Distribution Statement

Distribution A: Public Release.

The views presented here are those of the author and are not to be construed as official or reflecting the views of the Uniformed Services University of the Health Sciences, the Department of Defense or the U.S. Government.

A Needs Assessment of the Documentation Intake in Military Primary Care

Sarah Hervey

Miranda Horne

Uniformed Services University

Daniel K. Inouye Graduate School of Nursing

Phase II Site: Navy Medicine Readiness and Training Command (NMRTC) Portsmouth

Authors: Sarah Hervey, LCDR, NC, USN; Miranda Horne, LCDR, NC, USN

Students, Doctor of Nursing Practice/Family Nurse Practitioner Program

Uniformed Services University of the Health Sciences

Phase II Site: Navy Medicine Readiness and Training Command Portsmouth

Disclaimer: In the early weeks of the 2020 COVID19 Pandemic, graduates of the Daniel K. Inouye Graduate School of Nursing were asked by the University leadership to graduate 6 weeks early to care for the health of the nation in their new APRN roles. All phases of the DNP Project were complete, and met the standards and rigors of a quality DNP Project with an abbreviated dissemination timeframe. The views expressed in the paper are those of the authors and do not necessarily reflect the official policy or position of the Department of the Navy, Department of Defense, or the United States Government. There are no financial relationships that exist between the authors and any commercial entity

Copyright Statement: I am a military service member. This work was prepared as part of my official duties. Title 17 U.S.C. 105 provides that "Copyright protection under this title is not available for any work of the United States Government." Title 17 U.S.C. 101 defines a United States Government work as a work prepared by a military service member or employee of the United States Government as part of that person's official duties.

Table of Contents

DISCLAIMERS 2

COPYRIGHT ACKNOWLEDGEMENT STATEMENT 2

ABSTRACT 5

INTRODUCTION 7

SIGNIFICANCE OF THE PROBLEM 7

CLINICAL QUESTION 9

PROJECT DESIGN 9

LITERATURE SEARCH STRATEGY 9

ORGANIZING FRAMEWORK 9

Setting 10

Procedural Steps 11

HIPAA 13

ANALYSIS OF THE RESULTS 13

DEVELOPMENT OF PROCESS IMPROVEMENT 15

ORGANIZATIONAL IMPACT AND IMPLICATIONS 18

FUTURE DIRECTIONS RESEARCH AND PRACTICE 18

CONCLUSION 18

REFERENCES 20

Appendix A: Organizing Framework & Project Design 25

Appendix B: Appraisal Tool 26

Appendix C: Literature Search Strategy and PRISMA 29

Appendix D: Provider Questionnaire 30

Appendix E: Abbreviated Evidence Table 35

Appendix F: TSWF Support Task List 36

Appendix G: Provider Needs Assessment Questionnaire Statistical Analysis 38

Appendix H: Documentation of Health Prevention Training Program 39

Appendix I: Completion Verification Form 39

Abstract

Phase II Site: Navy Medicine Readiness and Training Command Portsmouth

Project Title: A Needs Assessment of the Documentation Intake in Military Primary Care

Authors: LCDR Sarah Hervey and LCDR Miranda Horne

Background: Documentation burden results in provider fatigue, decreased job satisfaction, reduced quality of patient care, and decreased productivity. Clinic efficiency may increase when support staff complete preliminary documentation thereby lowering burden on providers. At Navy Medicine Readiness and Training Command (NMRTC) Portsmouth the documentation process was unknown.

Purpose: Assess the patient documentation intake process in the electronic health record (EHR) and compare to primary care provider (PCP) preferences within three NMRTC Portsmouth clinics, including the Internal Medicine (IM) Clinic, the Tricare Prime Clinic Virginia Beach (TPC-VB) and Boone Clinic with the goal of identifying evidence-based recommendations to decrease provider documentation burden.

Project Design: Rosswurm and Larrabee's model for evidence-based practice change was used as the organizing framework. Data was collected from provider questionnaires and direct observations of the patient intake process and then compared to the Tri-Service WorkFlow (TSWF) support staff task list. A training program to improve documentation of the top three provider-preferred tasks was proposed.

Analysis of the Results: Results from the questionnaire show that 68 percent of providers spend 2-4 hours documenting after normal work hours. Telephone consults were identified as the primary barrier to documenting during normal duty hours, and 90 percent of providers preferred to have preliminary documentation completed. Direct observations identified that the

documentation completion rates were less than 45 percent, and none of the support staff were aware of the TSWF support staff task list. Currently, there is no standard documentation process within the three primary care clinics.

Organizational Impact: Providers are spending additional duty hours performing documentation components that could be completed by support staff. Documentation burden could be reduced by training support staff on how to appropriately document and by having support staff complete preliminary documentation. Addressing the problems of incomplete documentation could decrease provider workload and increase the length of time for provider-patient interaction.

Introduction

Healthcare providers are doing most of the documentation for each patient encounter (Arndt et al., 2017). This documentation burden leads to provider fatigue, a decline in job satisfaction, reduced quality of patient care, and decreased productivity (Arndt et al., 2017). Considering the fact that the average primary care appointment is 20-minutes, it makes it difficult for providers to complete required documentation during working hours, while adhering to their stringent patient schedule. Unfortunately, many providers are forced to complete their documentation outside of working hours to keep up with the number of patients they are seeing (Arndt et al., 2017). According to Arndt et al. (2017), providers spend more than 50 percent of their time documenting in the electronic health record (EHR). Every member of the health care team can and should have a role in the documentation process, not just the providers (Bodenheimer, Willard-Grace, & Ghorob, 2014). Although the Defense Health Agency (DHA) has mandated the use of the Tri Service WorkFlow (TSWF) Core form in AHLTA, the military EHR, for each primary care patient encounter (Tricare, 2018) (DHAPI 6025.06, 2018), each provider has the autonomy to determine how that information is documented (DoDI 6040.45, 2015). Navy Medicine Readiness and Training Command (NMRTC) Portsmouth does not have a defined policy that addresses which staff should make entries on each patient encounter in primary care clinics.

Significance of the Problem

The intent of the EHR was to increase patient care delivery through more cohesive documentation for all providers. However, across the literature, authors have found that EHR implementation, although advantageous in many ways, is associated with increased workflow disruptions and provider documentation burden (Obrien, Weaver, Settergre, Hook, & Ivory,

2015). According to Arndt et al. (2017), providers spent a total of greater than 50 percent of their time during the weekday working in the EHR; 4.5 hours during a 9-hour duty day and at least 1.4 hours at the end of the regular duty day. Ineffective documentation within the EHR has negative impacts on providers such as: increased workload, increased stress, decreased productivity, decreased job satisfaction, and disruptions in patient care (Arndt et al., 2017, Contratto et al., 2017, Shanafelt et al., 2016, Linzer et al., 2016). Reduced job satisfaction negatively impacts provider well-being leading to resignation, affecting workplace productivity (Shanafelt & Noseworthy, 2017). Authors Fred and Scheid (2018) estimate that it costs $500,000- $1,000,000 of revenue when a physician leaves a practice, and the reason for leaving is often due to burnout. Additionally, it costs $90,000 to recruit and replace each new physician. Considering provider burnout is often reported to be closely related to increased time spent documenting and working after hours, improving documentation may reduce burnout and ultimately decrease provider attrition rates (Fred & Scheid, 2018).

Providers are often charting information that could be performed by the ancillary staff. Support staff often lack appropriate training to perform charting (Babbot et al., 2014; Linzer et al., 2016). Also, improper documentation by support staff can result in documentation errors. These errors can lead to inaccurate coding, billing and reimbursement, which are economically damaging to the healthcare practice (Srinivas & Ravindran 2018). Suggestions for decreasing provider burnout include increasing the scope of practice of non-licensed personnel, increasing patient self- care, and technological innovations, among others (Bodenheimer & Smith, 2013). However, staff education and training remain paramount across the literature as the best means to improve the overall documentation process.

