
If the "Scribe" Fits

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Physicians struggle with the increased regulatory requirements of documenting a patient encounter in the Electronic Health Record (EHR). The majority of physicians chose medicine as a career path to take care of patients only to find that they spend an overwhelming amount of time and energy documenting patient encounters. One option that some physicians have found helpful is the use of scribes to help ease this burden. Let's take a look at some examples of the benefits practices have realized with the use of medical scribes.

A large cardiology practice uses medical scribes by having them accompany each physician into the exam room to document the patient encounter directly into the EHR as the physician verbalizes the assessment. Additionally, the scribe gathers data for the physician including nursing notes, prior records, labs and radiology results. "Our medical scribes do the bulk of the documentation for the physicians," says one of the cardiologists in this practice. "They are handling about 80% of the ancillary duties for us. It has been the best investment we have made."

A solo dermatologist uses his LPN as a scribe. This physician comments, "She does 75% of my documentation. She enters vitals, medication and recent medical history. Upon entering the exam room, I assess the patient and verbally dictate my findings as she documents directly into the EHR. I then go into the next exam room without ever touching the computer. I have more one on one with my patients and know I provide much better patient care."

Whereas some practices realize positive benefits, this is not always the case. A primary care practice tried numerous times over the course of two years to use scribes. After talking to colleagues, reading articles about the increase in productivity, the efficiency in the clinical area and the reduction of the documentation burden, using medical scribes seemed like the best thing for this busy practice. Unfortunately, for them it did not work. The physicians and staff put much effort into making this successful, but the complexity of the patients' visits, variety of complaints, and numerous procedures performed in the practice made it difficult for the scribes to keep up and document the information correctly.

With the continued push to document a more detailed patient encounter for not only liability reasons, but also for better coding, we are seeing a growth in the use of scribes. The American College of Medical Scribe Specialists estimates that physicians and hospitals will employ approximately 100,000 medical scribes by 2020. While this number continues to grow, the position remains minimally regulated. The only certification

program offered for scribes in the United States is by the American College of Clinical Information Managers (ACCIM). A significant number of medical scribes are not certified. Essentially, the physician is the one who decides the level of risk he/she is willing to accept when using a scribe.

Scribes have almost the same security rights in the EHR as the physician, while a clinical assistant enters information independently within his or her range of responsibilities. A scribe's responsibility, on the other hand, is to enter exactly what the physician says during that patient's visit. If a scribe is not properly trained or familiar with medical terminology, medications, procedures, etc., false or incorrect information can easily be entered into the EHR. To make sure there is no misunderstanding between the role of a scribe and a clinical assistant, it is essential the scribe logs into the EHR and documents as a scribe and not as a clinical assistant. The two roles are performed differently and security rights/documentation in the EHR should reflect that distinction.

A scribe is an extension of the physician, and it takes time and effort to train scribes to manage physician workflow while not exposing the provider to additional risk. The scribe job description is unique in medical practices in that they are exclusively dependent on physicians. If the decision is made to use medical scribes in your practice, take the time to establish policies and procedures regarding responsibilities, carefully manage the process/workflow, set clear goals, and monitor and conduct on-going training. Organizations such as the American Health Information Management Association (AHIMA) provide practical suggestions, which may be useful in developing policies and procedures.

Whether you decide a scribe is right for your practice or not, it is definitely a trend in healthcare right now and something to consider. With an increasing documentation burden, many practices are seeing the use of scribes as a cost effective and efficient way to help physicians spend more time with patients. Be aware that using scribes comes with risks, though, and use resources that are available to ensure you mitigate these risks to the maximum extent possible.

[1] <https://theacmss.org/wp-content/uploads/2016/08/ForTheRecordAug2016.pdf>

[2] <http://library.ahima.org/doc?oid=106220>

The Joint Commission issued guidelines in the use of scribes in healthcare organizations:[1].

The Joint Commission does not endorse nor prohibit the use of scribes. However, if your organization chooses to allow the use of scribes the surveyors will expect to see:

- Compliance with all of the Human Resources, Information Management, Leadership (contracted services standard), Rights and Responsibilities of the Individual standards and Record of Care and Provision of Care standards including but not limited to:

- A job description that recognizes the unlicensed status and clearly defines the qualifications and extent of the responsibilities (HR.01.02.01, HR.01.02.05).
- Orientation and training specific to the organization and role (HR.01.04.01, HR.01.05.03).
- Competency assessment and performance evaluations (HR.01.06.01, HR.01.07.01).
- If the scribe is employed by the physician all non-employee HR standards also apply (HR.01.02.05 EP 7, HR.01.07.01 EP 5).
- If the scribe is provided through a contract then the contract standard also applies (LD.04.03.09).
- Scribes must meet all information management, HIPAA, HITECH, confidentiality and patient rights standards as do other hospital personnel (IM.02.01.01, IM.02.01.03, IM.02.02.01, RI.01.01.01).
- Signing (including name and title), dating of all entries into the medical record-- electronic or manual (RC.01.01.01 and RC.01.02.01). For those organizations that use Joint Commission accreditation for deemed status purposes, the timing of entries is also required. The role and signature of the scribe must be clearly identifiable and distinguishable from that of the physician or licensed independent practitioner or other staff. Example: "Scribed for Dr. X by name of the scribe and title" with the date and time of the entry.
- The physician or practitioner must then authenticate the entry by signing, dating and timing (for deemed status purposes) it. The scribe cannot enter the date and time for the physician or practitioner. (RC.01.01.01 and RC.01.02.01).
- Although allowed in other situations, a physician or practitioner signature stamp is not permitted for use in the authentication of "scribed" entries-- the physician or practitioner must actually sign or authenticate through the clinical information system. (RC.01.02.01).
- The authentication must take place before the physician or practitioner and scribe leave the patient care area since other practitioners may be using the documentation to inform their decisions regarding care, treatment and services. (RC.01.02.01 and RC.01.03.01).
- Authentication cannot be delegated to another physician or practitioner. The organization implements a performance improvement process to ensure that the scribe is not acting outside of his/her job description, that authentication is occurring as required and that no orders are being entered into the medical record by scribes. (RC.01.04.01).

[1] [Joint Commission guidelines](#)

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