Virtual Medical Scribes: Making Electronic Medical Records Work for You

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There is increasing buzz around the term "medical scribe" in healthcare today. Medical scribes help meet the growing electronic medical record (EMR) data entry challenge healthcare providers face. Medical scribes reduce providers' paperwork burden, increase a medical practice's net margins, and reduce stress levels for doctors and their staff. They do this by charting patient encounters in real-time during patient examinations, thus reducing significantly the data entry workload that EMRs place on providers. Medical scribes can work onsite or offsite from a HIPAA-secure location, the latter being known as "virtual medical scribes." This article explores the uses and benefits of scribes to give you the background to employ them effectively in your clinic or hospital.

KEY WORDS: **Medical scribes; medical practice management; EMR data management; medical staffing; healthcare innovations.**

Having been in the medical scribe business since 2007, we have noted a lot of buzz surrounding the term "scribe" just in the past year. However, there is still widespread misunderstanding of what a scribe is exactly and what a scribe does for doctors and their clinic staff. Often when providers say they use a medical scribe, what they really are saying is that they have converted their highly trained nurses or medical assistants (MAs) into $12- to $14-per hour data entry clerks. Just as a doctor should never be reduced to having to do hours of data entry, neither should MAs and nurses. Like doctors, nurses and MAs also need to focus on patient in-take and patient care to ensure a well-run and profitable clinic.

A medical scribe is a trained medical information manager who specializes in charting physician-patient encounters in real-time during medical examinations. Medical scribes can work onsite at a hospital or clinic, or from a remote, HIPAA-secure facility, the latter being known as "virtual medical scribes."

The Joint Commission released best practice guidelines in July 2012 for using medical scribes. The Commission's guidelines explain: "A scribe is an unlicensed person hired to enter information into the electronic medical record (EMR) or chart at the direction of a physician or practitioner (Licensed Independent Practitioner, Advanced Practice Registered Nurse or Physician Assistant). It is the Joint Commission's stand that the scribe does not and may not act independently but can document the previously determined physician's or practitioner's dictation and/or activities. Scribes also assist the practitioners listed above in navigating the EMR and in locating information such as test results and lab results. They can support work flow and documentation for medical record coding. Scribes are used most frequently, but not exclusively, in emergency departments where they accompany the physician or practitioner and record information into the medical record, with the goal of allowing the physician or practitioner to spend more time with the patient and have accurate documentation."[1]

THE EMR DATA ENTRY CHALLENGE

But let's back up a moment. Haven't healthcare systems and clinics purchased expensive EMR software packages to make providers and staff more productive? Why talk of medical scribes at all?

There are more than 1000 EMR systems on the market today. With the Centers for Medicare & Medicaid Services continuing to push and underwrite the adoption of EMRs in ever larger numbers, the EMR market is expected to grow to over $6 billion by 2015. EMRs are sold under the promise of delivering greater productivity and efficiency to physicians. But that is not happening.

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Studies by the medical practice management consultancy firm KarenZupko & Associates found that, on average, a doctor documenting a patient visit via the old-fashioned pen-and-paper method took, on average, two to three minutes to complete a single patient chart.[2]

But with EMRs, for the same visit it takes, at a minimum, five minutes to complete the same patient chart; and for less computer-savvy doctors, it can take 10 to 15 minutes. As a result, productive physicians are reporting drops in their patient workloads from 35 to 40 per day to 20 to 25 per day once they adopt an EMR system. (And if they continue to see 35 to 40 patients a day, they have hours of data entry and typing they must then do after hours and during the weekend.) In sum, this is why it is such a struggle for a provider with an EMR system to see half the number of patients he or she once saw in a full day when charting patient encounters on paper.

This drop in productivity not only negatively impacts a medical practice's bottom line, but increases the doctors' and clinical staff's stress levels, knocking out of whack the life-work balance doctors prize so much. And this hit to a provider's productivity has affected not only clinicians, but busy emergency department (ED) doctors as well—approximately half of their time is now spent on indirect patient care activities like charting.[3]

Additionally, the American Health Information Management Association released a report, "Using Scribes in a Medical Practice," that echoes the need for medical scribes: "The time providers spend during a patient visit capturing and entering data rather than focusing on the patient can be a hindrance to the quality of care. One current solution gaining popularity is the use of scribes. Scribes can provide many benefits to the practice of medicine, ultimately impacting the overall quality of healthcare delivery."[4]

One question looming large in healthcare—and largely ignored or unanswered—amidst this EMR adoption push has been: *Who is going to input, organize, and manage all of this patient data?* To date, the answers have run along the lines of: "Well, the doctors, of course! They'll enter it into the EMR themselves. This is the new normal."

Having more EMR software in providers' hands in a well-meaning effort to make them more productive has had the opposite effect.

However, we argue that this approach fundamentally misunderstands what physicians, physician assistants, nurses, and MAs do—and that is *patient care*, not data entry. Asking providers to input hoards of data into EMRs either during or after patient examinations has led inadvertently to doctors having to act as highly paid secretaries for large portions of the day.

