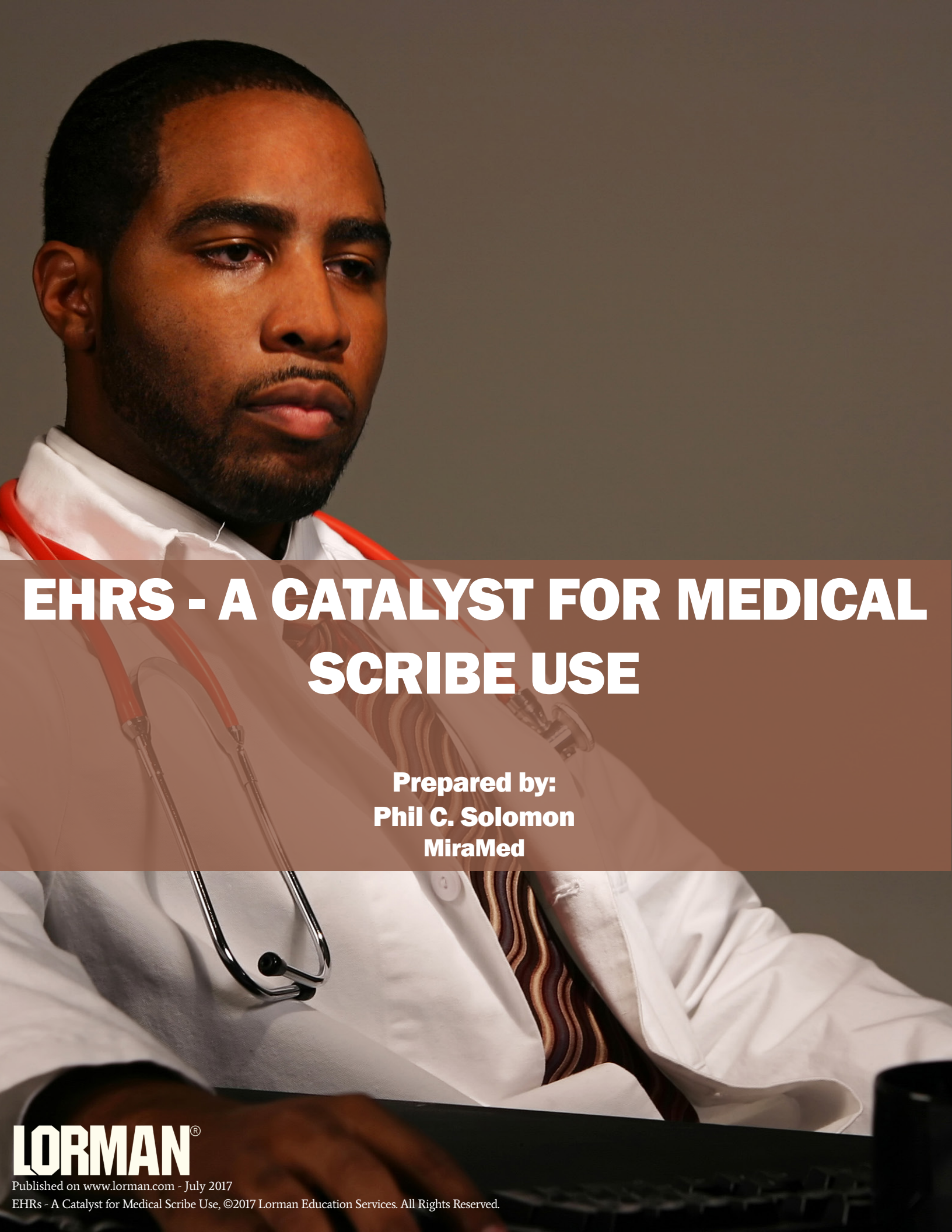

EHRS - A CATALYST FOR MEDICAL SCRIBE USE

Prepared by:
Phil C. Solomon
MiraMed

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EHRs - A Catalyst for Medical Scribe Use

Written by Phil C. Solomon

A physician's responsibility is to provide the best possible care for sick patients. A key for delivering quality healthcare is open communication between the physician and patient to discuss issues and develop a care plan. Today, providing quality care is becoming more difficult due to increasing patient loads and administrative challenges. This dilemma has become a catalyst for the growth of medical scribes or what some call the physician's medical sidekick.

