The Perks of Hiring a Medical Scribe

Here's a way to increase productivity and time with patients.

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The vast number of physicians transitioning from paper to electronic medical records has spawned a new healthcare job description: the medical scribe. This scribe typically shadows a doctor and enters his/her patients' examinations, treatment plans, and follow-up conversations directly into an EMR. The driving force behind this new job category is the long-standing physician complaint that using an EMR is complex and requires too much "doctor time." This, they say, decreases the practitioner's productivity—some claim by as much as 30%.

A 30% drop in productivity is obviously unacceptable for any practice, and the use of a medical scribe is one potential solution for this possibility. Even physicians who have not experienced decreases in productivity as a result of using an EMR perceive medical scribes as a way to further increase productivity and decrease the amount of time spent entering "data" into medical records after hours—especially in a busy practice.

Medical scribes were first employed in emergency rooms in the mid-nineties. Emergency departments were prime candidates for the use of scribes because they experience high volumes of patients, and they adopted EMRs early on. Many emergency room scribes are part-time college students who are planning careers in medicine and see this as a training opportunity. Career staff working in your practice can be trained to perform this same task.

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While some expect the use of scribes to decrease as younger, more tech-savvy doctors enter into medical practice, the biggest group driving the use of scribes will be those physicians who are extremely busy and see a scribe as 1) a way of boosting treatment quality and productivity by freeing more time for patient treatment and 2) creating a better work-life balance by making it possible to have documentation

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completed within the work day.

Before the advent of electronic medical records, doctors already spent too much "patient care" time documenting charts. The amount of time spent examining and treating a patient relative to that spent documenting that same visit can be particularly significant. Loma Linda Hospital has estimated that its doctors spend about two minutes with an ER patient and then take four more to enter the information from that visit into a computer. This means that for a six-minute visit, EMR documentation "eats up" 67% of the doctor's "patient time"—making the decision to initiate the use of scribes in the emergency room a "no-brainer."

In a medical practice, the differential between the time spent interacting with a patient and that required to enter the patient's information into the EMR varies by specialty and may not be as dramatic as it is for the typical emergency room visit; however, the busier a practice, the more significant the impact that even a few minutes of documentation time, per patient visit, can have on daily productivity. For example, at 200 patient visits a week, in a forty-hour week, the average time available, per visit, is 12 minutes. If the average amount of time that a doctor spends entering the history, exam, treatment, tests, patient conversations, and other clinical information into the electronic medical record is three minutes, these "few minutes" represent 25% of those 12 minutes of productive time.

A good place to start would be to measure the percentage of patient care time you currently utilize entering data into the electronic medical record.

Extrapolate this number to the number of patients seen weekly, and you can see just how much it is worth for a doctor to capture this time and use it instead for patient care. While one cannot put an exact dollar amount on its value, it is likely that redirecting this time spent documenting patient treatment would translate to an increase in productivity of a percentage approaching 25% of the practice's revenue. For a practice averaging 200 visits a week, the financial outcome could be substantial—a value that would easily be equivalent to many times the cost of hiring a scribe.

Analyzing the Benefits

While an opportunity to increase productivity is a significant reason for a busy practitioner to consider the use of a medical scribe, given the expected direction of healthcare—where the intent is to eventually pay for quality, prevention, wellness, and coordinated care—all of which *require* the use of an EMR—the value of utilizing a scribe is likely to be even greater. When analyzing whether a scribe's services would be beneficial for your practice, a good place to start would be to measure the percentage of patient care time you currently utilize entering data into the electronic medical record.

Assuming your average documentation time is three minutes, and based on a range of average visit times, Table 1 estimates the percentage of your time you would spend documenting a patient visit.

If your average documentation time is higher, or lower, than three minutes, you can adjust the spreadsheet accordingly. If your documentation time exceeds 15% of your total patient care time and you have a backlog of more than two days for seeing a non-urgent new patient, you definitely should investigate the use of a medical scribe. Beyond the goal of having more patient treatment time, if you currently set aside charts to complete documentation "after hours," adding a scribe and having all documentation completed within regular office hours will create a better work-life balance. This adds value well beyond increased productivity. **PM**

TABLE 1:

Documentation Time as a Percentage of Dr.'s Time

Average Visit Time	Average Documentation Time	Documentation Time as a Percentage of Dr.'s Total Time
5	3 Minutes	60.00%
10	3 Minutes	30.00%
15	3 Minutes	20.00%
20	3 Minutes	15.00%
25	3 Minutes	12.00%
30	3 Minutes	10.00%

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