Using Medical Scribes in a Physician Practice

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With the push to develop and deploy electronic health records (EHRs) and the need for more detailed documentation, there is a growing concern in the medical community regarding the time expended to capture information-electronic or otherwise. The time providers spend during a patient visit capturing and entering data rather than focusing on the patient can be a hindrance to the quality of care. One current solution gaining popularity is the use of scribes. Scribes can provide many benefits to the practice of medicine, ultimately impacting the overall quality of healthcare delivery.

The Joint Commission defines a medical scribe as an unlicensed individual hired to enter information into the electronic health record (EHR) or chart at the direction of a physician or licensed independent practitioner. A scribe can be found in multiple settings including physician practices, hospitals, emergency departments, long-term care facilities, long-term acute care hospitals, public health clinics, and ambulatory care centers. They can be employed by a healthcare organization, physician, licensed independent practitioner, or work as a contracted service.

This practice brief will explore some of the benefits and challenges of scribes within the physician practice setting. In addition, this practice brief will provide recommended practices for the use of scribes. Key components for implementation of a successful scribe program will also be discussed.

Roles and Responsibilities

A scribe's core responsibility is to capture accurate and detailed documentation (handwritten, electronic, or otherwise) of the encounter in a timely manner. Scribes are not permitted to make independent decisions or translations while capturing or entering information into the health record or EHR beyond what is directed by the provider. The general duties of a scribe may vary and can include:

- Assisting the provider in navigating the EHR
- Responding to various messages as directed by the provider
- Locating information for review (i.e., previous notes, reports, test results, and laboratory results)
- Entering information into the EHR as directed by the provider
- Researching information requested by the provider

The role of a scribe is dependent upon the provider practice and setting. It is possible for a provider to select a clinical assistant (non-licensed clinical staff) who has performed clinical duties and worked with the provider to perform scribe services. It is not recommended, however, to allow an individual to fill the role of scribe and clinical assistant simultaneously during the same encounter. This practice raises legal and other issues regarding job role and responsibilities.

EHR security rights (role-based access) for a scribe and clinical assistant are different. Scribes have nearly the same security rights as a provider, while a clinical assistant enters information independently and only within the individual's scope of practice. Thus, the individual security rights are more limited for clinical assistants than those of the provider and must be considered in the decision making process.

When a scribe is also acting as a clinical assistant during the same encounter, the scribe will log in with one set of security rights as a clinical assistant, log out, and then log back in with another set of rights to perform the scribe duties. The dual role results in the scribe logging in and out between roles multiple times during one encounter-wasting valuable time and resources. To avoid this situation, some practices limit the scribe to filling only one role during a single encounter.

The role of a scribe in the practice must be clearly defined and communicated, with documented job descriptions and set policies and procedures, to optimize their use and minimize challenges. It is also important to obtain a signed agreement between the provider and the scribe delineating expectations and accountability.

Scribe Legal Considerations

Since medical scribes are a relatively new phenomenon in healthcare, it is difficult to find information addressing the legal issues that have surfaced as a result of using scribes. Regulatory agencies have not forbidden the use of scribes, but regulatory requirements and guidance concerning their use differ. As a result of these differing guidelines and requirements, scribes may have more responsibilities in one care setting but face greater restrictions in another.

It is also important that individual state laws are thoroughly reviewed to ensure compliance and proper use of scribes by mid-level providers. For example, in some states physician assistants are not considered licensed independent practitioners and therefore may not be eligible to use scribes.

A scribe's responsibilities are ultimately controlled by the regulatory requirements and policies established by a healthcare setting, and the level of risk an employer is willing to accept. As the use of scribes becomes more prevalent, the potential for expanded legal guidance and direction grows. Practices must monitor federal, state, and regulatory changes to ensure their practices consistently meet compliance with standards.

