Hate Dealing With an EHR? Use a Scribe and Profits Increase

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Medicine's Best-Kept Secret?

Like many doctors, you may have resigned yourself to life with an electronic health record (EHR): the torturous clicking, the precious minutes ticking away, the patients squirming in their seats as you squint at the screen, and the hour or two it takes you at the end of each day to catch up on your charts.

It doesn't need to be this way.

A growing number of doctors are saying, "Enough!" They are hiring medical scribes to enter notes, test results, and other data into the software while the doctors devote their full attention to their patients. When the visit is done, so is the patient chart, ready for doctor review.

Patients love it. When scribes are used, patient satisfaction scores increase, often dramatically, studies show. [1-3] Doctors love it too. Documentation is so thorough that a higher-level Current Procedural Terminology (CPT) code is often earned. [4] The scribe suggests which codes to use, sends electronic prescriptions to the patient's pharmacy on the doctor's behalf, and generates referral letters to specialists.

Between patients, the doctor reviews the scribe's work in the EHR and does whatever tweaking is necessary. A few moments and it's done.

Asfer Shariff, MD, an ENT surgeon in Toledo, Ohio, as well as Founder and Chief Medical Officer of a scribe service called Physicians Angels, says he is now able to review 15-20 scribe-produced charts in as many minutes in his practice. Without a scribe, he was spending up to 2 hours at the end of each day updating charts in the EHR. "I got my family back," he says.

Physicians who work with scribes see, on average, one additional patient an hour, experts maintain. Despite this greater productivity, at the end of the day, all the charts are done. This is true even for high-volume specialists who may generate 50-75 charts per day. [4] The doctors are free to go home at 5 or 6 PM.

Scribe Boom Sparked by Dissatisfied EHR Users

That doctors are seeking help with their patient records isn't a new phenomenon. Transcription services have been around since the 1960s. In the 1990s, a few doctors hired stenographers to follow them from exam room to exam room, taking dictation and

later typing up a transcript of what was said to file in paper charts. They were known as scribes. But the idea never caught on.

The adoption of EHRs changed all that. Five years ago, only 10% of hospitals and outpatient practices used EHRs. [5] Now, thanks to meaningful use incentives offered by the Centers for Medicare & Medicaid Services, nearly 70% do. [5]

For many doctors, it was and is a marriage made in hell. According to a 2013 report by the RAND Corporation produced for the American Medical Association, "Aspects of current EHRs that were particularly common sources of dissatisfaction included poor usability, time-consuming data entry, interference with face-to-face patient care, inefficient and less fulfilling work content, inability to exchange health information, and degradation of clinical documentation." [6]

Cheryl Toth, MBA, a consultant and writer at KarenZupko & Associates, a practice management consultant in Chicago, Illinois, points out that physicians' initial hopes that EHRs would improve workflow were quickly dashed.

"Research shows a physician using an EHR sees, on average, 11.2 patients fewer per week -- a potential revenue loss of up to $3800 per month -- than before adoption of an EHR," Toth says. [4]

EHRs also cost a bundle in inefficient use of physician time.

"A doctor's cost runs up to $4 a minute or $240 an hour," Shariff observes. "Would you pay $240 an hour to have someone type and click information into an electronic medical record? Would you take your most expensive employees and make them data entry staff? That's what has been happening."

"An EHR is no different from a CT scanner or EKG machine," he offers by way of perspective. "An EHR is a data-acquisition device. You don't see the radiologist operating the CT or the cardiologist operating the EKG. They have technicians, thus allowing their mental energies to be devoted to the interpretation of data and management of the patient."

But if a doctor isn't going to type and click information into the EHR, however laborious it may be, who is? Enter the modern medical scribe.

What Is a Medical Scribe?

The Joint Commission defines a medical scribe as an unlicensed individual hired to enter information into the EHR or chart at the direction of a physician or licensed independent practitioner. [7] Physician practices, hospitals, emergency departments (EDs), long-term care facilities, long-term acute care hospitals, public health clinics, and ambulatory care centers all use scribes. Scribes can be employed by a healthcare organization, physician,

or licensed independent practitioner. They can also be subcontracted from a scribe service.