Clinical Question

Among primary care providers within NMRTC Portsmouth, including the Internal Medicine (IM) Clinic, the Tricare Prime Clinic Virginia Beach (TPC-VB) and Admiral Joel T. Boone Branch Health Clinic (Boone), what is the existing process for documenting patient intake in the electronic health record (EHR) as compared to provider preferences?

Project Design

This descriptive process evaluation used questionnaires and direct observation to describe the patient in-take process. Preparation and documentation completed prior to the provider entering the room increases feelings of provider support and improves overall patient flow and clinic efficiency (Backer, 2002). Therefore, the plan for this EBP was to perform a detailed needs assessment followed by proposing a sustainable process improvement at the NMRTC Portsmouth IM clinic. The project design used Rosswurm and Larrabee's model for evidence-based practice change (Melnyk & Fineout-Overholt, 2015) (see Appendix A).

Literature Search Strategy

PubMed, Embase, and Cinahl were searched using a systematic search strategy and resulted in 715 evidence-based articles related to the topic. The appraisal tool that was used to evaluate each article was the John Hopkins Nursing Evidence-Based Practice Appraisal Tool (Appendix B). This tool was chosen because it outlined a stepwise process that systematically walked the user through the appraisal process. The Literature Search Strategy diagram outlined the breakdown of all of the evidence-based articles found (Appendix C). Following systematic appraisal of all literature found, nine solution articles were found (Appendix E).

Organizational Framework

Rosswurm and Larrabee's Model for Evidence-Based Practice Change was used as the organizing framework because it is designed to implement practice change in a clearly-defined

six-step process (Melnyk & Fineout-Overholt, 2015). Step one was to assess the need for change; the literature review showed that documentation burden was a concern. The process was unknown at NMRTC Portsmouth, so a needs assessment was completed that consisted of the provider questionnaire (Appendix D), followed by direct observations. Step two was to link the problem with potential solutions, in which five main solutions in the literature were found. Step three was to synthesize the best evidence. Nine articles in the literature search addressed solutions (Appendix E). During this phase strong evidence supported pre-visit planning as a potential method to decrease documentation burden.

Step four was to design a practice change. Step five was to implement and evaluate a practice change. Step six was to integrate and maintain the practice change.

Setting

The needs assessment portion of the project was carried out at the NMRTC Portsmouth IM Clinic, TPC-VB, and Boone Clinic. All three clinics are responsible for providing primary care to active duty, dependents and retirees. The IM Clinic is located in the Charette Health Care Center in Building 2, second floor at NMRTC Portsmouth. The clinic operating hours are from Monday through Friday from 0730 to 1600. There are approximately 45 providers and 35 support staff (nurses, medical assistants, corpsman, and administrative personnel) that work in this particular clinic. There are more providers in this clinic as it is a training facility (residents and medical students). Providers in this clinic see an average of 12 patients seen each day in 30-minute appointment slots. TPC-VB is located in Virginia Beach, VA. The clinic operating hours are from Monday through Sunday 0700 to 1900 and there are approximately 19 providers and 32 support staff. Providers in the clinic see an average of 20 patients each day in 20-minute appointment slots. Boone Clinic is located in Virginia Beach, VA on Joint Expeditionary Base,

Little Creek-Fort Story. The clinic operating hours are from Monday through Sunday 0700 to 1900 and there are 25 providers and 38 support staff. Providers in the clinic see an average of 20 patients each day in 20-minute appointment slots.

Procedural Steps

The following procedural steps were followed in conducting the DNP Project:

Clinical Question Development. Developed in conjunction with the DNP project team at Uniformed Services University (USU) during Phase 1.

Literature Review. A detailed literature review was completed during Phase 1 of project development.

Proposal approval. Project proposal was developed during Phase 1 of project.

Questionnaire Development. Upon arrival at Phase 2, the project team developed the questionnaire used for data collection in collaboration with Phase 2 Site Director and Portsmouth research team. A twelve-item self-reported needs assessment questionnaire (Appendix E), was developed to determine providers current view of the patient intake process, their preferences for documenting this process in the TSWF, and their perceptions regarding time spent documenting. This questionnaire was developed with the assistance from the Phase 2 Site Director and the research team at NMRTC Portsmouth and was guided by data from the literature.

IRB approval. Before the project could begin at NMRTC Portsmouth, an Institutional Review Board (IRB) application was submitted, and it was determined that this project was exempt from IRB review.

Subject Recruitment and Request for Participation. Data gathering occurred in two parts, a needs assessment via provider questionnaire (Appendix D) and direct observation (Appendix F). Questionnaires were distributed to all 82 providers in the three clinics. No personally identifiable data was collected from participants. The direct observation portion of the needs assessment was achieved by observing hospital corpsmen and medical assistants during the check-in process. Direct observation of the documentation process was a crucial part to this project as it allowed for real-time observation within each of the three clinics. During these observations, intake documentation tasks that were completed by support staff were documented and compared to the DHA released TSWF support task list, which consisted of 75 administrative task lists (Appendix F). This support task list is updated quarterly (Tricare, 2018).

Data Analysis. The data collected from the needs assessment was analyzed. Data was collated and summarized using simple statistics to describe the findings from the provider questionnaire and direct observations. The intent of this project was to develop a process improvement or practice change; therefore, the data did not lend itself to complex data analysis.

Development of Practice Change. Once the data was analyzed, the project team collaborated with clinic leadership to develop a recommendation for a practice change. Data from the needs assessments and direct observation findings were compiled with evidence-based recommendations and used to guide the development of a training program to improve the documentation process.

HIPAA Concerns

Safeguarding protected health information (PHI) was a priority of this evidence-based practice (EBP) project. Personally, identifiable information (PII) and protected health information (PHI) for this portion of the EPB project was not aggregated, as this project was focused on addressing provider documentation burden. This EBP project was submitted to the NMRTC Portsmouth Institutional Review Board (IRB) for review, but this project did not involve any human research subjects (Gunter, 2002). This project did not meet the definition of research, "a systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge," defined by criteria published by the Office of Human Research Protections in the Code for Federal Regulations, Title 45 Public Welfare, Part 46 Protection of Human Subjects (Department of Health and Human Services, 2009, page 4). The use of PHI was not utilized. However, a review by the NMRTC Portsmouth IRB was appropriate to rule out any PII/PHI concerns.

Analysis of the Results

Data was compiled from both the questionnaires and the direct observations. Meaningful data was derived by the project members by calculating simple statistics. Statistical analysis calculations were performed with the help of the statistician at NMRTC Portsmouth (Appendix G). A total of 61out 82 questionnaires (74%) were completed and returned (47 from IM Clinic, 6 from TPC-VB, and 8 from Boone Clinic). The direct observation portion of the needs assessment was achieved by observing a total of 75 direct patient check-ins performed by five different hospitalmen and nine medical assistants (27 from IM Clinic, 24 from TPC-VB, and 24 from Boone Clinic).

The majority of the providers who responded were physicians (27.9%), residents (21.3%), interns (27.9%) and medical students (13.1%). There were significantly fewer Nurse

Practitioners (NPs) (4.9%) and Physician Assistants (PAs) (4.9%) who participated in completing the questionnaire, primarily due to the fact that there were simply less of these types of providers in general in MTFs.