Implement Scribe Documentation Guidelines

When using scribes, documentation guidelines for the place of service (i.e., inpatient, outpatient) must be followed. In addition to the normal documentation requirements of an encounter, a scribed encounter also carries separate authentication duties. It is imperative that any and all entries regarding a patient's health information be completed in the presence of and at the direction of the provider. It is also important that authentication of each entry be completed in a timely manner as defined by a practice's policies and regulatory requirements.

Scribes accompany providers into the exam room and enter information in real time, using their individually assigned security rights to access the EHR. Providers should direct the scribe on the proper responses for advisories and other alerts that may appear on the screen.

Third party payers may have specific guidelines for how a scribe documents and how the electronic signature must be applied. Each facility must contact their third party payers for any further requirements.

In 2011, the Joint Commission released guidelines recognizing that scribes may be used across various settings. The guidelines help to regulate the use of scribes:

- Verbal orders may neither be given to nor by scribes.
- Signing (including name and title) and dating of all entries into the medical record is necessary-for both electronic or manual documentation (RC.01.01.01 and RC.01.02.01). For those organizations that use Joint Commission accreditation for deemed status purposes, the timing of entries is also required. The role and signature of the scribe must be clearly identifiable and distinguishable from that of the physician or licensed independent practitioner and other staff. Example: "Scribed for Dr. [name of physician] by [name and title of scribe], [date and time of entry]."
- Orientation and training must be given specific to the organization and role (HR.01.04.01, HR.01.05.03).
- Competency assessment and performance evaluations should be performed (HR.01.06.01, HR.01.07.01).
- If the scribe is employed by the physician, all non-employee HR standards also apply (HR.01.02.05 EP 7, HR.01.07.01 EP 5).
- Scribes must meet all information management, HIPAA, HITECH, confidentiality, and patient rights standards, just as other hospital personnel (IM.02.01.01, IM.02.01.03, IM.02.02.01, RI.01.01.01).

Common Documentation Duties for Medical Scribes

Examples of information entered by a scribe may include, but are not limited to:

- History of the patient's present illness
- Review-of-systems (ROS) and physical examination
- Vital signs and lab values

- Results of imaging studies
- Progress notes
- Continued care plan and medication lists

A scribed encounter note should indicate the involvement of a scribe. The scribe's note should include:

- The name of the provider providing the service
- The date and time the service was provided
- The name of the patient for whom the service was provided
- Authentication, including date and time

Since the provider is ultimately responsible for the contents of the documentation, the provider's note should indicate:

- Affirmation of the provider's presence during the time the encounter was recorded
- Verification that the provider reviewed the information
- Verification of the accuracy of the information
- Any additional information needed
- Authentication, including date and time

Managing Scribe Costs

Incorporating scribe services requires budgetary consideration and determination of where costs will be allocated. There are generally three options for cost allocation:

1. Provider
2. Provider practice
3. Shared

One option-that the provider employs the scribe-assumes that providers receive the greatest benefit from scribe services and should pay for the service directly. The cost of a scribe program can be offset if there are significant measurable increases in provider revenue. For the allocation to be made as a provider cost, providers can pay a scribe a set hourly wage based on the added value the scribe offers the provider in terms of revenue, time, and increased productivity.

A second option would allow the practice assuming responsibility for the cost to regulate what scribe service will be used, the hourly rate, and education and training requirements. Current transcription compensation models (i.e., paying per line, per minute, or a combination) are a good tool that can be used to determine how to pay for scribe programs.[1] Governance of a scribe program at an organizational level presents other options for scribe compensation. For example, scribe reimbursement could include using the existing employee base and redefining currently existing job roles instead of layoffs or sharing scribes among specialties.

The third alternative is for providers and organizations to cost-share given the mutual benefits of using scribes. In this arrangement, providers who use scribes are responsible for a certain percentage of the cost. A thorough analysis should be completed to determine how the costs of a scribe will be allocated. An accurate and comprehensive analysis includes, but may not be limited to:

- Time and motion studies
- Tools used to scribe
    - Dictation
    - Handwritten
    - Data entry
- Turnaround time
- Specialties assigned
- Size and organization of practice

- Patient volume
    - Number of lines scribed
    - Number of records scribed
    - Account turnaround

Benefits Include Freeing Physicians from Data Entry

As previously stated, scribes are responsible for capturing medical information at the point of care which allows the provider to focus on bedside manner and provide hands-on, attentive, face-to-face care that increases both patient and provider satisfaction.