Scribes help physicians by documenting the patient encounter and retrieving diagnostic results, nursing notes and other information recorded in the patient's electronic record. The introduction of electronic health records (EHR) has created an overload of documentation and the associated clerical responsibilities slow physicians down and take them away from providing one-on-one patient care. To relieve documentation overload, physicians have turned to scribe services for assistance.

The Rules Governing Scribes

Scribe companies operate with few requirements and virtually no regulations required outside of the healthcare industry. The main bodies that regulate healthcare, The Centers for Medicare and Medicaid Services (CMS) and The Joint Commission (JC), have no rules or guidelines that limit, endorse or prohibit the use of scribes. The JC permits scribes to document previously determined and approved physicians' dictation and activities but does not authorize scribes to act independently, except obtaining past family social history and a review of systems, a technique providers use to gain the patient's medical history. CMS does not provide official guidelines on the use of scribes and does not bar non-physician providers, such as physician assistants, nurse practitioners and clinical nurse specialists, from using scribes.

With few rules governing scribes, the value proposition for physicians is enticing; however, using scribes is not without risk. When a physician is removed from part of the care continuum, it opens the door to miscommunication that can negatively affect patient care. The industry is minimally regulated, with only a high school diploma required, and scribes are not required to have medical backgrounds or

become certified. That said, there is a potential for scribes to misinterpret a physician's instructions and make documentation mistakes that would negatively affect patient care. Even with the risks associated with using scribes, the industry segment has grown rapidly and physician acceptance has been high.

The Role of a Medical Scribe

A medical scribe is a person, or paraprofessional, who specializes in charting physician-patient encounters in real-time during medical examinations. They are called clinical scribes, emergency room or emergency department scribes or just scribes. A scribe can work onsite at a hospital or clinic or remotely from an HIPAA-secure facility. Medical scribes who work at off-site locations are known as virtual medical scribes.

Scribes can generate referral letters for physicians, manage and sort medical documents within the EHR system and assist with e-prescribing. Scribes essentially are data care managers enabling physicians, medical assistants and nurses to focus on patient intake and care. By managing data for physicians in real-time, scribes free the physician to increase patient contact time and improve productivity.

A scribe must be trained in health information management technologies to support their work. They follow a physician through their work day and chart patient encounters using a medical office's EHR system. An EHR refers to the organized collection of patient data electronically stored in a computerized system. EHRs can be shared across various healthcare settings and made available through network-connected information systems or other information networks and exchanges. They include an array of data, including demographics, medical history, medication and allergies, immunization status, laboratory test results, radiology images, vital signs, personal statistics like age and weight and billing information.

The role of a scribe entails more than shadowing a physician and capturing patient interactions. The American Healthcare Documentation Professional Group has outlined scribes' responsibilities and job duties:

1. Accurately and thoroughly documenting medical visits and procedures as they are being per formed by the physician, including, but not limited, to:
    a. Patient medical history and physical exam;

    b. Procedures and treatments performed by healthcare professionals, including nurses and physician assistants;
    c. Patient education and explanations of risks and benefits;
    d. Physician-dictated diagnoses, prescriptions and instructions for patient or family members for self-care and follow-up;
    e. and Referral letters as directed by the physician.
2. Dictation/faxing/phone calls and clerical tasks. Scribes are asked to prepare referral letters as directed by the physician via dictation or summary of the medical record. Also, they ensure that letters are mailed or faxed on a daily basis to all physicians involved in a patient's care, research contact information for referring physicians, coordinate referrals and prepare operative reports.
3. Provide quality control oversight by spotting mistakes or inconsistencies in medical documentation. Since information documented in the medical record must be approved by a physician, scribes must ensure that all clinical data, lab or other test results and the interpretation of the results by the physician are recorded accurately in the medical record. Scribes must comply with specific standards that apply to the style of medical records and to the legal and ethical requirements for preparing medical documents and for keeping patient information confidential.
4. Scribes collect, organize and catalog data for physician quality reporting system and other quality improvement efforts and assist in developing and maintaining systems to track patient follow-up and compliance.