The provider needs assessment questionnaire concluded that 68 percent (42) of the providers spent two to four hours documenting after working hours (see Appendix G). Also, 90 percent (55) of providers preferred to have preliminary documentation performed prior to the provider portion of a patient encounter. The top three documentation items the providers preferred to have documented by clinical staff were vital signs, medication reconciliation, and health prevention services. The top barrier to being able to document during regular duty hours was telephone consults. It was identified on the provider needs assessment questionnaire that the number one advantage of having support assist with documentation was it helps save time. The number one disadvantage of having support staff assist with documentation based off of the provider needs assessment questionnaire was concern for documentation errors and inaccuracies.

The second part of the needs assessment was achieved by observing a total of 75 (27 from IM Clinic, 24 from TPC-VB, and 24 from Boone Clinic) direct patient check-ins by following five hospitalmen and nine medical assistants. The health prevention/promotion/ screening portion of the check-in was under-documented, documented only 60% of the time across all three clinic locations. Direct observation of this documentation process was a crucial part to this project as it allowed for real-time observation within each of the three clinics. During these observations, intake documentation tasks that were completed by support staff were documented and compared to the DHA released TSWF support task list, which consisted of 75 administrative task lists (Appendix F). This support task list is updated quarterly (Tricare, 2018); however, it was discovered that most of the providers and support staff were completely unaware

of these updates. Additionally, none of the staff members were aware of this task list. The goal of phase two was to determine what proportion of information is documented by support staff versus the provider. Results of this portion of the project demonstrated that only minimal data is entered by this staff, leaving the responsibility in the hands of the providers. The completion rates in IM Clinic was 42 percent, at TPC-VB it was 45 percent, and at Boone Clinic it was 38 percent. Much of this problem was attributed to provider preferences. During the direct observations, all of the support staff indicated that the way they documented was based on provider preferences. Due to the low documentation completion rates (60%) of health promotion/prevention/screening, (vital signs were not observed/recorded during the direct observations, and medication reconciliation average completion rates were 90% across the three clinics) this item was chosen as the focus for the training implementation.

Development of Process Improvement

The needs assessments and direct observation findings were compiled with evidence-based recommendations and then used to guide the development of a training program to improve the documentation process within the IM Clinic. The decision to use the IM Clinic to implement a training program was made due to the fact that the providers in this clinic indicated the most interest in a practice change, and provided the most feedback on the project. The data collected from the provider questionnaires (see Appendix E-question #8) from the questionnaire and the completion rates gathered from the direct observations were used as the foundation for building the training program. Question eight inquired as to the top five items from the TSWF core sheet that providers would like to have documented by support staff in the EHR prior to their first encounter with the patient. The top three items from the TSWF core sheet that providers preferred to have documented for each patient encounter were vital signs, medication

reconciliation, and health prevention/promotion/screening. It was discovered that health prevention/promotion/screening measures were under-documented; documented 60% of the time across all three clinic locations. So, the decision was made to focus on this aspect of pre-visit documentation for the project intervention.

Project members were able to present the data findings to the IM Clinic manager and gain input and buy-in for the project implementation. Based on this meeting and the information gathered from the provider questionnaires and direct patient observations, it was decided that a tailored training program was the best course of action. Project members developed a detailed, phased-approach for training, practice change, and sustainment (Appendix H). As the plan involved significant buy-in and involvement of the clinic staff, the training manager from the appropriate clinics were engaged in the process. Handouts, training slides, and a video were developed as part of the implementation process. Project members discovered a detailed PowerPoint explaining how to document health prevention/promotion from Defense Health Agency (DHA) and then created a tutorial video that walked users through training. A competency checklist and SWANK post-test for all staff members was also created as part of the training program. Dissemination to the clinic staff was curtailed due to the COVID-19 pandemic. Sustainment of a practice change will be assessed by clinic staff. Education and training on health promotion, prevention, screening will be provided by the IM Clinic during morning huddles as well as during the designated weekly training day. A training champion will be utilized on each team who will facilitate the sustainment of the training program (Melnyk & Fineout-Overholt, 2015). The main goal is to ensure that the corpsmen and technicians receive the appropriate training on how to obtain and document the items in the health promotion, prevention, and screening box in the EHR, and that it is standardized throughout the clinic. To

evaluate the training program implementation, the clinic will perform follow-up data collection to assess how well the training was implemented and sustained after project completion.

Health prevention/promotion/screening updates includes many items including; lipid screening, diabetes screening, aspirin prophylaxis, HIV screening, hepatitis C screening, colorectal cancer screening, cervical cancer screening, mammogram, gonorrhea/chlamydia screening, osteoporosis screening, aortic aneurysm screening (smokers), low-dose computed tomography (CT) lung cancer screening (smokers), and prostate cancer screening. All of this information is listed in the health prevention box in AHLTA in the TSWF core form. The expectation is that this information will be updated for each patient encounter.

Resources available online through the TSWF training website were utilized to create a comprehensive training program on documenting health prevention/promotion/screening updates. The preventive services box in AHLTA can be correctly updated by utilizing the clinical registry's health maintenance report (CRHMR). CRHMR is accessible through the Military Health System (MHS) population health portal (or MHSPHP) through the Care Point website (an electronic patient portal system). DHA released a PowerPoint that walks the user through each part of the preventive services box in AHLTA and how to correctly document each piece of information in that box. This PowerPoint can be accessed through the TSWF website by typing in tswf-mhs.com and searching for CRHMR. The project members planned to provide this DHA PowerPoint, a tutorial video walking the user through the steps in the PowerPoint, and a competency checklist for staff members in the IM Clinic to complete. All items of this comprehensive training program were created, but project members did not have sufficient time to disseminate to the IM clinic for implementation due to the COVID-19 pandemic.

Organizational Impact & Implications

Documentation burden could be reduced by having support staff complete preliminary documentation. The best recommendations for clinical practice to decrease documentation burden are; training, creating a standardized documentation process instruction, complete pre-visit planning with increased documentation by support staff, and using scribes. Although scribes were the number one way to decrease documentation burden, this was not an option at NMRTC Portsmouth due to costs. One lesson learned during this evidence-based project was that there is no standardized documentation policy for MTFs, the Navy, and throughout the Department of Defense. Another lesson learned is that because there is no standard, charting varies between providers, with provider preference drastically impacting how documentation is completed.

Future Directions for Research and Practice

There are three primary recommendations for future practice and research. The first is to implement a DoD/DHA documentation instruction for all MTFs, outlining what information needs to be documented and by whom. Another is to increase ambulatory care training in corps school. Augmenting ambulatory care training which includes patient documentation during initial training will lead to better overall documentation. A final recommendation is to implement documentation policies that are specific to each clinic. Each MTF functions a little differently, therefore each one should have a documentation policy that is specific to that location.

Conclusion

Documentation is a vital component of the healthcare system. DHA released ample training for TSWF, but none of the providers or clinic staff were aware. Documentation burden could be reduced by training support staff on how to appropriately document and by having

support staff complete preliminary documentation. Addressing the problems of incomplete documentation will decrease provider workload and will increase the length of time for provider-patient interaction, resulting in safe, high quality improved patient care.

References

Arndt, B. G., Beasley, J. W., Watkinson, M. D., Temte, J. L., Tuan, W., Sinsky, C. A., & Gilchrist, V. J. (2017). Tethered to the EHR: Primary care physician workload assessment using EHR event log data and time-motion observations. *Annals of Family Medicine. 15*(5). p. 419-426. doi:10.1370/afm.2121.

Babbott, S., Manwell, L. B., Brown, R., Montague, E., Williams, E., Schwartz, M., . . . Linzer, M. (2014). Electronic medical records and physician stress in primary care: results from the MEMO study. *Journal of the American Medical Informatics. 21*(E2). p. 100-106. doi:10.1136/amiajnl-2013-00187.

Backer, L. A. (2002). Strategies for better patient flow and cycle time. *American Academy of Family Physicians.* p. 45-50.

