Is Medical Scribing for You?

It's time to take a closer look at this service.

BY PAM THOMPSON AND LYNN HOMISAK

There may be no more truthful statement about charting than that it has become the bane of a physician's existence. The time it takes physicians to document patient visits and care is one of the major causes of physician burnout in the U.S. Could scribing solve this ever-increasing problem? Will it make your life easier? Does it make charting more (or less) efficient? Is scribing profitable? Is it a waste of time? You hear that some offices make it work, but wonder, "Is it right for MY office?" It depends on whom you talk to. Doctors seem to love it or hate it.

Setting the Groundwork

Let's break down some of the unknowns to help you decide if having a medical scribe in your practice is a benefit or a drawback. The best place to start is always at the beginning and in this case, that means defining what a scribe is from an operational standpoint.

From there, we'll explore some particulars: recruiting the right employee (outsourcing vs. internal training; required skills and qualifications), integrating a scribe's role into everyday clinical work flow and the overall effect that scribing has on productivity and efficiency.

Let's share real-life experiences, take into consideration patient perception, and even provide some metrics to help you calculate your ROI.

Back to the Future

Before we move forward, let's go back. Back in the day, way back in the early 1970s, doctors scribed medical notes for each patient on 5 x 7 index cards. And by scribing, we mean writing with a pen on paper.

These hand-written notes were usually one-liners with a lot of abbreviations. Those of you who can decipher this line; "OV, H, SD C&C, NP, RA 4wks" know what we mean. (Spoiler alert: It translates to: "Office visit, hydrotherapy, surgical debride-

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ment of corns and calluses, nail prophy, re-appoint in 4 weeks").

The follow-up visit, provided the patient was seen for the same condition, was even more cryptic. A series of simple ditto marks on a new line, with the sole intent to mimic the note from the previous visit. Done.

Early on, this unsophisticated style of documentation was the norm with simple paper charts, no insurance guidelines, regulations to follow, forms to file. No nightly file backups. Doctors weren't required to sign notes and there were no mandatory security measures. No HIPAA laws; patient privacy was a given. It didn't matter if a patient had five nails or ten, fungal infection or not, that needed treatment; or if they had bilateral corns and/or calluses, or just one; whether they presented with one chief complaint or multiple ones. The chart notes were minimal—and finished before the doctor saw his next patient.

Fast forward to today. Insurance companies each devise their own set of pull-your-hair-out regulations, creating the need for absurd, extensive note-taking to match even more absurd coding. Doctors today rightly complain regularly that documentation requirements associated with patient care do, in fact, negatively impede the doctor-patient dynamic.

Cries of "Why can't I just do what I enjoy doing—treat my patients—without all the documentation obligations?" are heard daily from physicians who feel that most of their time is spent in administrative perdition rather than quality time with their patients. Or, if they DO allow themselves more face time during clinic hours, they write their notes at home, robbing precious time from family! Drs. Welby, Kildare, and Casey (remember them?) would roll over in their graves! Enter the medical scribe.

What Is a Medical Scribe?

Simply stated, today's medical scribe documents patient encounters, including coding in some cases, progress notes, prescription information, and plans. They retrieve diagnostic results and other information from the EHR. Scribes might also transmit prescriptions and orders, draft referral letters, order supplies, set appointments, and sometimes act as the doctor's personal assistant.

There are three types of scribes—onsite/dedicated, virtual, and remote. Onsite scribes follow the doctor exclusively. A true scribe is not qualified to provide any clinical service. Appropriately delegated clinical care always falls to skilled medical assistants.

Virtual and Remote Scribes

Virtual and remote scribes are, well, remote. A virtual scribe works with the doctor in real time. This requires high speed Internet, video and audio capability, typically using a handheld tablet and app. Less often, treatment rooms and the doctor's office are hard-wire mic'd, with no video.

Doctors log into a service provider and the virtual scribe is live. Although the terms "virtual" and "remote" are used interchangeably, some companies distinguish between them. "Remote" scribes enter data into the EHR from uploaded audio. Remote scribing delays note completion by a few hours and clearly isn't scribing real-time.

Job Description and Tasks—Your Search for the Right Fit

While finding the "perfect medical scribe" right out of the gate may be extremely difficult, that doesn't mean you shouldn't set your sights high. Do your homework when recruiting and selecting new scribes by carefully defining your needs and expectations. Have a detailed written job description prepared in advance to share with your applicant so there is no misconception of duties.

