Scribes in the Urgent Care

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For years I was subjected to corporal punishment at the hands of nuns who used to beat me when they could not read my handwriting – at least that is how I remember it. For reasons unknown, my handwriting was never legible. Even back in the day, using the T-System's "slash and check" charting, my medical records looked like I had either DTs or Benign Essential Tremor, or both.

One can then imagine how thrilled I was to move into the world of the electronic health record (EHR). I was an early adopter of electronic medical records and survived many of the various fits and starts of the industry. The early EHRs we used in the urgent care world and in the emergency department (ED) eventually became second nature and we subsequently became very efficient whilst using them.

The EHR we used in the ED up until last April was incredibly efficient and we could really fly through the various screens when using it to document the patient's ED course. On May 1st last year, our ED throughput, documentation, and work-related sanity all went out the window when our hospital picked a new enterprise-EHR for the entire hospital system. I can describe it in one word — horrific. Actions that used to be "1-click" now took 3. Between every click a little second hand would go around a little clock until the next click. We all wanted to quit.

In truth, it could have been much worse save for one thing — Scribes. Per the Joint Commission, a medical scribe is an unlicensed individual hired to enter information into the EHR or chart at the direction of a physician or licensed independent practitioner.[1]

We learned early on that the EHR the hospital picked was near the bottom for usability, particularly in the fast-paced setting of an ED. Like urgent care medicine, emergency medicine revolves around efficiency, appropriate documentation to protect you in case of an untoward event, and generation of the E and M code consistent with the work performed.

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We started investigating the various scribe companies about a year before implementation. In a nutshell, scribes are generally college age, pre-health or premedical students who are interested in learning while working. Most of the scribes we use had just graduated or are enrolled in a local university. To a person, they are hard-working, computer-savvy (as only young adults can be), pleasant, very enthusiastic, and willing to learn. They are all, in-effect, on job interviews inasmuch as most of them at some point want letters of recommendations and connections.

Prior to a scribe being hired, the scribe company performed a background search, a thorough interview that focused on interpersonal skills, and testing to determine computer skills and a medical terminology test. Once hired, the new scribes went through both in-classroom and on-the-job training while being paired with a more seasoned scribe.

When you think about it, the economic justification for a scribe is obvious. If a provider's cost runs $1 to $2 per minute, why would you want the most expensive asset sitting behind a computer banging away when they could and should be interacting with patients, i.e. taking care of people and generating revenue?

My own personal experience is that I can see on average about .5 to 1 patient more per hour or 3 to 6 more relative value units (RVUs) per hour using a scribe than my colleagues who don't. One study evaluated 13 emergency physicians over an 18-month period. RVUs per hour increased by 0.24 units, and the number of patients seen per hour increased by 0.08 for every 10% increment of scribe usage during a shift.[2] Even more important, my charts are more complete and are actually all completed at the end of my shift.

In addition, the patients seem to feel more engaged because they hear a narrative about what I am thinking and the medical direction their care is most likely to take when I relate to the scribe. Although it has not been measured in our department, I suspect that our patient satisfaction scores have improved since the advent of scribes inasmuch as the providers focus more time on the patient and less time on the computer.

Here is how I use a scribe:

1. The scribe alerts me to a patient in the triage or exam room and signs me up for it.
2. On the way to the room, the scribe tells me the patient's last visit and diagnosis if applicable.
3. When I enter the room, I introduce myself and the scribe. If my scribe is a female and the exam requires a chaperone, the scribe functions as both.
4. I start asking the patient questions, starting with the chief complaint and then going through the rest of the history. Occasionally, once I get past the HPI, I go into the physical exam and leave the scribe behind to ask ROS, PMH, FH and Social History.
5. After the history is completed, I start my physical exam by organ system. Obviously, I avoid saying anything that I wouldn't want to eventually make their way into the chart; i.e. this foul-smelling, meth-addicted patient has again disproved Darwin by finding his way into our emergency department.
6. Next I discuss my game plan with the patient as the scribe enters it into the medical decision portion of the chart. "Although the only risk factor you have for a blood clot in your lungs is a family history of protein c deficiency, you did present with shortness of breath so I think it is important to make sure you don't have a blood clot in your lungs. With your permission, here is what I would like to do..." I have left rooms where the scribe has said, "You forgot to mention that you were going to do a XXX." I am always amazed at how much medicine they learn while working with a variety of providers.
7. As I am standing in the room, I enter the orders using check boxes on my tablet computer. I will often put in discharge instructions and prescriptions at the same time.
8. Once back in the office, I review what the scribe wrote, make any changes and continue to educate the scribe on alternative phraseology; i.e. always make sure the provider asks about worst headache of the patient's life if the patient presents with a headache, etc.
9. Between patients, the scribe lets me know when labs and images are completed. During procedures, the scribe writes down what I do and during critical care events, records times, interventions, and responses.

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Cost

From my research, the average cost of a scribe is approximately $19 to $24 per hour using an outsourced scribe service. Thus, if your clinic's average net collection is $100 per patient in a 12-hour shift and the clinic has a 20% margin, your providers will need to see about 1 patient more per hour to break even. What this does not account for is the reduction in overtime because the charting will be completed at time of service as opposed to after the clinic closes, the improvement in documentation and E and M coding, and the increase in patient satisfaction.

The downside

1. Cost: Before committing to a scribe service, the practice needs to calculate the ROI. If it is break even, the benefit still outweighs the benefit cost in my mind because the use of scribes should improve patient and provider satisfaction.
2. Medical–legal: The provider is still responsible for the medical records. Thus, if the scribe writes down something incorrect and the provider misses it and still signs the chart, the provider, not the scribe or scribe service, owns any attached liability.

Conclusion

Adding scribes in our department was one of the best decisions we have made. In fact, I may start using two at once to see if I can improve my productivity. Moreover, I really like the scribes. They remind me of how we all used to be when we were in college and medical school and still should aspire to be during our day-to-day profession – enthusiastic, energetic, and thoroughly committed to the practice of medicine. ■

1. The Joint Commission. Use of unlicensed persons acting as scribes. May 18, 2011. http://www.jointcommission.org/mobile/standards_information/jcfaqdetails.aspx?StandardsFAQId=345&StandardsFAQChapterId=66 Accessed April 3, 2014.
2. Arya R, Salovitch DM, Ohman-Strickland P, Merlin MA. Impact of scribes on performance indicators in the emergency department. *Acad Emerg Med.* 2010;17:490-494. Abstract