Ball, J. W., Dains, J. E., Flynn, J. A., Solomon, B. S., & Stewart, R. W. (2015). *Seidel's Guide to Physical Examination, 8th Edition.* St. Louis, Missouri: Elsevier.

Beauvais, B., Richter, J., & Brezinski, P. (2017). Fix these first: how the world's leading companies point the way toward high reliability in the military health system. Journal of Healthcare Management, 62(3). p. 197-208. doi:10.1097/JHM-D-15-00048.

Bodenheimer, T. S., & Smith, M. (2013). Primary care: proposed solutions to the physician shortage without training more physicians. *Health Affairs, 32*(11). p. 1881-1886. doi:10.1377/hlthaff.2013.0234.

Bodenheimer, T., Willard-Grace, R., & Ghorob, A. (2014). Expanding the roles of medical assistants: who does what in primary care? *Journal of the American Medical Association, 174*(7). p. 1025-1026. doi:10.1001/jamainternmed.2014.1319.

BJC Healthcare. (2020). Barnes-Jewish St. Peters Hospital: Vital Signs (Body Temperature, Pulse Rate, Respiration Rate, Blood Pressure). St. Peters: Missouri. Retrieved from https://www.bjsph.org/Health-Library/View-Content/contentTypeId/85/contentId/P00866

Card, A. J. (2018). Physician burnout: resilience training is only part of the solution. *Annals of Family Medicine, 16*(3). doi:10.1370/afm.2223.

Contratto, E., Romp, K., Estrada, C. A., Agne, A., & Willett, L. L. (2017). Physician order entry clerical support improves physician satisfaction and productivity. *Southern Medical Journal, 110*(5). p. 363-368. doi:10.14423/SMJ.0000000000000645.

Department of Defense Instruction 6040.45, Dated 16NOV2015. DoD Health Record Life Cycle Management.

Defense Health Agency. (2017). The Defense Health Agency 2017 Stakeholder Report. 1-32.

Department of Health and Human Services. (2009). *Code of Federal Regulations, Title 45 Public Welfare, Part 46 Protection of Human Subjects.* Retrieved from http://www.hhs.gov/ohrp/policy/ohrpregulations.pdf.

Department of the Navy. (2010). *Primary care services in Navy Medicine* (BUMED Instruction 6300.19). Washington, D.C: Bureau of Medicine and Surgery.

Downing, N. L., Bates, D. W., & Longhurst, C. A. (2018). Physician burnout in the electronic health record era: are we ignoring the real cause? *Annals of Internal Medicine, 169*(1). p. 50-53. doi:10.7326/M18-0139.

Fred, H. L., & Scheid, M. S. (2018). Physician burnout: causes, consequences, and cures. *Texas Heart Institute Journal, 45*(4). p. 198-202. doi:10.14503/THIJ-18-6842.

Gidwani, R., Nguyen, C., Kofoed, A., Carragee, C., Rydel, T., Nelligan, I., . . . Lin, S. (2017).

Impact of scribes on physician satisfaction, patient satisfaction, and charting efficiency: a randomized control trial. *Annals of Family Medicine. 15*(5). p. 427- 433. doi:10.1370/afm.2122.

Gunter, K. P. (2002). The HIPAA privacy rule: Practical advice for academic and research institutions. *Journal of the Healthcare Financial Management Association*, *11*(3). p. 50-54. Retrieved from http://go.galegroup.com.lrc1.usuhs.edu/ps/i.do?p=EAIM&u=beth43189&id=GAL.

Hamidi, M. S., Bohman, B., Sandborg, C., Smith-Coggins, R., de Vries, P.,, Albert, M. S., . . . Trockel, M. T. (2018). Estimating institutional physician turnover attributable to self-reported burnout and associated financial burden: a case study. *BMC Health Services Research, 18*(851). p. 2-8. doi:10.1186/s12913-018-366-3-z.

Health IT. (2014). Benefits of EHRs. Retrieved from HealthIT.gov.

Linzer, M., Poplau, S., Babbott, S., Collins, T., Guzman-Corrales, L., Menk, J., . . .Ovington, K. (2016). Worklife and wellness in academic general internal medicine: results from a national survey. *Journal of General Internal Medicine, 31*(9), p. 1004-1010. doi:10.1007/s11606-016-3720-4.

Lister, E. D., Ledbetter, T. G., & Warren, A. (2015). The Engaged Physician. *Mayo Clinic proceedings, 90*(4). p. 425. doi:10.1016/j.mayocp.2015.02.005.

Melnyk, B. M., & Fineout-Overholt, E. (2015). *Evidence-based practice in nursing & healthcare: A guide to best practice, 3rdEdition.* Philadelphia, PA: Wolters Kluwer Health.

Morawski, K., Childs-Roshak, J., & Weitberg, A. (2017). Scribes: re-writing the story on

patient and provider experience. *Healthcare, 5*(3). p. 95-97. doi:10.1016/j.hjdsi.2017.04.001.

Narcisse, M., Kippenbrock, T., Odell, E. & Buron B. (2013). Advanced practice nurses meaningful use of electronic health records. *Applied Nursing Research, 26*(3), p. 127-132. doi:10.1016/j.apnr.2013.02.003.

O-Brien, A., Weaver, C, Settergren, T, Hook, M, & Ivory, C. H. (2015). EHR documentation: The hype and the hope for improving nursing satisfaction and quality outcomes. *Nursing Administration Quarterly, 39*(4). p. 333-339. doi:10.1097/NAQ.0000000000000132.

Saitwal, H., Feng, X., Walji, M., Patel, V., & Zhang, J. (2010). Assessing performance of an Electronic Health Record (EHR) using Cognitive Task Analysis. *International Journal of Medical Informatics, 79*(7). p. 501-506. doi:10.1016/j.ijmedinf.2010.04.001.

Sargent, P., Millegan, J., Delaney, E., Roesch, S., Sanders, M., Mak, H., . . . Webb, J. (2016). Health care provider burnout in a United States military medical center during a period of war. *Military Medicine, 181*(2). p. 136-142. doi:10.7205/MILMED-D-14-00449.

Shanafelt, T. D., & Noseworthy, J. H. (2017). Executive leadership and physician well-being: Nine organizational strategies to promote engagement and reduce burnout. *Mayo Clinic proceedings, 92*(1). p. 129-146. doi:10.1016/j.mayocp.2016.10.004.