Physicians Cope with EHRs, Added Administrative Tasks

In the 1980s computers became a mainstream addition to small business operations. Physicians, typically operating as a small business, initially pushed back on the concept of using computers to help run their healthcare practices because of cost, complexity and lengthy learning curves. However, price compression and the creation of Windows-based, user-friendly interfaces quelled their concerns. It became widely accepted in physician circles that the small business computer could help physicians manage the vast demands of providing patient care.

During that same decade, computer systems for medical applications were evolving into fully automated electronic record platforms. EHR systems became available to physicians to manage the clinical side of their business. Like all computerized technologies, EHRs have experienced rapid transformation over the

past 20 years. Improvements in the technology have greatly accelerated since the January 2009 passage of the Health Information Technology for Economic and Clinical Health Act (HITECH), a $30 billion dollar effort to transform healthcare delivery through the widespread use of EHR technology.

For decades, physicians hoped EHR systems would help them manage the overwhelming demands of practicing medicine. Instead, for some physicians, EHRs have become more of a hindrance than the problem they set out to solve.

Today, EHRs' technological and administrative tasks are cutting into available time for physicians to spend with patients. According to a time-motion study conducted by the American Medical Association (AMA) and published in the Annals of Internal Medicine (AIM), nearly half of a physician's work day is now occupied by data entry into EHRs. Further, from 2011 to 2014, 54 percent of study participants said they experience some signs of burnout, an increase of 46 percent over the three-year period. The burden of working with EHRs is a key factor of physician burnout.

Physicians are coping with EHRs newfound administrative duties, but they are not happy about it. The demands of data capture duties with EHRs have become a real impairment to practicing medicine. In 2004, only 20.8 percent of physician offices used EHRs. As of 2015, nearly 9 in 10 (87 percent) of office-based physicians had adopted an EHR system. The expansion of EHRs is not indicative of the satisfaction level of the physicians who use them. A 2013 study, Factors Affecting Physician Professional Satisfaction and Their Implications for Patient Care, Health Systems, and Health Policy, published jointly in October by the AMA and RAND Corporation, found that EHRs were a major contributor to physician dissatisfaction.

The study indicated that for many physicians, the current state of EHR technology significantly worsened their professional satisfaction. The tasks associated with EHRs that were a common source of frustration included poor usability, time-consuming data entry, interference with face-to-face patient care, inefficient and less fulfilling work environment, inability to exchange health information and disintegration of clinical documentation.

Administrative Tasks – An Overwhelming Obstacle to Physician Productivity

The physician's effective use of his or her time is crucial to the successful delivery of care. The time-motion study by the AMA and AIM on the Health Affairs website,

Electronic Health Record Logs Indicate That Physicians Split Time Evenly between Seeing Patients and Desktop Medicine, highlights the importance of a physician's time. The study used data taken from EHRs to examine physicians' work effort. The data captured on physicians' time allocation patterns came from over thirty-one million EHR transactions in the period 2011–2014 recorded by 471 primary care physicians, who collectively worked on 765,129 patients. The results indicate that the physicians logged an average of 3.08 hours on office visits and 3.17 hours on desktop medicine each day. Desktop medicine consists of activities such as communicating with patients, responding to patients' online requests for prescription refills, ordering tests, sending staff messages and reviewing test results. Over time, log records from physicians showed a decline in the time allocated to face-to-face visits, accompanied by an increase in the time allocated to desktop medicine. Staffing and scheduling in the physician's office, as well as provider payment models for primary care practice, should also account for these desktop activities.

Physicians are clearly challenged to keep up with administrative tasks and still deliver quality care. The adage "do more with less" really doesn't apply in these circumstances. For physicians to cope with the increasing demands of desktop medicine, they must "do more with more." Moreover, that is why injecting medical scribes into the care equation may be a solution for physicians seeking to increase face time with patients.

The Return on Investment of Scribes

Medical scribe services are a growing business. The American College of Medical Scribe Specialists estimates 20,000 scribes were employed by the end of 2014, and it expects the number to grow to 100,000 scribes by 2020. As of April 2015, at least 22 companies suppl ied scribes across 44 states, according to the Journal of the American Medical Association. There are tangible reasons for the recent growth in the use of scribes. An article in the January 26, 2016 edition of Becker's Hospital Review, 17 things to know about medical scribes, listed five examples where utilizing scribes in a physician's practice would lead to a substantial ROI.