Without question, the main duty of the scribe is to document patient care, input patient data (electronic or paper; real time or dictated) and prepare and organize clinical notes for the doctor's review. This involves knowing and anticipating the physician's protocol for various conditions.

If a doctor chooses to have an individual exclusively for that purpose, the scribe is attached (figuratively speaking) to the physician's coattails as he/she enters each treatment room for the sole purpose of documenting treatment, prescriptions, supplies dispensed, and patient instructions in real time.

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Dedicated on-site scribes are ever present during clinical hours and may take on some clerical tasks such as faxing, phone calls, and referral paperwork as they relate to the notes. Whether dedicated or dual-role, a scribe's effectiveness relies on having a strong set of skills, qualifications, and physical characteristics.

Due to patient interaction and access to confidential/sensitive data, scribes are, by necessity, unobtrusive, good listeners, responsible, self-motivated, adaptable, and professional at all times. They must have a willingness to learn, attention to detail, organizational skills, good acumen, and must interact effectively with other members of the staff as well as the physician.

A standard job description would include the following attributes:

- An understanding of the EMR and dictation systems utilized by the practice as well as podiatry terminology and anatomy, treatment protocols, and pharmacology.
- Computer skills, knowledge of applications, Internet, scanners and electronic filing methods are mandatory. Scribes are required to input

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data, research information, prepare medical reports and other documents, and handle necessary correspondence (mail and email) relative to their work.

• Proficiency in typing/keyboard, spelling, punctuation, grammar and oral communication (language and writing skills).

• Chart and graph preparation and interpretation—flow charts in Microsoft Excel

• Logic and reasoning, problem solver—Must be able to use common sense to resolve unexpected difficulties, receive and follow instructions, spot (and correct) mistakes or irregularities in documentation, and notify doctor if charting is incomplete.

• Physical demands—Standing for long periods of time, walking, hand and finger dexterity, ability to adjust visionary focus between close to screen and distance.

• Ability to travel from main to satellite offices, if applicable.

• Education—High school diploma (or equivalent), background check and no criminal record are essential. Medical transcription experience preferred, but not required. Must attend varied training sessions (on or off premises) as instructed to strengthen expertise.

• Compliance—Scribe must have an understanding of HIPAA and other regulatory compliances, legal doctrines, billing and coding, and patient scheduling.

• Other unlisted tasks as required.

Integrating Scribes in Daily Workflow

Rather than hiring a scribing specialist or employing a virtual or remote scribe outside the practice, some offices opt to train existing employees internally to either act as dedicated scribes or assign them a dual role, similar to any one of the following:

1) Scribe-Dedicated. An employed, experienced, and competent medical assistant (MA) with extended practice history becomes a dedicated scribe. This leaves an empty MA position and/or the need to hire a replacement. Because these individuals are familiar with podiatry anatomy and terminology, treatment protocol, template setups, and the EHR system, specific scribe training would be minimal.

2) MA/Scribe—Dual Role. Some practices prefer all clinical staffers to train as scribes so that any one of them can step in when needed. In addition to performing all scribing duties, they carry out routine clinical tasks and responsibilities aligned with their original podiatric medical assistant job description.

3) Patient-Dedicated. These MA/Scribe Dual Role employees are dedicated to one patient at a time, from reception to discharge, instead of following the physician. They room and set up the patient, update their records, scribe when the doctor enters the room, perform all necessary orders, follow up with post treatment dressings, DME, and instructions while the physician moves along to his/her next patient and their dedicated scribe.

Whether you hire externally or give an existing staff

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member a new role, you should make a point of interviewing for the position. To achieve an overall smooth process, the scribe must competently interact with the physician (and other staff members), be ever-mindful of the flow and functionality of the practice, and perform duties with speed and competence. The more complicated or unpredictable the practice's operations, the more challenging it is for the scribe to successfully acclimate.

No License, No Training Regulation

If you're hiring a "true" scribe (not using a dual role MA) here are a few things to know:

There's no standardized background or training protocol required of scribes in the U.S. No licensure or certification is mandated by law or regulation. Scribe agency training differs from company to company. All scribes require training well beyond what a scribe service provides, and that training can take weeks or months. In fact, in an unfamiliar practice, the more likely expectation that a scribe can completely adapt fine-tune their skills is closer to three months. Agency-supplied scribes are paid full rate while training occurs, even if the scribe is part-time during the training period.

There will be an estimated 100,000 scribes working for U.S. doctors by 2020, up from 20,000 in 2015. According to a recent Doctor's Company survey, 55 percent of scribes are trained by the doctor and 44 percent of scribes had no prior experience. Where are all the high-quality scribes going to come from?

