Use of medical scribes in a primary care setting;

THE EXPERIENCE OF OUR OFFICE AND POSSIBLY YOURS.

The Basics:

- The use of scribes in medical office settings is on the rise;
- Estimates for 2013 of about 5,000 scribes nationwide
- Estimates for 2018 of about 50,000 scribes nationwide
- There are now 22 companies that specialize in supplying scribes across 44 states
- Scribes are commonly being used in specialty and primary care as well as in the ER setting

Why the rapid rise in scribe use?

- Because EHR use can suck
  - We all use one so we all know…
- EHR struggles ranked #2 in cause of physician burnout in last years Doximity survey

Roles and responsibilities of the scribe in our primary care setting

- Capture and enter accurate and detailed documentation of an encounter in real time
- Locating information for review before or during an encounter (specialist notes, lab reports, radiology reports, etc.)
- Entering data for performance metrics in the appropriate fields for later reporting (BMI, HGBA1C, etc.)
- Capturing and entering appropriate codes in the superbill for review by clinician
  - F-codes for AWVs, charges for UA, EKG, PFT, uHCG, strep/flu tests, etc.
  - Entering accurate and precise HCC codes to maximize RAF

Challenges that we (and other primary care offices) have faced

- Every chart and every order entry must be verified by a provider
- The EHR must have the ability to show that documentation was done by a scribe
- There should be clear written policies and procedures detailing expectations of the position including that scribes acknowledge that they are not acting in a clinical role and that they cannot interject their personal interpretation (see sample)
- There should be written agreement between the scribe and the clinician (see sample)
- How or Who pays the money?
  - Pay range is $10-17 per hour

More Challenges

- There is no broadly established national scribe training protocol (most businesses train scribes according to their model).
  - Our office decided to use individuals trained as MAs to fill the role of scribe, though they specifically do not do MA jobs while scribing.
  - Our providers found a 4-6 week training interval was sufficient to allow the scribe to craft a note that only needed rare tweaking by the provider. This is consistent with what other offices have found nationally.
- Other issues:
  - Another person in the room
  - Legal ramifications
  - Becoming "scribe dependent"

So Why Do It?

- While increasingly common, they may need extensive training, they may be expensive, there are policies and procedures required, there are possible challenges with respect to workflow including need to verify all notes written, AND the potential for legal headaches and for crowding an exam room…sounds like a hassle.

The Benefits

- Clinician Satisfaction:
- All charts completed by the end of the day
- Enhanced pre-visit chart preparation for a more organized visit
- More time involved in direct “heads up, and eyes on” patient care
- Less drudgery with EHR button pushing
- Improved reporting on performance metrics
- Improved HCC and RAF scores

Patient Satisfaction

- " I seem to have much more time with the doctor spent talking directly to me instead of face down in the computer"
- "I'm no longer talking to the back of his head"
  - Less typing means more direct face to face care time
- "I am not waiting as long in the waiting room"
- "I know that I can call Brittany and she can help me get what I need"
  - Another point of contact in the office

Productivity

- Increased wRVU rates per hour are noted in our office and this experience is seen nationally as well from (4-10%).
  - 2 of our 3 scribes have been to coding classes and can provide real time feedback to the provider about ways to enhance coding or to appropriately code the visit
- Increased number of patients per hour is also seen in our office and nationally from (9-12%).
  - One of the partners has used this to reduce his wait times, and one is now booking a 5th patient for some hours during the day.
- Improved RAF scores and improved performance metrics along with improved coding capture

Improved workflow efficiency

- Decreased time per visit spent in data entry by clinician allows for increased time to review labs, ancillary and specialist notes and radiology reports.
- Finishing documentation earlier in the day allows for improved ability to triage some calls and get things done during the day, meaning getting home earlier

Questions?