"A medical scribe shares the provider's burden of data gathering and EHR documentation," explains emergency physician Michael Murphy, MD, Founder and CEO of ScribeAmerica, a scribe vendor based in Aventura, Florida. "In doing so, the physician's individual productivity and patient throughput increase, so that the goal of providing cost-effective, quality medical care is achieved."

"A medical assistant or nurse takes the patient's weight and vital signs and accompanies the patient to an exam room," Toth explains. [4] "The scribe accompanies the physician when he or she enters the exam room and records the history, examination, treatment plan, and other clinical data in real time, while the physician interacts with the patient.

"The scribe does additional typing and other documentation while the physician moves on to the next room," she continues. [4] "At the end of the clinic session, the physician reviews the documentation and makes any corrections to the scribe's documentation and signs off."

"Scribing is not merely listening to a doctor dictate a note and typing it into the EHR," adds Shariff. "It is interpreting the physician-patient interaction and converting it into a concise document with relevant information, then doing appropriate coding to send to the coders/billers, while also creating the letter to the referring physician and doing all the associated tasks."

"The physician-scribe relationship goes beyond transcription," Toth agrees. [4] "For example, scribes remind physicians of treatment plans and other recommendations from previous visit notes and provide a check-and-balance system to ensure visit documentation requirements are met, test results are received, and prescriptions are refilled."

Scribes aren't licensed coders or otherwise licensed, but they do receive from 3 weeks to 3 months of training, depending on the vendor, during which they learn, among other things, clinical terminology and common CPT codes for the specialties for which they are being groomed as well as compliance with Health Insurance Portability and Accountability Act (HIPAA) patient privacy mandates.

Of course, scribes are also trained to use a client doctor's EHR. Typically younger adults for whom computers are second nature, they can click their way through complex software with jaw-dropping speed. Because different EHRs are similar in design, a scribe can generally master a new EHR in about 3 days, Shariff says. Physicians Angels supports over 25 of the most popular EHRs.

Benefits of Using Scribes

Doctors who personally interact with the EHR during a patient visit tend to be minimally communicative with the patient. [6] However, with a scribe in the exam room (or sometimes sitting just outside), the doctor is not only free to verbalize the details of the patient's diagnosis and treatment more completely, the doctor *must* do this so that the scribe understands enough of what is being said to craft a proper note in the EHR while the doctor interacts with the patient in real time.

ScribeAmerica's Michael Murphy calls this a "narrative physical exam" and a "narrative assessment and treatment plan."

"Patients love this," he says. "Even though it's just bread-and-butter medicine, the physicians sound smarter, and patients love the physician's display of intellect. As a result, we've seen patient satisfaction scores go dramatically up."

How dramatically?

"We've had orthopedic surgeons consistently in the 20th percentile in patient satisfaction over 20 years of practice who suddenly leap to the 85th percentile because they do a narrative physical exam while working with a scribe," Murphy says. "Patients like that interaction, the doctors are happier, and they are able to focus on the patients even more."

Physician satisfaction scores, if anything, are even higher. [1,2]

"It's amazing when you see the difference between a dictated note and one that's generated by a computer," marvels William A. Rivell, MD, a family physician in North Augusta, South Carolina, who began using a scribe for the first time last September. "Even if you're using the templates, it just sounds terrible; whereas I can just tell the scribe what's going on, and it comes out much more fluid."

"Scribes create comprehensive, nuanced documentation that might improve reimbursement by allowing a physician to bill a higher level evaluation and management (E&M) code than he or she would have without this level of documentation," Toth explains. [4] "Many physicians gain a sense of security, knowing that their documentation was completed thoroughly and according to regulations and guidelines."

Ironically, this more comprehensive, nuanced documentation results from spending more time with patients and less time with the EHR.

Internist Joshua Brown, MD, lead physician at IMD Practice Management Group, an 8-doctor internal medicine group in Santa Fe, New Mexico, "was overworked and so behind in my dictations that I'd wake up at 4:30 or 5 AM just to catch up," he recalls.

