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Meet the Presenter…

On the topic:
Scribes: Proper Training and Utilization

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Scribes: Proper Training and Utilization

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Overview

• Definition and History of Scribe
• Roles and Responsibilities
• Scribe Legal Considerations
• Implement Scribe Documentation Guidelines
• Common Documentation Duties for Medical Scribes
• Benefits of Having a Scribe
• Evaluate the Cost of a Scribe
• Tips for Managing and Monitoring Scribes
• Monitor Scribe Education and Qualification
• Maintain Provider Engagement
Overview

• Transitioning to electronic health records (EHRs) and the need for more detailed documentation
• Increased time spent capturing this information
• Less face-to-face time with providers viewed as “hindrance to quality of care”

Definition of Scribe

Joint Commission defines a medical scribe:

“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.”
History of Scribe

The job of being a scribe is an ancient one, and has its roots in ancient Egypt, where a scribe was considered one of the most important professions.

At that time, scribes were used primarily for copying texts and making records using hieroglyphics. Scribes were part of the royal court and did not have to pay taxes.

With the invention of printing over the next few millennia, the scribe profession became obsolete… until now!

Roles and Responsibilities

- To capture accurate and detailed documentation (handwritten, electronic, or otherwise) of the encounter in a timely manner
- 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
- Assisting the provider in navigating the EHR
Roles and Responsibilities

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

Roles and Responsibilities

- Dependent upon the provider, practice, and setting
- 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.
- Not recommended to allow an individual to fill the role of scribe and clinical assistant simultaneously during the same encounter
  - Raises legal and other issues regarding job role and responsibilities
Roles 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. A clinical assistant enters information independently and only within the individual’s scope of practice.
- Security rights are more limited for clinical assistants than those of the provider.

Roles and Responsibilities

- When a scribe is 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.
- To avoid this situation, some practices limit the scribe to filling one role during the single encounter.
Roles and Responsibilities

- Role must be clearly defined and communicated, with documented job descriptions and policies and procedures to optimize their use and minimize challenges.
- Important to obtain a signed agreement between the provider and the scribe delineating expectations and accountability.

Scribe Legal Considerations

Important that state laws are 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.

Scribe responsibilities are controlled by the regulatory requirements and policies established by a healthcare setting, and the level of risk an employer is willing to accept.
Implement Scribe Documentation Guidelines

In 2011, the Joint Commission released guidelines recognizing that scribes may be used across various settings:

- Verbal orders may neither be given to or by scribes.
- Signing (including name and title) and dating of all entries into the medical record is necessary. Must be clearly identifiable and distinguished from that of the physician or licensed independent practitioner and other staff.

For example:
“Scribed for Dr. (name of physician) by (name of scribe), (date and time of entry).”

- Orientation and training must be specific to the organization and role.
- Competency assessment and performance evaluations should be performed.
- If the scribe is employed by the physician, all non-employee HR standards also apply.
- Scribes must meet all information management, HIPAA, HITECH, confidentiality, and patient rights standards, just as other medical personnel.
Common Documentation Duties for Medical Scribes

- 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

The scribe’s notes 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
The provider’s notes should include:

- Affirmation of 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 name and time

Benefits of Having a Scribe

Scribes focus on capturing medical information at the point of care.

Physicians focus on bedside manner and provide hands-on, attentive, face-to-face care that increases both patient and provider satisfaction.
Benefits of Having a Scribe

• Patients may perceive their visit negatively if the provider spends the majority of their time looking at the computer monitor instead of the patient.
• Improves the overall quality of documentation
  • granularity,
  • level of specificity,
  • improved documentation to support “meaningful use” EHR Incentive Program
  • improve compliance with quality monitors, billing and reimbursement

Benefits of Having a Scribe

• Increases provider efficiency and productivity
• More time for physicians to engage patient care
• Quicker availability of scribes’ documentation
• More detailed and comprehensive documentation
• The patient’s plan and details of the encounter captured in “real time”
• Increased physician job satisfaction, retention and lower burnout rates as they spend the day doing what they were trained to do
Managing the Cost of Scribes

• Cost allocation options:
  – Provider –
    • provider employs the scribe
    • pays hourly wage
  – Provider practice
    • regulate what scribe services will be and use current transcription compensation model (paying per line, per minute, or both)
  – Shared
    • providers and organization share the cost-share
    • providers who use scribes are responsible for a certain percentage of the cost.

