Good Governance Case Study

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ER Scribes Bring Quality to EHR Program

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ORGANIZATION:
Tri-City Medical Center, Oceanside, CA

PERSON INTERVIEWED:
Richard Burruss, M.D., Chief of Staff

Statement of Interest

Today's emergency department physicians struggle to keep pace with growing patient volume in EDs across the country. Additionally, hospitals are facing the difficult but necessary transition from paper medical records to electronic records (EHRs). Once initial kinks in the process are worked out, EHRs are intended to minimize errors and maximize physician efficiency—but this is not always the case. Tri-City Medical Center in Oceanside, CA has found a solution that addresses both growing patient volume and a way to maximize the efficiency of EHRs, while benefiting both the doctor and patient. The hospital hired scribes to work in the ED. Using hand-held, wireless tablet computers that connect to the system-wide electronic health record, scribes record patient assessments in real-time. Physicians are able to spend more time talking with patients and less time dictating and documenting. The scribes are undergraduate, pre-med students who work side by side with the doctors as they examine patients, review lab results, and decide on a course of treatment. The scribes are eager to learn, and the ER provides them with an environment where they see every different kind of patient on a given day.

Description of the Organization

The Tri-City Hospital District was founded in 1957 by a mandate of the residents of North Coastal San Diego County to establish a full-service hospital to serve the needs of the area's growing population. A 397-bed, full service acute-care medical center, Tri-City serves residents of Oceanside, Carlsbad, Vista, San Marcos, Camp Pendleton, Bonsall, San Luis Rey, and areas of Escondido and Fallbrook. The board is made up of publicly elected representatives, and board meetings are open to the public. Arthur A. Gonzalez, Dr. P.H., FACHE serves as president & CEO.

Dr. Burruss, appointed chief of staff on July 1, 2007, is a non-voting member of the board. He was on the medical executive committee for four years, and was previously chair of the Department of Emergency Medicine, which is his specialty.

Transition to Computerized System

In March 2004, Tri-City began implementing a comprehensive, system-wide software application that included a module for CPOE in the emergency room. The original module for physician documentation was found inadequate for optimal coding and billing. Shortly after the initial implementation, the hospital received new a documentation program from the same company that provided the original CPOE system. At the time, about 12 hospitals nationwide were using this new program, but those hospitals actually saw a drop in physician productivity, not the rise they were anticipating. Research done by Tri-City revealed a 27 percent drop in productivity among physicians who used this documentation software.

The hospital needed a real solution to increase efficiency in the ED. The management team found that other hospitals of similar size and patient volume were using scribes, but with a paper system—and these hospitals were actually showing a 30 percent increase in productivity.

Hospital leaders at Tri-City knew they did not want to go back to a paper system, so they began to entertain the idea of joining both ideas into one solution.

An Unusual Solution That Benefits All

Here is how it works: the physician evaluates a patient in the ER with a scribe at the bedside. As the physician takes the patient's history and does the exam, she verbalizes the findings, both so the patient is made aware of the diagnosis and proposed treatment, and the scribe can document it in real-time. It is a simple solution that accomplishes many things that were not accomplished before the scribe program.

Without scribes, the patients were in an "information providing mode" and the physician was in a "receiving" mode. There was little time for back and forth interaction, especially in the high-paced, high-volume ER at Tri-City. Now, when physicians verbalize to both the patient and the scribe, the patient is given much more information and more opportunity to interact with the physician.

With scribes, the patient record is created at the bedside, and is immediately available via the computer network to anyone in the system. It provides real-time documentation that can be accessed by referring physicians or used by any other staff in the ED. It is more accurate and more comprehensive.

> "The scribes are highly motivated and very interested in learning about how medicine really works, and what physicians really do for patients. You can really see them learning and growing as the program progresses.
>
> **—Dr. Richard Burruss** "

The scribes are employed through ScribeAmerica, based in Lancaster, CA. They go through an intensive, two-week training program to learn medical technology, become familiar with ER computers, and practice taking physician notes. They work shifts of eight to nine hours. They can record information by tapping the touch-sensitive screen, writing longhand with a light pen, or plugging the pad into a portable keyboard. Scribes help doctors keep track of patients as they move through the hospital, letting them know when lab tests have been completed or X-rays arrive. The scribes learn quickly, and, according to Dr. Burruss, are more computer literate than the average physician who has practiced for 20 years. And the program benefits the scribe, by providing education, valuable experience, and the potential for a recommendation for medical school or other employment opportunities.

In the Old Days, Room for Error

Before this program was in place, doctors at Tri-City had to dictate patient notes from memory, sometimes at the end of a busy night. A clerk would then transcribe the notes, and patient records were not available until a day or two later. This model is still in place in most hospitals.