Orders Risk

If a scribe (or anyone else) enters CPOE (Computerized Physician Order Entry) on your behalf and an alert pops up, you may not see it, so there is a potential for loss of clinically relevant information and med-legal risk. Mitigate this risk via training and protocol. Keep in mind that a physician must review and sign off on all scribed notes since, ultimately, the physician is legally responsible for its content.

Advantages and Disadvantages

"Pro-Scribe" physicians claim that with the burden of medical documentation lifted, they have more time to interact with their patients and focus more intently on their care plans, resulting in more comprehensive patient encounters and job satisfaction. Other leading advantages of having a scribe are overall increased productivity, improved patient flow, and—because seeing more patients is possible—increased revenue.

Alternatively, some of the biggest downsides reported by physicians include inconsistency in the quality of scribes, an over-reliance on them, and rapid turnover. The latter begs the question, "what would I do if my scribe leaves?" There is always the fear that a fully trained scribe will leave for a better job, resulting in the physician spending extra hours and energy every day re-training, overseeing, and correcting a new hire until they become efficient. As you might expect, and like losing ANY good employee, there is financial loss associated with the period of adjustment before being able to resume normal work flow.

Being able to work well with the physician and having their work acknowledged is key to retaining staff. In fact, a recent survey by OC Tanner Research indicates that 79% of employees will quit their job if they don't feel appreciated. That goes for non-agency scribes, office managers, clinical assistants, billers, or receptionists. Appreciation is non-discriminatory, costs absolutely nothing, and as clearly documented, has an excellent track record for employee retention.

Personal Testimonies

Two doctors who utilize scribes in their practice have shared how they chose to successfully integrate scribes into their practices.

Case #1: Patrick McEneaney, DPM—Northern Illinois Foot & Ankle Specialists:

Dr. McEneaney owns and operates a four-doctor practice with two locations in Cary, IL. He employs approximately twenty-two staff, including one scribe, and sees his decision to hire her, in his words, "as a luxury that pays off over time." Dr. McEneaney utilizes an "MA/Scribe, Dual Role" and has described scribe integration in his practice as "a very easy, smooth transition."

Dr. McEneaney

According to Dr. McEneaney, "In the beginning, my full time scribe, Shelby, focused on care plans, and later helped with physical exams. She follows me around like a shadow and does all my dictation. The templates are very helpful in that regard.

In addition to knowing podiatric anatomy and how to document the physical exam portion of the patient encounter, she knows my protocol, so she makes sure I have the things I need prior to seeing my patients."

"Because she stays aware of the activities in other treatment rooms, she effectively guides me and points me in the right direction. She gives me verbal cues (who is in the room, what she/he is being seen for, previous treatments, how they are doing, etc.) and knows how to interpret my non-verbal signals to begin specific treatment plans."

After finishing up the note, she'll pull the x-ray (if applicable) and I will dictate that addition to our note. The more she does it, the better she gets. On occasion, when I am not in the office, she will act as an MA for the other doctors."

Drawbacks? He admits an un-

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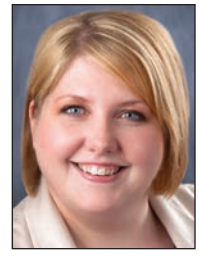
comfortable dependency on her availability. "If she's out sick, I kind of feel lost. I'm thinking of getting a backup scribe for that reason."

Dr. McEneaney acknowledges that having a scribe has resulted in significant note-taking productivity as well as more comprehensive documentation. It has decreased his charting time while simultaneously increasing the time he can spend with his patients. "Previously, I would make notes in a paper chart and transcribe them myself at home. It was not uncommon for me to be up until 1-2 am every day doing this. On Fridays, I'd take more charts home again. I didn't have my weekends to myself."

Dr. McEneaney recommends that his colleagues calculate what their time is worth, then figure out the cost of investing in a scribe. "What they will find is that it will save them a lot of money overall…and free up their personal time. Transitioning to a scribe for me was life-changing!"

Case #2: Melissa Lockwood, DPM—Heartland Foot and Ankle:

At the time of our interview, Dr. Lockwood was a solo practitioner in private practice since 2008, seeing between 90-110 patients a week. She has since taken in an associate to keep pace with her growing practice. Her desire to utilize a scribe started almost right from the beginning and she considers herself an early adopter.