In today's healthcare environment of increased regulations, documentation incentives, and reimbursement requirements, charting and documenting takes time. Scribes can help to reduce the documentation time needed by the provider during a visit. Many providers feel the pressures of increased clerical responsibilities and learning curves with the implementation of new and upgraded systems. The use of scribes can help to increase provider morale by reducing the amount of clerical tasks and resulting stress while learning a new system.

EHRs are becoming more commonplace in today's practice. The patient may perceive their visit negatively if the provider spends the majority of their time looking at a computer monitor instead of the patient. A scribe can enter information into the EHR without intrusion or interruption, allowing the provider to focus more on the patient diagnosis and treatment plans.

Employing scribes to capture and enter health information into the EHR during a patient encounter may improve the overall quality of documentation-not only in the level of granularity, but also in the level of specificity. Improved documentation in turn can be used to support achieving "meaningful use" EHR Incentive Program criteria as well as improving compliance with quality monitors and billing and reimbursement.

Provider efficiency and productivity can increase with the use of scribes as well. When implemented with a successful clinical workflow, providers may see more patients rather than spend valuable time documenting.

The documentation completed by scribes is also often available more quickly for review. As a result, documentation by a scribe can be more detailed and more comprehensive. When the provider is verbally summarizing decisions and plans, the scribe is able to capture the details of the encounter in the provider's words and in real time.

Cost, Workflow Challenges

The implementation of any new system, program, or practice brings its own separate set of challenges that must be considered and managed carefully. The use of a medical scribe is no exception to that fact. Challenges include:

- A non-physician provider (i.e., nurse practitioner, physician assistant) in the role of a scribe in a physician setting would only be counterproductive in most cases. The non-physician provider would be used most effectively by independently seeing other patients.
- Scribes in the exam room may cause patients to be less honest and forthcoming with pertinent information for accurate diagnosis and treatment, impacting the overall quality of care.
- Scribes will change current documentation workflows and responsibilities. These workflows will need to be redefined and responsibilities identified to streamline the process.
- Provider verification and authentication of scribed documentation for accuracy may slow down overall workflow.
- Use of scribes may help cut costs. However, if the scribe is inexperienced and does not have medical terminology and clinical workflow knowledge, this may cause documentation errors leading to greater issues (i.e., increased costs, decreased turnaround time, and billing and medical errors).
- Some providers may not take the time to review scribed entries for accuracy before authentication. So, the possibility for errors is present. These errors can affect patients' plan of treatment, coordination of care, coding, billing, and other documentation requirements due to lack of detailed and accurate documentation in the health record.
- Scribes in the exam room may not result in the providers' ability to generate additional revenue to offset the expense of the scribe.

- When a scribe is not available, providers may not be able to navigate the system independently or efficiently.

Tips for Managing and Monitoring Scribes

Scribe documentation must be managed and maintained with the same quality assurance and compliance expectations of other patient care documentation. It is crucial that scribe programs are included in the organization's overall compliance program. It should be closely monitored for accuracy and adherence to applicable guidelines through the development of policies and procedures, training, and overall management.

Policies and procedures identify responsibilities and outline requirements for scribes. They also set the tone and define expectations and accountability. When creating policies and procedures for implementing a scribe program, the following considerations, at a minimum, should be taken into account (see "Appendix A," for a sample medical scribe policy):

- Documentation guidelines
- Authentication guidelines
- Regulations and guidance
- Minimum knowledge, experience, and education qualifications
- Definition of roles (i.e., scribe vs. provider)
- Responsibilities and clear scope of practice
- Performance expectations (i.e., productivity)
- Continuous training
- Sanctions
- Documentation auditing protocols
- Privacy and security auditing protocols
- Certification and/or licensure

Communication is a tool necessary for meeting compliance. All staff must be educated and receive ongoing training for adherence with policies, procedures, and overall management expectations. Monitoring is also a key factor towards meeting compliance. The use of medical scribes must not only be audited for documentation quality and good privacy and security practices, but also to ensure that policy and procedures are being followed.