1. Annual Impact of Scribes on Physician Productivity and Revenue, a study published by the Nat iona l Center for Biotechnolog y Information found physician productivity in a cardiology clinic was 10 percent higher when

scribes were used. The study compared the productivity during routine clinic visits of 10 cardiologists using scribes versus 15 cardiologists without scribes. According to the study, physicians with scribes saw 9.6 percent more patients per hour than physicians without scribes. Physician productivity in a cardiology clinic, overall, was 10 percent higher for physicians with scribes.

2. This same study showed physicians with scribe's generated additional revenue of $24,257 by producing clinical notes that were coded at a higher level. Total additional revenue generated was $1.4 mil lion at the cost of roughly $99,000 for the employed scribes.
3. The study, Impact of Scribes on Patient Interaction, Productivity, and Revenue in a Cardiology Clinic: a Prospective Study, showed a correlation between using scribes and thousands of dollars in savings per patient. The study compared standard visits (20-minute follow-up and 40-minute new patient) to using a scribe (15-minute follow-up and 30-minute new patient) in a cardiology clinic. Direct and indirect revenue combined resulted in $2,500 more per patient with the use of scribes.
4. While the use of scribes has resulted in increased productivity and a revenue boost, evidence also suggests scribes may improve clinician satisfaction, as well as patient-clinician interactions, according to a study published in the Journal of the American Board of Family Medicine.
5. Five peer-reviewed studies from 2000-2014 assessing the effect of medical scribes on healthcare productivity, quality and outcomes. Three studies assessed the use of scribes in an emergency department, one assessed the use of scribes in a cardiology clinic and one assessed the use of scribes in a urology clinic. Two of the studies reported that scribes improved clinician satisfaction, and one study reported improved patient-clinician interactions.

Calculating Return on Investment for Scribe Use

Scribes help physicians by documenting the patient encounter and retrieving information from a patient's electronic record. Physicians are increasingly turning to medical scribes to reduce the administrative burden associated with EHR use and to free up time to care for more patients.

Kevin Brady, President of scribe service Physicians Angels, says "market validation and willingness of healthcare organizations to adopt medical scribes has taken off in the past several years as EHRs have failed to deliver on their promise of greater productivity. Even the fastest typing doctor will need three – five minutes to

complete a simple chart." Brady said. He added, "Fundamentally, medical scribes are EHR data managers that give back lost time to doctors, and allow doctors to remain doctors and not become highly paid data entry clerks."

TABLE 1 A Simple Method For Calculating ROI

Step One: The example formula for calculating incremental cost is:	Hourly wage of $20.00 x eight hours worked = $160.00 in wages
	Wages x 20 percent benefits costs = $32.00 in benefits cost
	Wages + benefits cost = $192.00 total cost
Step Two: The example of the formula for calculating incremental revenue is:	If Dr. X can see eight more patients a day, multiply that figure by the average reimbursement per patient (not charges) for a typical office visit. If Dr. X's typical patient visit is billed as a 99213 code (99213 is a level of care is located "in the middle" of the coding spectrum for typical office visits), then Dr. X receives an average of $73.08 per patient.
	Eight extra patients/day x $73.08 reimbursement/patient = $584.64 in incremental revenue per day.
Step Three: The formula for calculating ROI is:	In this example, the daily incremental revenues are $584.64, and the incremental costs are $192.00 leaving a positive ROI of $392.64 per day. Annualized over 240 work days, the ROI is $94,233.60.

It is important to calculate an ROI to evaluate the financial worth of a scribe at a medical practice. When attempting to determine the value of employing a medical scribe, the following is a simple method for calculating ROI (See Table 1.) Typically, an ROI must produce a minimum of 3:1 return to be considered a good ROI. In this example, the physician's ROI exceeded a 4:1 ratio of return validating the value of adding a scribe to support physician activities. Employing scribes offer a viable option to improve physician productivity and financial reimbursement.

The Risks Associated With Scribes

Meaningful use has caused physicians to invest more and more time with their EHRs. Those who use scribes to help share the burden of their administrative duties experience positive results. However, there are risks.