Dr. Lockwood

Dr. Lockwood feels that in order to be efficient in a busy office, a solo DPM needs three MAs on the floor and in her office, all clinical staff are cross-trained to take on the dual scribe/MA role. In fact, when hired, the full extent of their job description is made totally clear. New staff train by shadowing the clinical supervisor. They spend additional time shadowing the doctor, with continuous training on the floor until Dr. Lockwood has full confidence in their ability.

The scribe is with their patient from start to finish. They are assigned a room each day and literally act as "tour guides" for the patients in their care. They use headphones to communicate internally and use laptop/tablets in conjunction with a computer in each treatment room.

Staff training includes learning how to enter some preliminary objective and assessment data using the comprehensive templates that are in place. Dr. Lockwood is quick to note that while they can start the process, the DPM MUST create and continually update the templates and MUST BE THE ONE to actually make the diagnosis as well as LINK the diagnosis to the treatment plan.

Everyone's goal is to have all notes completed within 24 hours. She makes sure to correct any errors (admittedly, very few) and signs off on each note before sending it to billing. To meet necessary medical-legal documentation, every EHR note indicates that the MA/scribe transcribed it.

Dr. Lockwood says that having scribes is not so much

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a cost as it is an investment. Her entire team of dual-role clinical staff have a positive impact on all areas of her practice, including the schedule. She claims she can see more patients, more effectively, in less time. She also notes an improvement in productivity and efficiency (IT execution), and patient satisfaction (now having the ability to communicate face-to-face with her patients). "For me, it was an obvious quality of life improvement. I leave the office at the end of the day knowing it was productive, with less stress!"

Dr. Lockwood urges her colleagues who do not currently use scribes in their practice to think about the stress of the documentation process and what it is "worth" to them in terms of dollars. "I think of the doctor as the $500 employee, the highest producer. At $500/hour (times) two hours a day (times) five days a week (times) 48 weeks a year, [500 x 2 x 5 x 48], I am saving approximately $240K—a worthwhile investment. I feel my time is better spent seeing patients. Our scribing method gave me that time to see them comprehensively."

Listen, Write, Comprehend: Pick Two

Scribing is a more advanced skill than most people realize. Scribing real-time is difficult. It is not simply transcription or copy and paste. There is always the potential for scribes to misinterpret a physician's instructions and make documentation mistakes.

Live scribing (especially virtual) may be more susceptible to error than other methods. Here's why: Scribes are not stenographers. They record data at a much slower pace than people talk. Most people speak at an average 225 words per minute, twice as fast as the best typists who are tapping out 100 words per minute.

Scribes are not using stenographer shorthand to capture narrative. They are typing and/or clicking in the EHR, which means they are, by necessity, mentally parsing, recalling, and sometimes interpreting, often missing some of what the doctor or patient is saying.

New research into multi-tasking shows we are biologically incapable of processing these types of attention-rich inputs simultaneously.

John Medina, author of *Brain Rules* says the term "multitasking" originated to describe the capabilities of a computer system. "The (human) brain is a sequential processor, unable (not wired) to pay attention to two things at the same time. The truth is, effective multitasking is an oxymoron."

In other words, if a scribe is typing a narrative, listening for discrete data he/she must interpret, and then the doctor asks a question (the third attention-rich input), the scribe's brain cannot process the task quickly as the sequential "attention switch" slows. Error rate increases to about 50%.

"Excellent" scribes are excellent because their "attention switching" is very fast for two of the three required skills (listen, write, comprehend).

Functional Creep

Functional creep (adding other duties like order entry, data finding, data interpretation, entering imaging, labs, meds, responding to patient messages) during patient sessions can further attenuate scribe comprehension and increase error rate.

Live scribing in a busy office with highly productive physicians naturally increases scribe stress/burnout. This contributes to inaccurate and incomplete work. Doctors must make some accommodation to minimize this possibility. Consider shared work load, staff rotation, and additional personnel.

Legal Liability

If the scribe is not an employee, and so covered under the physician's malpractice, scribe interpretation and errors can create med-legal liability in a claim. Any contracted scribe must have liability insurance to cover such an event. If they don't, get a rider to cover them.

HIPAA/HITECH violations by scribes outside of the U.S. pose additional risk. It would be wise to speak to an attorney about what will protect the practice in case of a breach by an internationally-based scribe. A Business Associate Agreement, or even HITECH-esque protections adopted by the country a scribe is in (like, say, the Philippines)may not cover your liability. Certainly, get a signed BAA from every scribe personally (not just the agency), no matter where they are.