That was 2 years ago. Brown had read about scribes back then, was intrigued, and thought, "Why don't I try a scribe for 10 hours a week and see how it goes."

It went so well that in the first week, he promoted the part-time scribe to a full-time position. Within 2 months, he had hired a second full-time scribe.

"It was very powerful in terms of improving the patient experience tremendously and improving my experience tremendously," he says.

Vascular surgeon Jeffrey Wang, MD, a member of Horizon Vascular Associates, a 5-doctor surgical group in Rockville, Maryland, tried using a scribe last September for the first time. Now his whole group uses scribes.

"The other doctors, who initially may not have been that interested, became very interested very quickly," he recalls. They realized that I was much more efficient. I was getting out on time. It made the office experience in general much better."

A 2013 report in the *Annals of Family Medicine* cited 5 innovations used in high-functioning primary care practices that lead to greater physician satisfaction and doctors who derive more "joy" from their jobs. [8] "Sharing clerical tasks with collaborative documentation (scribing)" was number 3 on the list.

A Godsend for Doctors From the Pre-Internet Era

Rivell, who operates a combination family practice and urgent care center, is part of Doctors Care, the largest chain of urgent care centers in South Carolina. Last July, the company introduced EHRs to its more than 50 centers.

Rivell is 58. Before joining Doctors Care, he had been a soloist for 28 years. He had only done paper charts.

"It was obvious to the office manager and people around me that I was getting pretty frustrated," he recalls. "I don't scream and yell and throw stuff, but I was just bummed out."

"I thought I was a real good diagnostician and great with patients, and suddenly, all that came to a screeching halt," he says indignantly. "I'm the highest-paid guy in the office by a factor of 10, and I'm sitting there whacking away at a computer!"

Emergency physician Thomas Gibbons, MD, President of Doctors Care, based in Columbia, South Carolina, was a personal friend. Gibbons asked Rivell if he would like to participate in a pilot project that Doctors Care was conducting on the use of scribes in urgent care.

"Hell, yes!" Rivell exclaimed.

"In the process of switching over to electronic medical records, it became apparent that it was slowing down our throughput in a large way as far as getting patients in and out of

the office," Gibbons says. "We sell high-quality care in a fast, friendly, efficient manner. It was impacting that. That was the reason we started looking at scribes."

"What I would like to do is have the physician spending more time with the patient and less time with the EHR," he says. "You can have better eye contact. You can focus. You can improve wait times. You can improve throughput times."

Rivell has now been working with scribes for about 4 months. A preliminary verdict?

"I can't say enough about them," he says.

Gains in Productivity as Well as Satisfaction

Research has found significant gains in physician and patient satisfaction with the use of scribes. [1-3,9] In one study, investigators randomly assigned scribes to 5 academic urologists and used surveys to evaluate patient and physician acceptance and satisfaction. [1] They found that patients not only were accepting of scribes, their satisfaction rates were higher (93% vs 87% in the absence of a scribe).

The satisfaction rates of the participating urologists were even higher. [1] "Physicians were dramatically more satisfied with office hours when a scribe was present (69% vs 19%)," the researchers observed. However, they were unable to determine whether the presence of a scribe improves productivity.

But scribes make physicians significantly more productive, most research on the subject has concluded. In a study on the impact of scribes on doctor performance in the ED, for example, 13 emergency physicians using scribes were retrospectively evaluated over an 18-month period. [10] Their relative value units (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.

Until last summer, emergency physician Christopher Hanes, DO, was Director of the Department of Emergency Medicine at St. Christopher's Hospital for Children in Philadelphia, Pennsylvania, which employs 10-15 scribes.

"We saw increased customer service, increased physician satisfaction, and increased productivity of our physicians," he says. "They were able to see more patients per hour or per shift. We had increasing and improved levels of documentation. It was an across-the-board winner."

"Scribes are phenomenal," he says.

Hanes is now introducing scribes at pediatric specialty outpatient practices affiliated with Children's Specialized Hospital in Philadelphia, where he is now Chief Medical Officer.