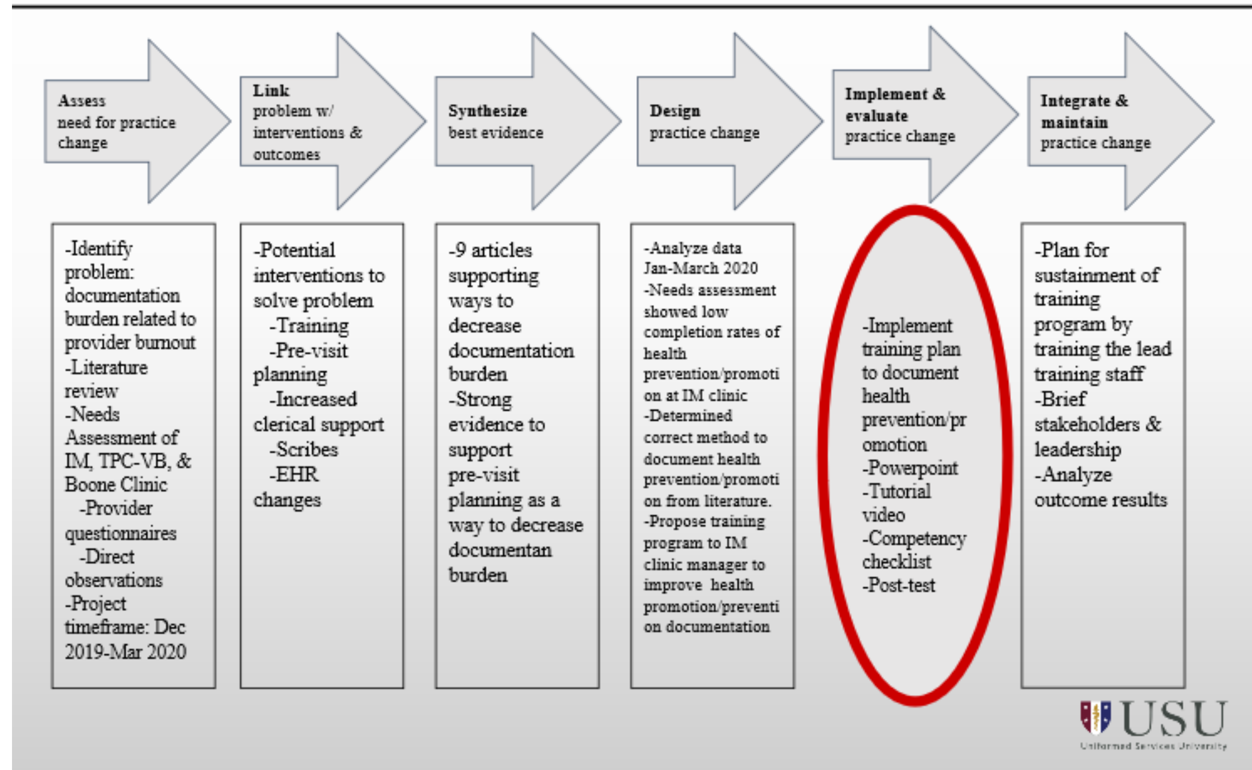
Shanafelt, T. D., Dyrbye, L. N., Sinsky, C., Hasan, O., Satele, D., Sloan J, & West, C. P. (2016). Relationship between clerical burden and characteristics of the electronic environment with physician burnout and professional satisfaction. *Mayo Clinic Proceedings, 91*(7). p. 836- 848. doi:10.1016/j.mayocp.2016.05.007.

Srinivas, S. & Ravindran, A. R. (2018). Optimizing outpatient appointments system using machine learning algorithms and scheduling rules: A prescriptive analytics framework. *Expert Systems with Applications, 102*, p. 245-261. doi:10.1016/j.eswa.2018.02.02.

Tricare. (2018). *Tricare West Region Provider Handbook.* Health Net Federal Services.

Whelton, P., Carey, R. M., Aronow, W. S., Casey, D. E., Collins, K. J., Dennison, H. C., DePalma, S. M., Gidding, S., Jamerson, K. A., Jones, D. W., MacLaughlin, E. J., Muntner, P., Ovbiagele, B., Smith, S. C., Spencer, C. C., Stafford, R. S., Taler, S. J., Thomas, R. J., Williams, K. A., Williamson, J. D., & Wright, J. T. (2018). 2017 ACC/AHA/AAPA/ABC/ACPM/AGS/AphA/ASH/ASPC/NMA/PCNA guideline for the prevention, detection, evaluation, and management of high blood pressure in adults: executive summary. *American Heart Association, Inc, 71*(6). p. 1269-1324. doi:10.1161/HYP.0000000000000066

Appendix A: Organizing Framework / Project Design



Appendix B: Appraisal Tool

Johns Hopkins Nursing Evidence-Based Practice
Appendix E: Research Evidence Appraisal Tool

Evidence Level and Quality:______________________

Article Title:			Number:
Author(s):			Publication Date:
Journal:			
Setting:		Sample (Composition & size):	
Does this evidence address my EBP question?	☐Yes	☐No Do not proceed with appraisal of this evidence	

Level of Evidence (Study Design)			
A. Is this a report of a single research study? ***If No, go to B.***		☐Yes	☐No
1. Was there manipulation of an independent variable?		☐Yes	☐No
2. Was there a control group?		☐Yes	☐No
3. Were study participants randomly assigned to the intervention and control groups?		☐Yes	☐No
If Yes to all three, this is a Randomized Controlled Trial (RCT) or Experimental Study →	☐ LEVEL I		
If Yes to #1 and #2 and No to #3, OR Yes to #1 and No to #2 and #3, this is Quasi Experimental (some degree of investigator control, some manipulation of an independent variable, lacks random assignment to groups, may have a control group) →	☐ LEVEL II		
If No to #1, #2, and #3, this is Non-Experimental (no manipulation of independent variable, can be descriptive, comparative, or correlational, often uses secondary data) or **Qualitative** (exploratory in nature such as interviews or focus groups, a starting point for studies for which little research currently exists, has small sample sizes, may use results to design empirical studies) →	☐ LEVEL III		
NEXT, COMPLETE THE BOTTOM SECTION ON THE FOLLOWING PAGE, "STUDY FINDINGS THAT HELP YOU ANSWER THE EBP QUESTION"			

© The Johns Hopkins Hospital/Johns Hopkins University. May not be used or reprinted without permission.

Johns Hopkins Nursing Evidence-Based Practice
Appendix E: Research Evidence Appraisal Tool

B. Is this a summary of multiple research studies? ***If No, go to Non-Research Evidence Appraisal Form.***		☐Yes	☐No
1. Does it employ a comprehensive search strategy and rigorous appraisal method (**Systematic Review**)? ***If No, use Non-Research Evidence Appraisal Tool; if Yes:***		☐Yes	☐No
a. Does it combine and analyze results from the studies to generate a new statistic (effect size)? (**Systematic review with meta-analysis**)		☐Yes	☐No
b. Does it analyze and synthesize concepts from qualitative studies? (**Systematic review with meta-synthesis**)		☐Yes	☐No
If Yes to either a or b, go to #2B below.			
2. For Systematic Reviews and Systematic Reviews with meta-analysis or meta-synthesis:			
a. Are all studies included RCTs? →	☐ LEVEL I		
b. Are the studies a combination of RCTs and quasi-experimental or quasi-experimental only? →	☐ LEVEL II		
c. Are the studies a combination of RCTs, quasi-experimental and non-experimental or non-experimental only? →	☐ LEVEL III		
d. Are any or all of the included studies qualitative? →	☐ LEVEL III		
COMPLETE THE NEXT SECTION, "STUDY FINDINGS THAT HELP YOU ANSWER THE EBP QUESTION"			
STUDY FINDINGS THAT HELP YOU ANSWER THE EBP QUESTION:			

NOW COMPLETE THE FOLLOWING PAGE, "QUALITY APPRAISAL OF RESEARCH STUDIES", AND ASSIGN A QUALITY SCORE TO YOUR ARTICLE

© The Johns Hopkins Hospital/Johns Hopkins University. May not be used or reprinted without permission.