Patient Perception

Does having a scribe present during patient encounters interfere in the personal physician-patient relationship, obstructing their ability to comfortably ask questions and honestly respond to those involving their health history, current symptoms, or treatment discussion? Or, do patients perceive it more positively—recapturing precious eye contact with their doctor, whose nose was previously buried in the computer recording notes during their shared conversations?

Patient satisfaction should not be underestimated. It matters—to them and more recently, to payers who survey their subscribers to determine patient quality of care.

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What Scribes Cost, and Are They Worth It?

International scribe costs range from $15,000-$30,000 a year per FTE (Full Time Equivalent) physician. Agencies charge more than their published pricing for an English-as-first-language U.S. scribe. Are scribes worth it? They could be, provided you find the right individual who sticks around and meets the requirements of the job description.

The average podiatrist costs $3-$4 per minute (compensation plus share of overhead). If a practice had to pay a physician to chart 20 visits/day, 4 days a week, 48 weeks a year, taking 4-6

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minutes per visit (which includes 4 new visits) it would cost $60,000-$80,000 a year. Pro-scribing practitioners justify the cost with increased revenue, patient satisfaction, having extra well-deserved free time and/or getting back to doing what they really enjoy doing—patient care.

Sometimes scribing just doesn't work. Scribe competency, flow, engagement, and a simpatico relationship must exist for scribing to work. Sometimes, it just doesn't happen—for no obvious or identifiable reason. Those who've had bad experiences with scribes say they've paid $30,000+ a year and still spent one to two hours every night correcting the scribe's work until that scribe leaves, and then they start all over training a new one.

Another Personal Testimony: Using Virtual Scribes

Case #3: David Laurino, DPM—Modern Foot and Ankle Centers; Dr. Laurino is also a co-owner and managing partner of Bottleneck Medical Virtual Services, a company offering professional growth opportunities—including virtual scribe services—for podiatrists:

Dr. Laurino is a partner in a 4-doctor/2-location practice and normally sees between 100-120 patients per week on a 4-day work week with 2 medical assistants. As charting became the bane of his existence, he knew there had to be a better way. "We did not go to medical school to be a glorified secretary or court reporter," he states.

Dr. Laurino feels that in order to run a high performance practice, you must implement strong systems, tight operations, and detailed protocols. He tried the dual scribe/ MA role, but quickly transitioned to completely virtual assistants and has realized a huge impact on patient care and satisfaction along with staff cost savings and increased revenues.

After reviewing an ROI/Quality of Life calculator and realizing he could save 2 hours/day, see an additional 5-7 patients/day (if wanted), and a potential net revenue gain of $220k, it was a clear no-brainer to hire virtual assistants.

The process: The insurance/ benefits VA's will check patient eligibility 48 hours prior to the office visit (including all DME and common procedure codes) and document it in the EHR. Next the virtual scribes will follow Dr. Laurino from room to room on a laptop or tablet via a HIPAA-secure Zoom connection. The virtual scribe will open the patient chart in a cloud-based EHR and document all the pertinent positives into an appropriate template designed by the doctors. If there are any questions about diagnosis or treatments rendered, they are quickly answered and documented while transi-

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tioning from one treatment room to the next. Charts are reviewed for accuracy at lunch time and the end of the day. This usually takes no more than 5 minutes. "It feels magical to walk out of the office at 5:10pm knowing that all my charting is done."

"As human capital gets progressively more expensive, reimbursement rates keep falling and overhead perpetually rises, business solutions need to be developed to help us survive," states Laurino. "Virtual assistants could be your secret weapon if utilized properly to help improve patient relations & experiences, save time, save money, supercharge productivity, decrease stress, increase revenue, decrease burnout, and improve overall job satisfaction."

Since implementing 4 virtual medical assistants (2 insurance/benefits VA's & 2 virtual scribes) into his medical practice nearly 18 months ago, Dr. Laurino has seen a massive Improvement in time, energy, money, and overall quality of life.

"We all know that time is a finite resource, but with my virtual assistants, I feel like I'm buying back time."

Summary

So, maybe scribes—whether onsite/dedicated, virtual, or remote—are for you, maybe they're not. Maybe the cost is worth it, maybe not. Maybe the question you really want answered is…is the cost worth the benefit for YOU? Only you can answer that. We've been occasionally told that by charting nights and weekends, the doctor avoids the added financial cost of a scribe (or other solutions). That's true; no financial cost. However, if it ends up depriving you of a more rewarding work-life balance. "Never get so busy making a living that you forget to make a life."…Dolly Parton **PM**

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