This model allows for the occurrence of many potential errors. When the physician takes the patient's history, assumptions are often made about the patient's condition, especially if the physician is hurried. For example, a physician who sees a scar on the lower right abdomen might assume that it is an appendectomy when it could actually be a hernia repair, or vice

versa. When the physician verbalizes the existence of an appendectomy scar to the scribe, the patient has the opportunity to set the record straight.

Secondly, when dictation is done at the end of a shift, physicians must pull these details from memory, when they are tired and rushed. A transcriptionist listens to the doctor's voice, which is often hurried, mumbled, or slurred, so transcription errors may occur. The document created by the transcriber is then reviewed by coders, who search through several pages of free text to find the elements needed to code the chart for reimbursement—providing yet another opportunity for error.

CPOE brought along its own challenges. "We were spending 70 to 80 percent of our time at the computer when we switched to the CPOE," Dr. Burruss said. "CPOE and all these computerized systems are supposed to increase our efficiency, but indeed, it turned out the environment was very click-intensive, and we were spending most of our time at the computer inputting orders, reviewing old records, pulling up lab tests, reviewing X-rays, doing documentation, all at the computer, and very little time at the bedside with the patient."

Improvements in Quality, Patient Safety, and Satisfaction

When documentation is done in real-time, at the bedside, physicians can take more time to describe the problem to the patient and discuss what the treatment plan is, greatly enhancing the patient experience.

Additionally, the electronic record enables physicians to catch allergies, drug interactions, and so forth, with instant access to old records, previous lab results, and X-rays. Dr. Burruss explained, "Sometimes in the ER you're faced with making split second decisions with the information at hand, and before the electronic record, that was a very limited amount of information."

Tri-City has focused this program in the ED for now, primarily because this is the primary department in the hospital where there is a "captive audience" of physicians who have great time constraints, in addition to the need to increase efficiency in the ED.

> Some hospitals have case managers on the floors to review physician documentation. They perform chart reviews, talk to physicians, and educate them on how to document differently. My feeling is that is happening after the problem has already been created.
>
> **—Dr. Richard Burruss**

Dr. Burruss considers the ED program to be a good case study with potential implications for the rest of the hospital. "There was some initial reluctance from a few of the older physicians to embrace the initial computerized system, and even some reluctance about the scribe program. But once they saw the benefits, they have become advocates and supporters. Doctors now look forward to spending time talking to patients. They are able to enjoy practicing medicine again," Dr. Burruss said.

The Bottom Line

The wireless tablet computers used by the scribes were considered a minimal part of the overall program expenses. (Tri-City has about 20 of the tablets, each ranging in price from $1500 to

$2000). The software itself used for documentation was the substantially larger portion of the expense, in addition to scribes' salaries (they get paid about $10 an hour).

However, from a financial perspective, it is imperative to have adequate documentation so the hospital can adequately bill and thus capture appropriate revenue. The hospital no longer has to pay for transcribing costs, causing a huge reduction in the number of days in accounts/receivable because bills are sent out so much sooner. The time-savings for physicians allow them to see more patients, also increasing revenue to the hospital. Tri-City estimates a cost savings of $2.3 million over the next five years.

The Board's Role

Dr. Burruss stressed the importance of the Tri-City board's establishment, from the beginning, of a culture to support patient safety, and one requirement to accomplish that culture was a paperless system. The board provided the vision (including diminishing waiting times and increasing patient satisfaction) and the commitment (by allocating funding) to enhance the ER experience overall, and the scribe program as a huge part of that enhancement.

"Almost 50 percent of our patients experience the hospital through the ER, and this number is going up as more and more patients seek care in outpatient facilities," Dr. Burruss explained. "We are constantly looking to improve our operations, and that's why we investigated this system and proposed it to the board," said Dr. Burruss. "Without the commitment from the board, no computerized system works. You have to have a real commitment from the board, which translates into a commitment from administration and the physicians, in order to make it happen. You have to overcome a lot of obstacles to make something like this happen."

And with the scribe program, Tri-City has accomplished the feat of benefiting all stakeholders, including patients, physicians, employees, and scribes, overcoming many obstacles and never losing sight of the vision.

When you take a pre-med student and put them in the ER, you're showing them an intense environment where they can see patients from the very worst of society and the very best. They see people who are very ill and those who are not that sick—pediatrics, geriatrics, OB/GYN, and orthopedics. They get the full spectrum and that really helps them to know if this is something they really want to do.

—Dr. Richard Burruss

For more information about Tri-City's Scribe program, contact Dr. Burruss at burrussrp@tcmc.com or (760) 724-8411.

References

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