Johns Hopkins Nursing Evidence-Based Practice
Appendix E: Research Evidence Appraisal Tool

Quality Appraisal of Research Studies			
• Does the researcher identify what is known and not known about the problem and how the study will address any gaps in knowledge?	☐Yes	☐No	
• Was the purpose of the study clearly presented?	☐Yes	☐No	
• Was the literature review current (most sources within last 5 years or classic)?	☐Yes	☐No	
• Was sample size sufficient based on study design and rationale?	☐Yes	☐No	
• If there is a control group:			
○ Were the characteristics and/or demographics similar in both the control and intervention groups?	☐Yes	☐No	☐NA
○ If multiple settings were used, were the settings similar?	☐Yes	☐No	☐NA
○ Were all groups equally treated except for the intervention group(s)?	☐Yes	☐No	☐NA
• Are data collection methods described clearly?	☐Yes	☐No	
• Were the instruments reliable (Cronbach's α [alpha] $\geq$ 0.70)?	☐Yes	☐No	☐NA
• Was instrument validity discussed?	☐Yes	☐No	☐NA
• If surveys/questionnaires were used, was the response rate $\geq$ 25%?	☐Yes	☐No	☐NA
• Were the results presented clearly?	☐Yes	☐No	
• If tables were presented, was the narrative consistent with the table content?	☐Yes	☐No	☐NA
• Were study limitations identified and addressed?	☐Yes	☐No	
• Were conclusions based on results?	☐Yes	☐No	

Quality Appraisal of Systematic Review with or without Meta-Analysis or Meta-Synthesis		
• Was the purpose of the systematic review clearly stated?	☐Yes	☐No
• Were reports comprehensive, with reproducible search strategy?	☐Yes	☐No
○ Key search terms stated	☐Yes	☐No
○ Multiple databases searched and identified	☐Yes	☐No
○ Inclusion and exclusion criteria stated	☐Yes	☐No
• Was there a flow diagram showing the number of studies eliminated at each level of review?	☐Yes	☐No
• Were details of included studies presented (design, sample, methods, results, outcomes, strengths and limitations)?	☐Yes	☐No
• Were methods for appraising the strength of evidence (level and quality) described?	☐Yes	☐No
• Were conclusions based on results?	☐Yes	☐No
○ Results were interpreted	☐Yes	☐No
○ Conclusions flowed logically from the interpretation and systematic review question	☐Yes	☐No
• Did the systematic review include both a section addressing limitations and how they were addressed?	☐Yes	☐No

Quality Rating Based on Quality Appraisal

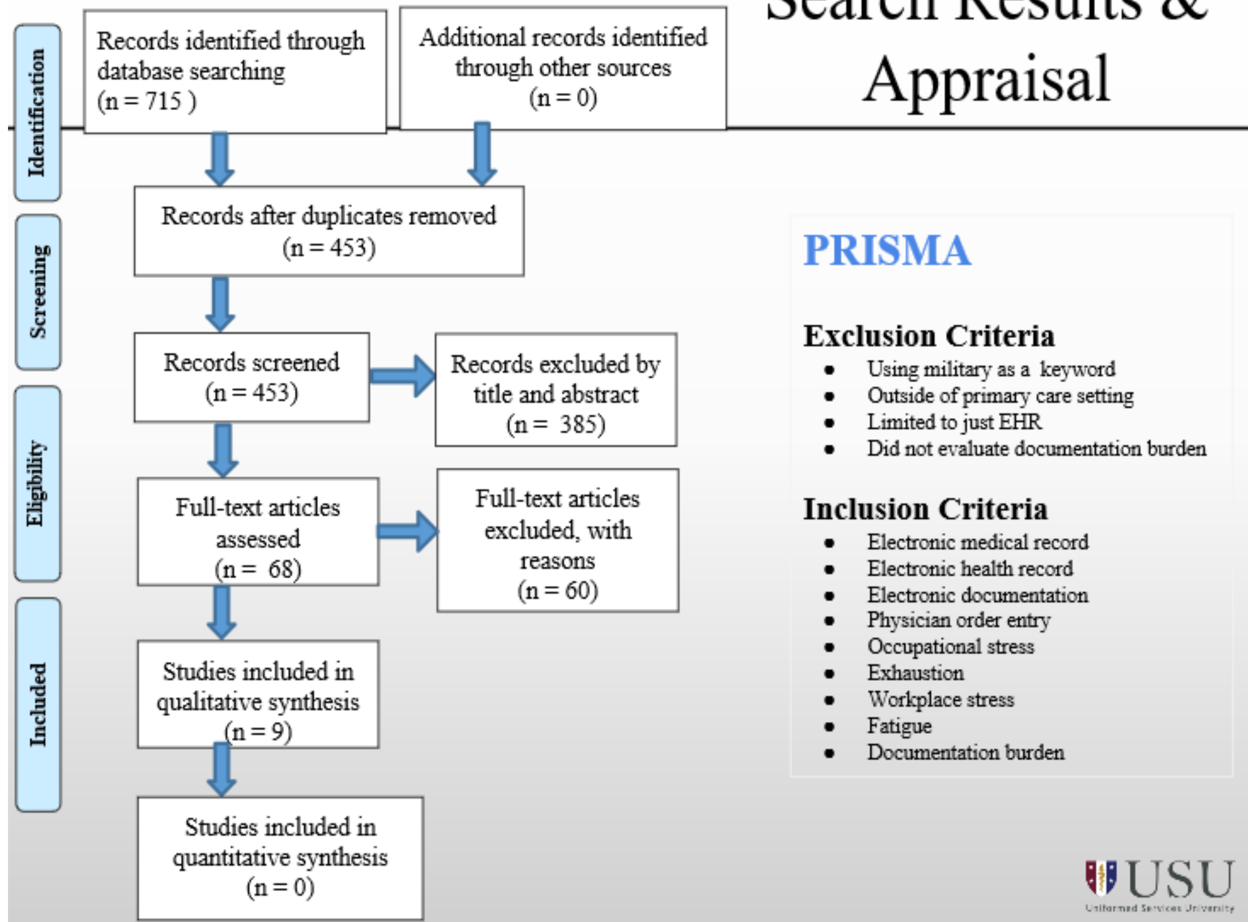
A **High quality:** consistent, generalizable results; sufficient sample size for the study design; adequate control; definitive conclusions; consistent recommendations based on comprehensive literature review that includes thorough reference to scientific evidence

B **Good quality:** reasonably consistent results; sufficient sample size for the study design; some control, and fairly definitive conclusions; reasonably consistent recommendations based on fairly comprehensive literature review that includes some reference to scientific evidence

C **Low quality or major flaws:** little evidence with inconsistent results; insufficient sample size for the study design; conclusions cannot be drawn

© The Johns Hopkins Hospital/Johns Hopkins University. May not be used or reprinted without permission.

Appendix C: Literature Search Strategy and PRISMA



Appendix D: Provider Questionnaire

Needs Assessment: Documentation of Screening in the Electronic Health Record

Credentialed Provider Questionnaire

We are a team of Doctor of Nursing Practice (DNP) students from the Uniformed Services University. We are completing a needs assessment for our DNP project to be used as a process evaluation. No personally identifying information will be collected/reported and no information that you provide can be linked back to you. Thank you for your assistance.

1. What is your role as a healthcare provider?

    a. Staff Physician

    b. Nurse Practitioner

    c. Physician Assistant

    d. Resident

    e. Intern

    f. Other________________

2. How many years have you been practicing in your current role?

    a. 0 to 4 years

    b. 5 to 8 years

    c. 9 to 12 years

d. >12 years

3. What portion of your time is spent in direct patient care?

    a. 0 to 25%

    b. 26 to 50%

    c. 51 to 75%

    d. 76 to 100%

4. On a typical day, how much time do you spend documenting patient encounters after normal duty hours?

    a. 0 to 1 hour

    b. 2- 4 hours

    c. 5- 7 hours

    d. 8+ hours

5. When thinking about the time spent during an average patient visit interacting with the electronic health record (EHR) (i.e. AHLTA), how would you rate the proportion of time with the EHR (e.g. reviewing information/ previous encounters, looking up labs, entering data, ordering, etc.) compared with the time spent interacting with the patient?

a. Too much time interacting with the EHR
b. About the right balance of time
c. Not enough time interacting with the EHR
d. I don't interact with the EHR during patient visits (please comment below on the reason why)
Comment____

6. Do you believe that having a portion of the TSWF Core Template in AHLTA completed prior to you entering the room with the patient would be helpful to your practice?

a. Yes
b. No

7. Do you believe that having the TSWF Paper Form completed prior to you entering the room with patient would be helpful to your practice? (Please see attached TSWF Form for example).

a. Yes
b. No

8. With appropriate training, which of the following areas of the TSWF Core Form should be completed by the clinic staff prior to you seeing a patient? Please pick top five and rate in order of importance. (1-most important, 5-least important).