Allocating Costs

• Time and motion studies
• Tools used to scribe
  – Dictation
  – Handwritten
  – Data entry
    • Turnover time
    • Specialties assigned
    • Patient volume
      – Number of lines scribed
      – Number of records scribed
      – Account turnaround
So, let’s look at the numbers..

*What is the average revenue per patient visit?*

Number of patients seen in last three months: 1056  
Receipts for physician’s services in last three months: $85,000  
Average revenue per patient visit: approximately $75

*How many more patients will you be able to see in a day with a scribe? The most conservative approach is to assume the scribe will get you to pre-EHR levels of productivity, although it is likely that an effectively utilized scribe will make your more productive.*

Number of patients seen in three months just before EHR implementation: 1320  
Number of weekdays in three months (3x22): 66  
Number of patients per day, pre-EHR: 20

*How many patients do you currently see each day?*

Number of patients seen in two months: 660  
Number of weekdays in two months: (2x22): 44  
Number of patients per day, post-EHR: 15

*What is the currently unmet demand for your services? The most conservative approach is to assume the demand for your services is what it was pre-EHR, although there may have been unmet demand then.*

Patient demand per day: 20 visits

*Estimated monthly increase in revenue with addition of medical scribe*

Average revenue per patient visit: $75  
Average days per month: 22  
$5 x $75 x 22 = $8,250
What is the average revenue per patient amount?

Jessica Yourdon, 3/21/2016
Estimated monthly increase in costs with addition of medical scribe

Monthly salary: $43,000/12 = $3,583
Monthly taxes and benefits: $3,583 x 3 = $1,075
$3,583 + $1,075 = $4,658

Marginal monthly income

Increase in monthly revenue - increase in monthly costs
= increase in monthly income
$8,250 - $4,658 = $3,592 x 12 = $40,084

Challenges

• A non-physician provider (i.e., nurse practitioner, physician assistant) in the role of a scribe in a physician setting would be counterproductive in most cases.
• Scribes in the exam room may cause patients to be less honest and forthcoming with pertinent information for accurate diagnosis and treatment that would impact quality of care.
• Using scribes will change workflows. These workflows need to be redefined and streamlined.
• Provider verification and authentication of scribed documentation for accuracy may slow down workflow.
• If scribe is inexperienced and does not have medical terminology and clinical workflow knowledge, this may cause documentation errors leading to greater issues.
Challenges

• Some providers may not take the time to review scribed entries for accuracy before authentication. These errors can effect patients’ plan of treatment, coordination of care, coding, billing and other documentation requirements due to lack of detail and accurate documentation in the heath 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

• Manage and maintain with the same quality assurance and compliance expectations of other patient care documentation.

• Must be included in overall compliance program.

• Monitored for accuracy, adherence to guidelines

• Develop policies and procedures, training, and overall management.
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. 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.

Clinical Information Manager Certification and Aptitude Test (CIMCAT)

- 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 offers maintenance of certification through the Medical Scribe Continuous Certification (MSCC).

Also, certifies scribe programs to set apart those that offer a higher level of professionalism and skill set from those that do not.

**Maintain Provider Engagement**

- Physician providers need to remain connected to all patient information.
- 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.
Tips, Tools, and Techniques

- View current processes and need for scribe to increase efficiencies, improve patient/provider satisfaction
- Conduct cost vs. benefits analysis
- Define roles and responsibilities
- Be aware of individual state regulatory requirements
- Monitor the Scribe Program, adherence to compliance standards, continued training opportunities
- Maintain provider engagement

References


Questions

• Thank you for your attendance!

• Get your questions answered on PMI’s Discussion Forum:
  http://www.pmimd.com/pmiForums/rules.asp