Scribes Lecture Michael Nielsen MD

Learning Objectives

1. Identify the barriers to providing patient focused visits and care
2. Explain how to design an efficient office workflow with documentation assistance
3. Describe roles staff can fill to improve documentation, orders and workflow efficiency
4. Show studies that support the use of scribes / documentation assistants to improve patient and doctor satisfaction.
5. Discuss rules from Medicare and CMS on the use of scribes in the outpatient setting.

Introduction:

Electronic health record systems have benefits but have placed a significant time burden on physicians to provide documentation and orders. This has led to decreased productivity and physician dissatisfaction and burnout. The average physician will spend over 2 hours per day providing documentation and over 70% of the patient encounter looking at the computer.

Team Documentation:

Scribing is one way to reduce this burden on the physician by utilizing team members such as medical assistants, nurses, transcriptionists or other non physician staff to assist the physician with documenting visit notes.

Benefits:

1. Improved Income - Studies show that physicians can improve patient flow by an average of 12% (avg 2.3 patients per work day) and billing by an avg of 15% through improved documentation leading to significant net practice revenue.
2. Improved physician job satisfaction
3. Improved documentation of the patient encounter

Determine which model will work for you:

1. Clerical Documentation Assistant – scribe assists only with record keeping, proposing verbal orders, scheduling tests and referrals under the direction of the physician. Orders are queue orders for the physician to sign. The assistant can also schedule return visits in the room.
2. Advanced care team model - a trained medical assistant (MA), nurse or PA starts the visit without the physician and may begin documentation of chief complaint and history including PMH, SH, FH and medication reconciliation. Physician then reviews history, medications and provides exam and diagnosis and treatment while assistant documents. Physician moves to the next patient with new assistant while the previous assistant completes the visit with the patient, re-enforces treatment plan, provides updated medication list and schedules follow up.

Challenges:

1. Is your practice ready for additional staffing?
2. Finding the right staff
3. Providing training
4. Will you use templates?
5. Are you comfortable “letting go” of your control of the notes/ documentation?
6. Adequate room space for additional personnel
7. Lack of patient privacy to discuss sensitive matters with the physician
8. Will you need 2 computers in each room to review last note, reports, labs and medications?
9. Will your EHR allow for two individuals to access the same patient chart at the same time?
10. When do you sign the notes, orders and patient charges
11. Staff/ scribe turnover
12. Will you hire and train your own staff or go with a contracted group to provide your scribes?

Implementation:

1. Have a plan and be prepared to change it!
2. Start small
3. Use templates
4. Have 2 computers in the room
5. Sign the notes and orders several times each day
6. Have clinical staff rooming patient ask the patient if there are sensitive items that they might need to discuss with just the physician in the room.
7. Huddle daily – before you start the day and at the end of each day
8. Plan for an hour each week to have a team meeting to discuss how to improve your process and flow.
9. Love being a Doctor again who treats patients and not computers for a living! (and tell your loved ones to expect you home an hour earlier each day)