_____ Vital signs
_____ Pain scale
_____ History of present illness
_____ Family history
_____ Surgical history
_____ Medical history
_____ Social history
_____ Medication list update
_____Health prevention/promotion/screening update (e.g. last colonoscopy, immunizations, pap test, HIV test, etc.)
_____Administering/confirming recommended screenings (PHQ-9, GAD-7, Audit-C, PTSD, Tobacco Screening)
_____Review of systems questions
_____Allergies
_____Pregnancy/LMP
_____None of the above (please comment)
Comment: ____

9. What are the advantages to having the clinic staff complete the screening identified in question 8?

10. What are the disadvantages to having the clinic staff complete the screening identified in question 8?

11. Are any of the following barriers that keep you from completing your documentation during working hours?
    a. TCONS
    b. Administrative Duties
    c. Collateral Duties
    d. Other________________
12. Is there anything else you would like to share concerning the current check-in process in your clinic?

Thank you for your participation.

Please complete ALL shaded areas. Complete other areas if this is your first visit or for any changes.

What is the reason for **today's visit**? ____

How **long** have you had this issue? ______________________ Please circle if this issue is getting **better** **worse**

Please list any **allergies** you have (drug, food, latex)____ ❑No Allergies

Please rate your **pain level** on a scale of 0 (no pain) to 10 (as bad as it could be): # ___/10 (ask to see the 'DVPRS pain intensity scale')

How would you rate your average pain the **last week** on a scale of 0 (no pain) to 10 (as bad as it could be)?: __/10 (also ask to see DVPRS)

With regard to pain, please indicate the following: Location:_______________ Duration: _____________ Quality:________________

Factors that correlate with onset:_______________________________ Frequency:____________ Average level of pain:____________

Worst level: _______ Least level: ________ What makes it better:_____________________ What makes it worse:__________________

❑Yes ❑No Since your last visit with us, have you had any medical care other than in this clinic?

Medical conditions	**Surgeries or hospitalizations** (Dates)	**Current medications**
High Blood pressure - High Cholesterol - Diabetes - Asthma - Heart Disease - Obesity - Cancer - Had a Heart Attack - **Other:**		(Include over-the-counter meds, Tylenol, vitamins, herbal supplements) ❑ Currently Nursing?
Family History ***HIGH BLOOD PRESSURE:*** ***HIGH CHOLESTEROL:*** ***DIABETES:*** ***HEART ATTACK: (who, age?)*** ***CANCER: (type, who, and what age when diagnosed?)*** ***OTHER:***	**Social History** (Family/Occupation issues)	**Occupational History and Exposure** (Include military duty related info)

Preventive Services	
Lipids - **Diabetes Screening -** **Aspirin Prophylaxis -** **HIV Screen -** **Hep C screening: Date:** **Colorectal Cancer Screening –** **[ ] Colonoscopy [ ] FOB x 3 [ ] Flex Sig [ ] CT Colonography [ ] FIT-DNA**	**Women:** **Cervical Cancer Screen - Pap: HPV:** **Mammogram -** **GC/Chlamydia Screen -** **Osteoporosis Screen -** **Men age 65-75 years:** **Aortic Aneurysm Screen (if ever a smoker) -**

❑Yes ❑No Have you traveled outside of the US in the last 90 days?

❑Yes ❑No Do you consume any alcohol?

❑Yes ❑Never Do you now or have you ever used **tobacco** products, including smokeless tobacco, e-cigs and vaping? If YES, check the following box that applies: ❑ I CURRENTLY USE Tobacco Products What type? ___________ How much per day? _________Interested in quitting? ❑Yes ❑No

❑ I QUIT USING Tobacco Products When did you quit?

Females Only: ❑Yes ❑No Could you be pregnant? Date of Last Period __________________ ❑Unknown

❑Yes ❑No Are you currently nursing?

❑Yes ❑No Have you ever been in a situation where you were being verbally or physically hurt, threatened, or made to feel afraid? (Recommended for females ages 14-46)

Ethnicity:

What is your preferred language (written or spoken)? _______________________________

What is your preferred method for learning: ❑ Verbal ❑ Written ❑Visual ❑ Other: _____________________

❑Yes ❑No Do you have a learning disability, language or emotional barrier, hearing/vision deficit?___________________________

How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

❑ Never ❑ Rarely ❑ Sometimes ❑ Often ❑ Always

❑Yes ❑No Do you have an advance directive? If yes, have you given a copy to your Primary Provider? ❑Yes ❑No

❑Yes ❑No Do you have any cultural or religious beliefs that may affect your care?

❑Yes ❑No Are you enrolled in EFMP (Exceptional Family Member Program)?

❑Yes ❑No Are you enrolled in Secure Messaging?

❑Yes ❑No Is this visit **deployment-**related? If yes, when and where was deployment? ___________________________

❑Yes ❑No Are you currently Active Duty? If yes, have you had a PHA in the last year? ❑Yes ❑No

❑Yes ❑No **Special Duty**? If yes check which applies **❑ PRP ❑ SCI ❑ PSP ❑ Flight status ❑ Dive status ❑ Performs Armed Duty**

Over the past 2 weeks, how often have you been bothered by any of the following?

	[0]	[1]	[2]	[3]
Little interest or pleasure in doing things	❑ Not at all	❑ Several days	❑ More than half the days	❑ Nearly every day
Feeling down, depressed, or hopeless	❑ Not at all	❑ Several days	❑ More than half the days	❑ Nearly every day

Think about the biggest threat to life you've EVER witnessed or experienced first-hand. In the PAST MONTH, how much have you been bothered by disturbing memories, feeling distant from others, or avoiding certain activities as a result of this experience?

❑ 0 ❑1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

Not bothered Extremely bothered

Appendix E: Abbreviated Evidence Table

Article	Year	Level of Evidence	Grade A	Grade B	Grade C	Solutions to Alleviate Documentation Burden
Arndt et al.	2017	III		X		Increased clerical & administrative support personnel to assist with documentation, order entry, billing & coding.
Babbot et al.	2014	III		X		Staff training.
Backer et al.	2002	III		X		Pre-visit planning & documentation with support staff
Contratto et al.	2017	II		X		Increased clerical & administrative support personnel to assist with documentation, order entry, billing & coding.
Gidwani et al.	2017	I	X			Scribes.
Gregory et al.	2017	III		X		EHR changes.
Linzer et al.	2016	II		X		Support staff training Measure stress & burnout annually
Morawski et al.	2017	I			X	Scribes & staff training.
Shanafelt et al.	2016	II		X		Staff training and implement scribes

Appendix F: TSWF Support Task List

Support Staff TSWF task list September 2019

TAB	#	ITEM
HPI	1	Chief complaint
HPI	2	HPI text box
HPI	3	Current DVPRS Score
HPI	4	Past week DVPRS Score
HPI	5	Functional Impact Assessment
HPI	6	Pain Assessment
HPI	7	Attending Physician
HPI	8	Care since last visit
HPI	9	Primary Opioid Provider
HPI	10	Meds
HPI	11	Medical Conditions
HPI	12	Surgeries
HPI	13	Social Hx
HPI	14	Occ history and exposures
HPI	15	Family Hx
HPI	16	Meds list updated at beginning of visit
HPI	17	Prev Services text box
Screening	1	Deployment-related
Screening	2	Military duty-related info
Screening	3	PHA status done/due
Screening	4	Armed Duty Y/N
Screening	5	Female only data
Screening	6	B.R.I.E.F alcohol counseling
Screening	7	Intimate partner violence
Screening	8	Motivated to learn Y/N
Screening	9	Limited Duty Y/N
Screening	10	Patient Profile Reviewed
Screening	11	Deployability
Screening	12	Deployability timeline
Screening	13	Ever use tobacco Y/N
Screening		Current smoker
Screening		Desire to quit Y/N
Screening		Former smoker/quit date:
Screening	14	Alcohol use Y/N & AUDIT-C date and score
Screening	15	Special Duty
Screening	16	Ethnicity
Screening	17	Preferred langauge
Screening	18	Preferred learning method
Screening	19	Learning disability
Screening		Language/Emotional Barrier
Screening		Hearing/Vision deficit
Screening	20	SILS question
Screening	21	Advanced directives
Screening	22	Copy of advanced directive in record