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MEDICAL SCRIBES FOR CLINICS: HOW THEY WORK

While most medical scribes today can be found working in hospital EDs, virtual medical scribes have been designed for long-term use by clinicians.

Among the core tasks virtual medical scribes perform during medical examinations for a clinic's providers are:

- Transcribe patient visits for doctors in real-time, using VoIP (voice over Internet protocol) software (e.g., Skype audio connectivity);
- Document clinical information in the doctor's EMR in real-time through a unique user ID and password, per HIPAA;
- Enter relevant CPT/ICD codes into the EMR for billing purposes; and
- Process e-prescriptions in the doctor's EMR.

Virtual medical scribes help providers to design templates to use with the EMR, to ensure maximum efficiency, and can help with referral letters and other tasks as directed by clinic staff. Figure 1 is a detailed illustration of how virtual medical scribes can work for a clinic. Virtual medical scribes learn a medical practice's EMR system within a few days—if they do not know it already—and adapt to the practice's existing IT infrastructure to work as seamlessly as possible with the provider and clinic staff. Virtual medical scribes are most effective when trained for certain high-volume medical specialties (e.g., otolaryngology, orthopedics). Some common questions we encounter when discussing virtual medical scribes, and the subsequent answers, follow.

Does the scribe transcribe everything from the doctor-patient conversation?

No. The scribe is listening in to capture the findings, the plan, prescription, and anything else the doctor directs the scribe to do.

Is the chart ready for review after every patient?

Just as it can take a doctor or MA 5 to 10 minutes to input data into an EMR for a simple patient chart, it can take as long for a scribe. The best practice is to review the charts once before lunch and again at the end of the day.

Do I have to work with a new virtual medical scribe every day?

A clinic will have the same scribe and/or team of scribes working with that clinic for the long term to ensure continuity and a high quality of service.

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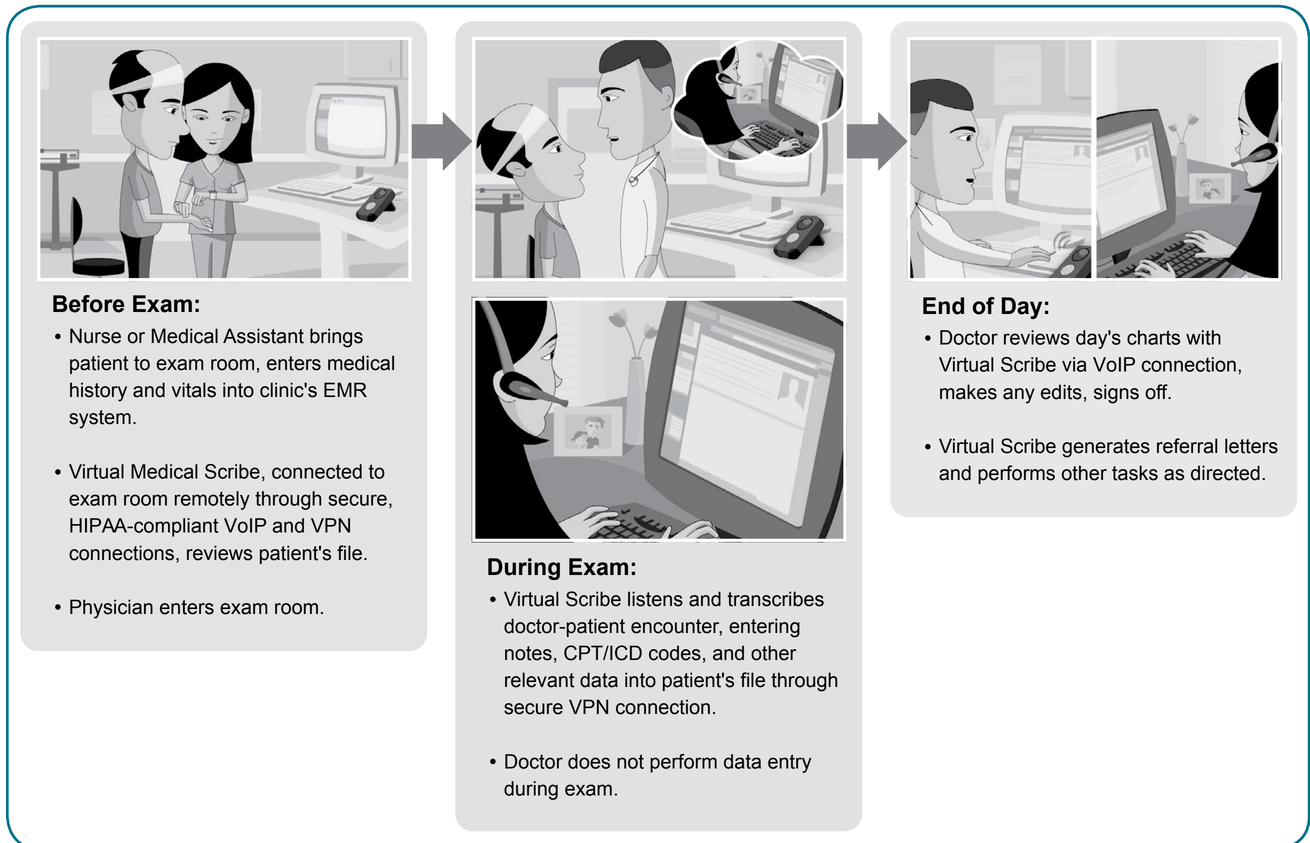

Figure 1. How virtual medical scribes can work for a clinic. EMR, electronic medical record; VoIP, voice over Internet protocol; VPN, virtual private network.

