volume, and patient satisfaction (Table 3). Data will be organized by facility-pay period for all outcomes to allow us to compare facilities with and without scribes for one year before and during the intervention period. We will also assess the provider efficiency outcomes at the provider-pay period level to allow us to describe differences between providers within treatment facilities based on their pairing with scribes. Detailed descriptions of each measure are contained in the appendix.

Productivity

Our primary productivity measure will be based on work relative value units (wRVUs) per facility-pay period and provider-pay period using the following formula.

$$\text{wRVU-based productivity} = \text{total wRVUs} \div \text{adjusted physician clinical FTE}$$

wRVUs are a way to measure the amount of work associated with a clinical activity or procedure, assigned by the Centers for Medicare and Medicaid Services (CMS). We will calculate wRVUs using the CPT (Current Procedural Terminology) codes of all medical procedures performed by specific providers during their encounters captured in the CDW. We will calculate the total wRVUs by multiplying the volume of each CPT code performed with the respective wRVUs assigned by CMS and then summing over all codes. We will divide by adjusted physician clinical FTE for each facility-pay period to make the measure comparable across facilities and time. As a sensitivity analysis, we will also use a productivity measure based on facility-pay period visit volume using the following formula. The MISSION Act also requires reporting on visits per day so we will also compute a version scaled by FTE days.

Visit-based productivity = total visits ÷ adjusted physician clinical FTE

Wait times

Consult wait times are a validated wait time measure for specialty care, and lower wait times are associated with improved patient satisfaction.⁷ We will use appointment and visit data in CDW to create two average wait time variables, one capturing time to completion of consults during the pay period and another capturing how long into the future patients are waiting for consults recently ordered. The first is a retrospective measure of days to a completed consult and is defined as shown below. Consults that are canceled or where the patient was a no show are not included in this measure.

Days to completed consult = completed consult date – consult creation date

The second is a prospective measure of days to a scheduled consult and is defined as follows.

Days to scheduled consult = scheduled consult date – consult creation date

We will calculate the pay period average wait times for each physician in cardiology and orthopedics as well as clinic-specific facility-pay period average wait times that include all physicians within each specialty.

Patient volume

We will use the patient visits data from CDW to count the patients seen with the following formula to calculate the patient volume:

Patient volume = unique patients per day ÷ adjusted physician clinical FTE

Patient satisfaction

We plan to use two V-Signals surveys to measure patient satisfaction: 1) Outpatient – Scheduling an Appointment and 2) Outpatient – Health Care Visit. Each survey includes several statements about the Veteran's experience and the Veteran assigns a number from 1 to 5 on a

Likert Scale to indicate whether they agree or disagree with the statements (1 is strongly disagree, 5 is strongly agree). We will use responses to seven questions in the V-Signals survey shown in Table 3 to measure their satisfaction, with only the final three questions used for emergency department patients. We will recode the Likert scales into binary variables to provide a percentage change interpretation in patient satisfaction (where strongly disagree, disagree, and neutral are set equal to zero; and agree and strongly agree are set equal to 1). We will calculate the average percentage change in patient satisfaction for each facility-specialty combination.

APPENDIX G

Power Analysis

We conservatively assumed 24 pay periods (1 year) worth of data given that hiring and training delays could result in less than two full years of implementation, with 24 providers (two scribes per provider) at 12 treatment sites and 48 providers in comparison sites. We used the observed standard deviation for each outcome in the baseline period, averaged across specialties, as our assumption in the power analysis. For provider efficiency and patient volume, the number of provider-pay periods corresponds to a sample size of 576 in the treatment group and 1,152 in the comparison group. As wait times are only measured for specialty care, the number of provider-pay periods corresponds to a sample size of 384 in the treatment group and 768 in the comparison group. For patient satisfaction, we had to make additional assumptions about patient volume and response rate to project the number of responses per provider-pay period. Based on baseline patient volume and a 15% response rate (historically 20%), we project 12 completed patient satisfaction surveys per provider-pay period, which yields sample sizes of 6,912 in the treatment group and 13,824 in the comparison group.

Under these assumptions, we would have 80% power to detect a 25.85 increase in wRVUs per physician FTE and a 13.63 increase in visits per physician FTE related to the introduction of scribes. Another study found a 95 wRVU increase on average per physician hour in a community ED, much larger than our minimum detectable effect sizes if re-scaled appropriately.⁶ We would be powered to detect a 5.82 day decrease in wait times for specialty care and a 0.55 increase in unique patients seen per day per physician FTE. For context, a prior analysis of 2012 VHA data found a 28.8 days to completion average for specialty care consults.¹³ A prior study examining scribes in primary care found an increase of 0.16 patients per hour.⁵ If we assume an 8 hour

workday and that these magnitudes are comparable for specialty and ED care, we would have power to detect an effect size considerably smaller. Our minimum detectable effect size for patient satisfaction, using “I am satisfied with the service I received from the VA clinic”, is an increase of approximately 0.82 percent, small enough to detect any meaningful difference in patient satisfaction. Assessment of differences in the effectiveness of VA-hired versus contract-hired scribes is Congressionally mandated, but not powered for analysis. We will rely on descriptive and qualitative analysis to explore whether there are any noteworthy differences by mode of hiring that might inform how such an intervention would be scaled nationally.

Table G.1. Minimum detectable effect sizes at 80% power

Outcome	Number of providers		Size of clusters		Sample size		Standard deviation	ICC	Minimum detectable effect size
	Comparison	Treatment	Comparison	Treatment	Comparison	Treatment			
wRVU-based productivity	48	24	24	24	1,152	576	163	0.01	+25.85
Visit-based productivity	48	24	24	24	1,152	576	86	0.01	+13.63
Days to completed consult ^a	32	16	24	24	768	384	30	0.01	-5.82
Patient volume	48	24	24	24	1,152	576	3.5	0.01	+0.55
Patient satisfaction	48	24	288	288	13,824	6,912	10	0.01	+0.82

ICC – intra-class correlation

Size of clusters represents the number of pay periods for wRVU-based productivity, visit-based productivity, wait times, and patient volume, and number of respondents per pay period for patient satisfaction. For patient satisfaction, the item “I am satisfied with the service I received from the VA clinic” was used in our power analysis.

^a Applies to specialty care only