

## Scribes: Letting Doctors Do What They Do Best

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Delegating the chore of data entry is not a new idea. In the past, physicians have utilized dictation software and transcriptionists to document patient records. As more and more hospitals and private practitioners are transitioning to an electronic medical record to be in compliance with “meaningful use,” a new class of medical professional has emerged to alleviate the burden of documentation. Many Emergency Departments and other high-volume practices have turned to medical scribes, highly trained individuals who document patient encounters and assist in a myriad of nonclinical tasks.

Typically, scribes are graduate or undergraduate students seeking clinical experience in pursuit of a career as a physician or midlevel provider. Many scribes work part-time throughout their college careers while others take advantage of a gap year while concurrently applying to professional schools.

The Joint Commission defines a scribe as an unlicensed person hired to enter health information into the electronic medical record under the direction of a licensed independent practitioner, physician assistant, or registered nurse.<sup>1</sup> Unlike transcriptionists, scribes work alongside physicians and are able to chart and edit the medical record in real time. Moreover, the role of a scribe is not limited to documentation. In addition to documenting the history and physical exam, scribes complete time-consuming forms, discharge paperwork, track test results, and retrieve old medical records and EKGs. They can also gather supplies for procedures and confirm medical information at outside facilities such as nursing homes and pharmacies. Their position is, in actuality, a hybrid between documentation specialist, personal assistant, and communications liaison.

Because scribes are not responsible for providing direct clinical care, they are more readily accessible to patients who rely on them to relay messages to the doctor and other clinical staff. Scribes fulfill a critical role by completing all of the necessary and increasingly tedious tasks mandated by various regulatory agencies. With the use of scribes, doctors are able to focus their attention on providing care while patients enjoy the undivided attention of the medical provider. The scribes equally appreciate this new role as they have an unparalleled experience, gaining invaluable insight into medicine and the cognitive process behind medical decision-making.

Five years ago legislators passed the American Recovery and Reinvestment Act, encouraging eligible providers to adopt an electronic health record (EHR). Incentive programs legislated rewards for early implementers who demonstrated “meaningful use” of the technology. The new laws also imposed penalties for late implementation after

2014. Beginning next year, Medicare reimbursements will decrease 1% annually for providers who are not compliant with the mandate.<sup>2</sup> Many physician practices anticipated negative impacts to revenue and productivity with the implementation of an EHR and subsequently piloted scribe programs to mitigate potential losses and maintain an efficient work place.

There are two practical ways to roll out a scribe program: outsource to an established medical scribe service or develop a program internally. Quotes from outside companies typically range from \$20 - \$25 per scribe hour,<sup>3</sup> a cost that includes human resources, ongoing training, scheduling and continuous management. Additionally, many companies charge significant initial assessment and start up fees when accommodating larger practices.<sup>4</sup>

Homegrown programs are an alternative to outsourcing and their success depends on three factors: 1) administrative oversight, 2) close proximity to colleges and universities and 3) an effective training program. Under the direction of a “physician champion,” trained personnel can provide program oversight, ensure accurate documentation, and evaluate employee performance.<sup>3</sup> Larger practices often utilize their own human resources department to assist with scribe recruitment and hiring. Groups located around institutions of higher learning are uniquely positioned to build their own scribe program because they enjoy a renewable pool of highly qualified applicants. These applicants are typically eager, tech-savvy, and academically accomplished. However, hiring these career-oriented individuals creates an inherent obstacle for these programs; employees often leave after one or two years of service. The high rate of turnover as scribes advance to professional schools necessitates a robust recruitment and training program.

Typically, before working in a clinical setting, trainees complete approximately 100 hours of clinical and didactic training, usually incorporating a review of anatomical and medical terminology, extensive shadowing, and EHR education. Successful programs maintain a strict standard of competency before allowing scribes to work clinically. Scribes must demonstrate an understanding of medical vocabulary, proficiency with documentation software, and an accurate understanding of evaluation and management (E/M) coding.

Both internal and outsourced programs need to meticulously monitor scribe performance to ensure quality documentation and compliance with governmental standards. Metrics from billing and coding organizations provide the necessary data to measure scribe productivity. Scribes routinely attend meetings for billing and compliance updates and are well versed in the medical and legal implications

of the permanent medical record. Physicians often rely on scribes for keeping them abreast of documentation requirements; some programs train scribes to review records in a live clinical setting and alert the physician of potential documentation deficiencies. Although initially viewed with skepticism by regulators, administrators, and even some physicians, the scribe role has demonstrated financial gains and improved efficiency. These benefits, coupled with increases in both provider and patient satisfaction, justify the expenditure of time and resources needed to implement a scribe program.

Although emergency departments most frequently employ scribes, many other specialties have expressed interest and considered the logistics of integrating scribes in their own practice. In one cardiology clinic physicians using scribes saw a 59% increase in patients seen per hour and a 57% increase in relative value units (RVU) per hour.<sup>5</sup> A California community health clinic assessed the quality of patient chart documentation with the use of scribes. The accuracy of the ICD-9 coding increased by 10%, while the accuracy of E/M coding increased by 17%.<sup>6</sup> Another retrospective study of scribes in an emergency department correlated scribe use with an increase of 2.4 RVUs billed per hour.<sup>7</sup> In all three studies cited, scribes generated a positive margin. In addition to improvements in efficiency and accuracy, scribe programs have consistently demonstrated an increase in both physician and patient satisfaction.

Physicians in many fields have expressed frustration in response to the widespread implementation of EHRs. In a study regarding EHR satisfaction, International Data Corporation (IDC) researchers report that up to 58% of users are dissatisfied with the new technology, and providers continue to cope with decreased productivity and impeded workflow.<sup>8</sup> Scribe presence has helped to mitigate much of this dissatisfaction. In one recent study a urology practice saw more than a threefold increase in physician satisfaction when working with scribes.<sup>6</sup> The reasons for the increase in satisfaction become readily apparent when looking at the role of scribes in the ED. It is not uncommon for EM physicians to stay several hours after a shift has ended to complete their unfinished medical records. Working with a scribe can lessen the frequency with which this occurs. Because scribes complete the majority of the chart in real time, most providers make simple adjustments to the record at the end of their shift, attest to what the scribe has written, and leave work on time.

Anecdotally various institutions have reported a positive impact on patient satisfaction with the use of scribes.<sup>6</sup> While patients wait to see a provider, scribes can greet them and begin to document parts of the medical history. E/M guidelines published by the Centers for Medicare and Medicaid Services (CMS) permit scribes to independently obtain a review of systems as well as the past medical, social and family history.<sup>9</sup> Throughout the medical encounter, scribes can continue to gather information, communicate test results, inquire about response to medications, and ensure patient comfort. In this way, scribes act as a liaison between nurses and doctors, relaying patient concerns and communicating changes in the plan.

Until a few years ago, few publications addressed the use

of scribes. As more physicians have begun to comply with the EHR mandate, there has been greater interest in utilizing scribes to transition from paper documentation to the use of an electronic record. Recent studies have bolstered anecdotal claims that scribes have a positive impact on overall productivity and patient/provider satisfaction. Until EHRs evolve in speed and simplicity, the use of scribes will allow doctors to do what they do best – care for patients.

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