How is the virtual medical scribe service really different from transcription?

A virtual medical scribe is a much more value-added proposition than employing a transcriptionist. In addition to having charts completed in real-time, think of a virtual medical scribe as a virtual assistant who can take care of prescriptions and handle other chores as directed.

PRACTICAL BENEFITS OF HAVING MEDICAL SCRIBES IN YOUR CLINIC

As a practice manager, imagine having medical scribes—devoted data managers—for your EMRs. Scribes will free-up your providers for patient care and other revenue-generating activities. Medical scribes allow the doctors to focus more on the patient to provide a higher level of billable service as well. Moreover, preliminary research shows that patients appreciate the doctor's attention focused on them, and not on the EMR, leading them to refer the physician to family, friends, and colleagues more frequently.

As a physician with a medical scribe, imagine having an extra two to three hours of every clinic day to see more patients—or to go home at a decent hour and to truly leave the paperwork behind at the clinic. Imagine having your EMR system work for you—not you working for it—while keeping your interaction with the EMRs, and the need to type and point and click on patient charts, to a bare minimum.

And as clinic staff, imagine having the burdensome data entry required of an EMR system handled by medical scribes, enabling you and your colleagues to focus on patient in-take and follow-up, and leaving the office at a decent hour without work hanging over your head the next morning. Scribes also can assist with referral letters, index incoming files to the patients' charts, and help with e-prescription.

THE BUSINESS CASE FOR MEDICAL SCRIBES

Let's take as an example a busy primary care physician who sees a high volume of Medicare and Medicaid patients. Using an average reimbursement of $86 per visit, this doctor would see 20 *fewer* patients every week once he adopts an EMR system, a revenue loss of up to $80,000 per year. Clinics that see a large number of Medicaid and Medicare patients simply cannot afford this drop in productivity.

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	Per Eight-Hour Day	Per Week at 4 Days/Week	Per Month	Per Year at 11 Months/Year
Revenue generated by seeing 8 additional Medicare/Medicaid patients per day	$688	$2,752	$11,008	$121,088
Average cost of two scribes at $12/hour (full-time plan)	($240)	($960)	($3,840)	($42,240)
Total Net Benefit	**$448**	**$1,792**	**$7,168**	**$78,848**

Figure 2. Net benefits of using virtual medical scribes. One scribe working an eight-hour clinic day logs, on average, 10 hours of work to complete all patient charts and tasks.

With virtual medical scribes, the same doctor could see more patients per day than he did before adopting an EMR system. Figure 2 shows the cost benefits for a physician who sees an additional eight Medicare/Medicaid patients per day with support from two virtual medical scribes.

BENEFITS OF USING VIRTUAL MEDICAL SCRIBES

Primary care physicians who use a virtual medical scribe can see a significant net effect on their bottom line—over $75,000 per year in this example—while reducing work flow stress and solving the EMR data entry challenges they face.

Specialists (e.g., otolaryngologists, orthopedists) who use virtual medical scribes can see their net revenue increase by $25,000 to $100,000 per year. This is due in large part because these specialists now have the time to see an extra 10 to 15 patients per week using a virtual medical scribe. The revenue boost that results is significant, given the ancillary revenue additional patient visits generate.

Another way to think of medical scribes is as highly skilled EMR data managers.

Additionally, for virtual, or offsite, scribes, the cost advantages are more pronounced than having onsite scribes at your clinic or ED. Offsite scribes require minimal, if any, training; you suffer no absenteeism with them; and overhead costs are eliminated. In terms of cost, an offsite, virtual scribe will cost a clinic $12 to $14 per hour flat; whereas an average onsite scribe costs $16 per hour plus another $8 to $12 per hour in overhead costs (taxes, benefits, training time, computer, electricity usage, desk space, absenteeism), resulting in a total cost closer to $26 per hour or more. Over the course of a year, one full-time offsite medical scribe will cost an office $23,000, while an onsite scribe will cost the same clinic $49,000 per year.

MEDICAL SCRIBES: A NEW WORKFORCE FOR NEW HEALTHCARE REALITIES

Another way to think of medical scribes is as highly skilled EMR data managers. We believe that the billions of dollars invested in EMRs, healthcare mobile applications, and other practice management software tools now need to be matched by a robust investment in an innovative and highly trained workforce to input and manage the data these new software tools require. Providers should not be asked to do it all themselves, and only so much of this work can be automated.

Despite the promises of software and automation, the human touch is still very much needed in healthcare, especially when it comes to the management and safety of sensitive patient data. A new generation of medical scribe workers will not only help providers to make better use of their time with EMRs—and to more securely and productively manage patient data—but will guarantee that patients have the undivided attention of their physician in the exam room, ensuring better patient outcomes.

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