In one much-discussed study, researchers tracked 4 doctors in a cardiology clinic who saw 129 patients using standard care and 210 patients using scribes during 65 clinic hours each. [2] The number of patients seen with scribes increased by 59%, and RVUs per hour increased by 57%.

While direct contact time with patients was shorter overall when scribes were present, the doctors actually spent more time interacting with patients than they had offering standard care. [2] The researchers' subjective assessment of physician-patient interactions was also higher on visits in which scribes took part.

The ability to see at least 1 additional patient an hour with a scribe is a standard anecdotal claim by scribe vendors that independent research supports. [1-3,4,9,10]

Emergency physician Kevin J. Parkes, MD, Medical Director at San Antonio Community Hospital in Upland, California, which has been using scribes since 2007, says that his providers can see 1-2 additional patients per hour. [11]

Will You Earn More Using a Scribe?

Practice management consultant Cheryl Toth says that paper charts took a physician 2 minutes to complete per patient. [4] EHR documentation requires an average of 3.5 minutes per patient to complete, a 1.5-minute increase.

An extra 1.5 minutes may not seem like much, but it adds up. Assuming that the average patient visit is 15 minutes, it means that you could see 11.2 fewer patients per week, Toth notes, assuming a patient load of about 110 patients per week. [4]

If your average reimbursement is $86 per visit, and you see 11.2 fewer patients a week, you potentially lose $963 per week or $3852.80 per month, she says. [4] The use of a scribe allows a physician to see an additional patient per hour during an 8-hour clinic, Toth says, adding that this is a conservative estimate. [4]

The increase in productivity is about the same for primary care, she says. That means the ability to see a minimum of 8 more patients a day.

Toth figures that with 3.5 clinics per week, 28 additional patients can be seen. [4] (Many KarenZupko clients are surgical specialists who divide their time between outpatient clinics and hospital work.) She assumes a 40%-60% mix of new and established patients. She uses CPT code 99203 (for a level 3 new patient office visit, the Medicare reimbursement for which was $102.95 in 2011, when her calculations were made) and CPT code 99213 (for an established patient visit -- a $68.97 reimbursement in 2011).

Based on these assumptions, Toth calculates that the gross potential revenue per week from being able to see 1 additional patient per hour is $660.50. [4] The gross potential revenue per month is about $2642.

Of course, you must then deduct to cost of a scribe to get net revenue gain. If you've been using a transcription service that a scribe renders unnecessary, the cost of that must be deducted from the cost of the scribe to get the true cost.

Hourly rates for scribes vary from $10 to $25 an hour, Toth says. [4] She thinks $20-$25 an hour for a scribe whom you personally hire to join your staff is more realistic. Add in the cost of benefits -- which typically adds 25% to the hourly wage -- and the cost of a scribe averages $28.12 per hour, she figures.

Total it up, and here's one scenario of how the profits stack up:

Gross potential reimbursement per week for seeing 1 additional patient per hour is $660.50. [4] Toth assumes that transcription is outsourced at $15 per hour, and a transcriptionist works 25 hours per week per physician. It comes to $375 a week per physician. That's money you save; add it back in. Now deduct the cost of the scribe, whom Toth assumes works 28 hours a week for an average rate of $28.12 an hour. The net potential revenue gain with a scribe is $248.14 a week.

"The average doctor using a scribe can see at least 1 more patient an hour," asserts Asfer Shariff of Physicians Angels. "One more patient covers the cost of a scribe and saves the doctor up to 2 hours of typing a day."

Other experts contend that seeing an extra patient every 3 hours is the typical break-even point for scribe use. Different assumptions about the cost of scribes, who range today from $14 to $23 an hour if subcontracted from a scribe vendor rather than hired independently by a practice, account for these variations.

ScribeAmerica's Michael Murphy estimates that you need 2-3 additional patients a day to break even, but he too contends that seeing an extra patient an hour is easy achievable. "Our practices are going from 3 patients an hour to 4, or 4 to 5," he says. "If you're seeing another 8 patients a day, you're budget-positive a significant amount of money."