Monitor Scribe Education and Qualification

The demand for medical scribes is rising and many organizations are rightfully concerned about the appropriate skill set, competency, and training of scribes when implementing a scribe program. Though endorsed by the American Healthcare Documentation Group (AHDG), the only certification program offered for scribes in the nation is issued by the American College of Clinical Information Managers (ACCIM). To be eligible for certification as a clinical information manager (CIM), individuals must have worked at least 100 hours as an unassisted scribe and have received training in an approved CIM training program. The Clinical Information Manager Certification and Aptitude Test (CIMCAT) verifies skills and knowledge in the following areas:

- Medical terminology and technical spelling
- Basic anatomy
- Basic coding
- HIPAA compliance
- Medico-legal risk mitigation
- Computer aptitude, including functions of the EHR
- Essential elements of documenting a provider-patient encounter
- Centers for Medicare and Medicaid Services Physician Quality Reporting System (PQRS)
- The Joint Commission's Accountability Measures
- General knowledge of the roles and responsibilities of medical personnel

ACCIM also offers maintenance of certification through the Medical Scribe Continuous Certification (MSCC) to develop and maintain the highest professional quality of medical scribes. Further, ACCIM also certifies scribe programs to set apart those that offer a higher level of professionalism and skill set from those that do not.

Recommended Scribe Practices

There is no right or wrong answer to the implementation and use of medical scribes. The lessons learned from the early adopters of medical scribes helps to establish best practices and guidance for the industry. Regardless of practice type or size, the decision to use a scribe is a significant one and must be carefully managed and maintained as such. Below are recommended practices for optimal outcomes when implementing a scribe program.

Set Scribe Program Goals

It is essential that the healthcare entity set clear and specific goals. Goals can include increasing revenue, provider productivity, patient satisfaction, timely record authentication, or an improvement in provider morale. Regardless, all goals should be clearly stated and metrically tracked. Establishing specific measurable objectives for the medical scribe program may involve an interdepartmental team that includes multiple disciplines.

Define Scribe Roles and Responsibilities

Scribes are responsible for capturing an accurate and detailed description of a patient encounter in the provider's words. Scribes are clerical in nature and do not interview or have direct contact with the patient. They do not perform clinical services, administer medication, or perform treatments and procedures. Some facilities utilize clinical staff to perform scribe functions, so it is important to clearly define and differentiate their clinical duties from their scribe duties. When defining the role and responsibilities of a scribe, it is imperative that appropriate medical record access and signature authentication is established as well.

Communicate with Patients

The healthcare entity should communicate with patients and introduce the position of medical scribe. It is important to recognize that some patients may not want an additional individual in the room while they are examined or when discussing sensitive medical information. Educate the patient on how the presence of a medical scribe provides them with more interactive time with their provider. However, the patient always has the right to refuse the presence of additional staff (i.e., scribes, residents) in the exam room. If the provider realizes that the patient is uncomfortable discussing an issue with the scribe in the room, a pre-arranged verbal signal such as "please check with the nurse about the blue form" would allow the scribe to leave the room without adding to patient discomfort.

Exam Room Setup

Physician practices need to evaluate the size of the examination rooms. In some practices, these rooms are small and may not allow the presence of a third person in addition to the provider and patient. Another challenge may be placement of computer equipment. Some patients may become distracted if the scribe types on a noisy keyboard. It is important to minimize or eliminate distractions to patient care.