Many accomplished healthcare executives understand the benefits and risks of scribe use. A seasoned industry executive, M*Modal's Chief Scientist Juergen Fritsch, PhD, believes scribes can be a valuable resource. Fritsch describes them as "trained medical information managers who specialize in charting physician-patient encounters in real time during medical exams." Additionally, "While many healthcare stakeholders believe scribes can help physicians deliver better care, their use is not without risks."

A major concern with scribes is documenting medical information accurately. When intermediaries work on behalf of a physician by entering information on a medical record, there are risks of errors, which could impact patient safety. Scribes document the patient encounter and physicians must always review the results of the documentation. The responsibility of medical record accuracy falls on the provider, not the scribe.
To mitigate the risks associated with using scribes and maximize the value of their use, physicians should follow a set of working principals and procedures. They are:

- The physician should introduce the scribe to the patient, so they feel comfortable with the scribe in the room.
- The physician should talk slow enough so that the scribe can capture everything said.
- The physician should confirm their thoughts out loud so the scribe can completely document the encounter.
- The physician should make sure all information entered into the EHR is complete and accurate.
- The physician should not confirm that the medical record is accurate until they review its entirety for inconsistencies and inaccuracies.

The Impact of Scribes on Patient Experience
Using medical scribes is becoming a more established strategy a s organizations look for ways to increase t he effectiveness and output of physicians. Traditionally, the role of the scribe was to help with documentation, permitting the physician more time to provide care and ensuring the medical record is accurate and supports the appropriate level of billing. Today, the role of the scribe has grown due to amplified cognizance around the impact that scribes can have on the patient experience.

In his article, The Effect and Impact Scribes Can Have on Patient Experience, Josh Kosowsky, MD, said “While an organization may hire scribes to improve efficiency and capture revenue, it is important to remember that scribes can also play an important role in enhancing the patient experience. Having a scribe in the room allows the physician to focus on key drivers of patient experience such as eye contact, body language, position (sitting vs. standing), therapeutic touch, and active listening. When administering care, physicians can discuss the diagnosis with the patient and the scribe at the same time, making the patient feel more informed and involved in their care.”

Kosowsky added “The presence of a scribe can enhance the physician’s ability to function as an active listener. For instance, when summarizing a conversation for the benefit of the scribe, the physician may state ‘What I hear you saying is that you have been having abdominal pain the last three weeks, but that it has gotten much worse in the last 24 hours.’ Asking clarifying questions like this shows that the physician is focused on the patient’s concerns while it allows the scribe to understand and summarize the important notes.”

Open and clear communication plays a central part in the delivery of care, and it is crucially important that the physician, scribe and patient have the same level of understanding about the patient’s medical condition.

Summary

The financial implications for the use of medical scribes in care delivery are substantial. Physician services make up 21 percent of health expenditures in the U.S. and spur the beginning of the care cycle. They are highly compensated individuals who are being asked to do more with declining reimbursement. Any change that improves physician productivity and efficiency (without impairing quality or physician or patient satisfaction) should have significant financial benefits for physicians, patients and the entire healthcare system.

EHRs enable the electronic documentation of diagnosis and treatment plans for patients. They offer the ability to capture required information that meets the requirements of meaningful use and value-based care reimbursement models. Conversely, EHRs have added a new level of administrative tasks on the physician’s shoulders that have taken its toll on physicians. Scribes have rapidly emerged to support physicians’ new administrative demands by entering information into the EHR on behalf of physicians.

Using scribes offers the opportunity to produce dramatic gains in physician capacity while potentially reducing job dissatisfaction and burnout. If widely adopted, adding scribes to a physician's practice can maximize the value of EHRs, their financial returns and ultimately improve patient care.

Phil C. Solomon serves as the Vice President of Marketing Strategy for MiraMed Global Services, a healthcare revenue cycle outsourcing company, and is the publisher of Revenue Cycle News, a healthcare business information blog. Phil has over 25 years' experience consulting on a broad range of healthcare initiatives for clinical and revenue cycle performance improvement. He has worked with the industry's largest health systems, developing executable strategies for revenue enhancement, expense reduction and clinical transformation. He can be reached at phil.solomon@miramedgs.comat (404) 849-8065 and on Twitter @philcsolomon.