Support Staff TSWF task list September 2019

Screening	23	Cultural/religious beliefs
Screening	24	EFMP
Screening	25	Secure Messaging
Screening	26	Contact Pref
Screening	27	PCM
Screening	28	Health Literacy
Screening	29	PRP, PSP Y/N
Screening	30	Illness during trip? Y/N
Screening	31	Traveled outside local area in 90 days? Y/N
Screening	32	Screen-2 Travel history
Screening	33	Symptom History
Screening	34	Traveled to Zika area? Y/N
Screening	35	Pregnant or planning? Y/N
Screening	36	Pre-travel counseling
Screening	37	Alcohol screening questions w/ neg/pos [ ]
Screening	38	Other Screening
Screening	39	Falls Risk
BH screen	1	PHQ-2 score
BH screen	2	SIPS-B score
BH screen	3	GAD-2 score
BH screen	4	PTSD screen date
BH screen	5	PHQ-9
BH screen	6	PCL-5
BH screen	7	GAD-7
BH screen	8	Epworth
BH screen	9	PHQ-9 score
BH screen	10	PCL-5 score
BH screen	11	GAD-7 score
BH screen	12	Epworth score
BH screen	13	TBI screener
CCP	1	Written Care Plan
CCP	2	Pt Info Sheet given
CCP	3	Self Care Mgmt
CCP	4	Lifestyle Questions

Appendix G: Provider Needs Assessment Questionnaire Statistical Analysis

Providers	Staff physician: 17, NP: 3, PA: 3, Resident:13, Intern: 17, Other: 8
Years of experience	0-4 yrs: 45, 5-8 yrs: 5, 9-12 yrs: 1, >12 yrs: 10
Hours spent in direct patient care	0-25%: 2, 26-50%: 20, 51-75%: 17, 76-100%: 20
Time spent documenting after hours	0-1 hr: 11, 2-4 hrs: 42, 5-7 hrs: 7, 8+ hrs: 0

Appendix H: Documentation of Health Prevention Training Program

Clinical Registries Health Maintenance (CRHMR) Competency Checklist

Procedure Steps	Performs independently	Performs with assistance	Unable to perform
1.Review the patient medical record prior to the interview.			
2.Scroll down to the Preventive Services box on the TSWF Core Aim Form			
3.Click on the box next to the Preventive Services Recommendations-All Patients to open the details.			
4.Enter today's date next to Date Last Updated within the Preventative Services box.			
5.Open CarePoint's MHSPHP			
6.If needed, set parameters for the date and provider encounters you are preparing			
7.Open PCMH Huddle or Appointments registry to find the HM column (or right click in any registry row, select Patient View; HM is in Patient Summary tab) ● NOTE: First ensure "Health Maintenance" is selected using column picker. This step is only needed once: use "column picker" to select columns to view & rearrange their position order as desired; settings stay until changed by the user. See backup slides for additional detail.			
8.Ensure the open AHLTA record and the HM entry are for the same patient.			
9.In the patient's MHSPHP Registry entry, scroll to the Health Maintenance column.			
10.Copy an individual element. (e.g. lipid results and date, 10-year CVD risk, etc.) 11.Paste into the AHLTA TSWF Preventive Services field. *(manually typing dates or values is not recommended due to the risk of errors.)* 12.Repeat as needed; clean up any undesired text from TSWF Preventive Services field as needed.			
13.Notify provider of any items that are DUE.			

Name____ Date____________________________

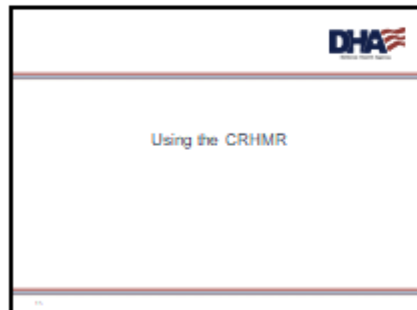
Observer______________________________________

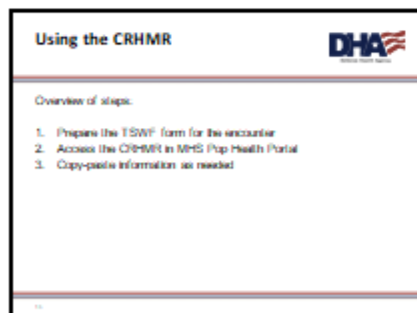
Clinical Registries Health Maintenance (CRHMR) SWANK Competency Post-Test

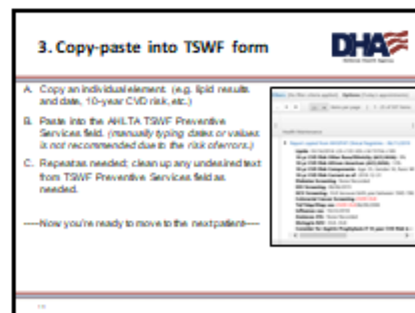
1. The Clinical Registries Health Maintenance Report compiles a patient's most recent preventative services data into a consolidated summary report.
    a. False
    b. True
2. Clinical Registries Data is available where?
    a. CarePoint
    b. Only the provider has the data
3. When assessing CRHMR, first ensure Health Maintenance is selected using column picker.
    a. True
    b. False

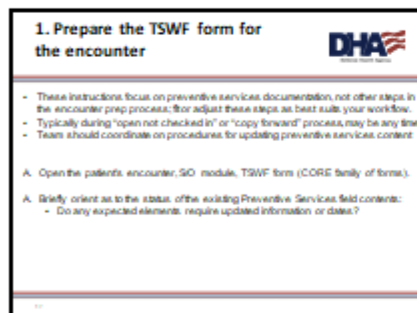
Defense Health Agency PowerPoint: Using the Clinical Registries Health Maintenance Report (CRHMR)

***For full PowerPoint presentation, go to www.tswf-mhs.com and search for CRHMR**









Appendix I: Completion Verification Form

Appendix G: Daniel K. Inouye Graduate School of Nursing
DNP Project Completion Verification Form

DOCTOR OF NURSING PRACTICE PROJECT
Completion Verification Form

The DNP Project titled: _A Needs Assessment of the Documentation Intake in Military Primary Care

was completed at Navy Medicine Readiness and Training Command Portsmouth

by the following student(s):

(type student name)		*(date)*
Miranda Horne		13MAR2020
Sarah Hervey		13MAR2020

The DNP Practice Project Team verifies that the following components of the DNP project, accomplished by the above students, is of sufficient rigor and demonstrates doctoral level scholarship to meet the requirements for USUHS GSN graduation:

- Presentation of DNP project to the leadership/stakeholders at the Phase II Site,
- Abstract/Impact Statement (*Appendix F*), and
- DNP Project written report.

Verified by:

(type name)	*(signature)*	*(date)*	
Dr Heather Johnson	Heather L Johnson	30 Mar 20	Senior Mentor
			Team Mentor
			Team Mentor
LCDR MeeDeessa Morgan	MeeDeessa Morgan	19 March 2020	Phase II Site Director

For RNA Students only *- add the following additional signature for final verification of project completion:*

RNA Project Director *(type name)*	*(Signature)*	*(Date)*