Evaluate the Scribe Program

The physician practice can monitor the success of the medical scribe program by measuring key indicators compared to the set goals. Examples of goals may include reductions in transcription costs, improvements in overall documentation, reduced turnaround time for authentication and increased patient satisfaction. Information from the John F. Kennedy Medical Center states that the use of scribes contributed to a 15 percent revenue increase and improved patient satisfaction scores.[2] Objective benefits of a scribe program can generally be analyzed through standard metrics currently in use in the facility or practice. Other metric examples include, but may not be limited to, relative value units per hour or day, number of patients seen per hour or day, percent of clinical time versus administrative time, number of incomplete medical records, arrival to discharge time, or the number of provider queries for additional information.

Maintain Provider Engagement

Physician practices need to ensure that providers remain connected to all patient information. When the provider no longer personally dictates or documents the services performed, he or she may miss computer prompts or not review the medical information in the same manner. The provider's review and authentication of the scribed documentation ensures medical procedures have been performed, ordered, and documented; electronic record alerts have been addressed; and patient care has been accurately recorded.

Appendix A: Sample Medical Scribe Policy

USE OF SCRIBES

PURPOSE: The purpose of this policy is to ensure proper documentation of clinical services when the billing provider has elected to utilize the services of a medical scribe. For the purpose of this policy, a scribe is defined as an individual who is present during the provider's performance of a clinical service and documents (on behalf of the provider) everything said during the course of the service. Any individual serving as a scribe must not be attending to the patient in any clinical capacity and must not interject their own observations or impressions.

POLICY: Individuals serving as scribes must sign a scribe agreement prior to scribing. Scribed documentation must clearly support the name of the scribe, the role of the individual documenting the service (i.e., scribe), and the provider of the service. The provider is ultimately responsible for all documentation and must verify that the scribed note accurately reflects the service provided.

PROCEDURE:

1. Any individual that desires to serve as a scribe must review the policy on the use of scribes and sign a policy agreement.
2. A scribed note must accurately reflect the service provided on a specific date of service.
3. A scribe's entry can be hand-written, dictated, or created/typed in an electronic health record (EHR). Documentation of a scribed service must include the following elements:

    - The name of the scribe and a legible signature
    - The name of the provider rendering the service
    - The date and time the service was provided
    - The name of the patient for whom the service was provided
    - Authentication of the scribe

4. The provider is ultimately responsible for the contents of the documentation. The provider note should indicate:

    - Affirmation that the provider was present during the time the encounter was recorded
    - Verification that the information was reviewed
    - Verification of the accuracy of the information
    - Any additional information needed
    - Authentication including date and time

5. Individuals can only create a scribe note in an EHR if they have their own password/access to the EHR for the scribe role. Documents scribed in the EHR must clearly identify the scribe's identity and authorship of the document in both the document and the audit trail.
6. Scribes are required to notify the provider of any alerts. Alerts must be addressed by the provider.
7. Providers and scribes are required to document in compliance with all federal, state, and local laws, as well as with internal policy.
8. Failure to comply with this policy may result in corrective and/or disciplinary action (See Human Resources Disciplinary Action Policy).

Appendix B: Sample Scribe/Provider Agreement

I hereby certify that I have reviewed the Use of Scribes Policy. I understand that as a scribe I am:

- Required to be present during the provider's performance of a clinical service and document (on behalf of the provider) everything said during the course of the service
- Not seeing the patient in any clinical capacity and must not interject my own observations or impressions

Scribed documentation must include the following elements:

- The name of the scribe and a legible signature
- The name of the provider rendering the service
- The date and time the service was provided
- The name of the patient for whom the service was provided
- Authentication of the scribe

I am aware that documenting in the EHR requires use of my own password/access to the EHR.

Documenting under someone else's login is prohibited.

Scribe Name: _____

(Please Print)

Scribe Signature:_____

Date:_____

I, the undersigned provider, agree that the scribe will only perform duties as described within the *Medical Scribe Policy*. I also agree that I am solely responsible for the accuracy, review, and authentication of all health record information captured and/or entered by the above named scribe.

Provider Name: _____

(Please Print)

Provider Signature:_____

Date:_____

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Notes

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