Scribes Who Are in the Office With You

Some 10-12 vendors offer scribe services, Murphy estimates. Most offer onsite scribes who are physical presences in the office and who shadow you in exam rooms. Once the scribe's role is explained to patients, few object, studies show. [1-3,9] On the contrary, patient satisfaction when a scribe is present usually goes up.

If you're doing a breast exam and the scribe is male, or a prostate exam and the scribe is female, the scribe remains outside the exam room. The doctor usually wears a lapel microphone to maintain communication with the scribe. The scribe typically has a laptop or tablet on which he or she enters notes or test data or scripts into the EHR as the physician details while conversing with the patient.

ScribeAmerica, begun in 2003, is the market leader in scribe services, Murphy, the CEO, claims. He figures that there are currently nearly 10,000 scribes in the United States. Of these, about 3600 work for ScribeAmerica. Sixty percent of ScribeAmerica's workforce is in preprofessional programs for aspiring physicians, nurse practitioners, physician assistants, and nurses; the rest hold 2- or 4-year college degrees and plan to scribe as a full-time career.

Cheryl Toth's calculations are based on a practice hiring its own scribe to join the staff, the cost for which in salary ($25 an hour) plus benefits came to $28.12 an hour. [4] The rate for ScribeAmerica scribes is $20-$23 per hour, depending on the contractual arrangement, total shifts, and other factors. Hiring your own scribe might well cost $25 an hour plus benefits, Murphy agrees. Scribe vendors generally charge less. "I don't feel the market could support that," he says.

Vendor-supplied scribes work for client practices, but they are employees of the vendor, which pays their salaries and benefits. Hourly rates are all-inclusive, although there may be an up-front fee if specialized training is involved.

About 70% of ScribeAmerica clients are EDs. EDs were early adopters of EHRs, Murphy says. Emergency physicians, for whom the pace of work is typically hectic, were the first to feel the pain. Their productivity plunged, as did patient satisfaction, and so EDs became early adopters of medical scribes.

The majority of studies on the cost/benefit ratio of scribes have been conducted by EDs. Those that have been published report dramatic improvements. [9,10]

The remaining 30% of ScribeAmerica clients are outpatient practices. "We have internal medicine, family practice, ob/gyn, orthopedics, hematology/oncology, pain, cardiology, spine surgery, ENT -- you name it," Murphy says.

Scribe vendors recruit, hire, and train scribes for client outpatient practices and hospitals. If one doctor in a multidoctor practice wants a scribe and the rest don't, no problem. It's not necessary for every doctor to buy into the concept. If other doctors change their minds later, as is common, Murphy says, additional scribes can be recruited on as-needed basis.

Scribes Who Work From a Remote Location

A relatively new concept is the virtual scribe, introduced by Physicians Angels, which began in 2007. Virtual scribes aren't physical presences in your office. They are in a remote location -- in this case, Chennai, India -- and you communicate with them via a microphone attached to your laptop or tablet.

If your EHR is cloud-based, as more and more are these days, issuing the credentials for secure access for a remote scribe is a simple matter. If your EHR is on a server in your office, a virtual private network (VPN) must be established. This is a bit more

complicated. However, Physicians Angels has a networking expert work with your local tech support person to establish a secure link.

Once the link is established, the scribe is an invisible presence in the exam room as you speak with a patient, capturing your dictated notes, the patient's responses, test results, and so on, choosing likely CPT codes for your review, sending electronic scripts to the patient's pharmacy on your behalf, generating referral letters, and the like. If you don't want the scribe to hear what is said, simply mute the microphone.

The rate for Physicians Angels virtual scribes is $14 an hour. Scribes are part of a pool of scribes. You may not always get the same scribe, but you do get a scribe with the same training, which is extensive -- up to 3 months, although this is partly due to cross-cultural differences that must be bridged, in addition to learning clinical terminology, coding, HIPAA compliance, and all the rest.

Can scribes in India do as good a job as American scribes? Many people clearly think so. Indian firms are also doing billing and medical transcription for doctors in the United States.

Physicians Angels provides scribes to over 100 US sites with nearly 980 doctors, Shariff estimates. "Most of our work right now is in 3 major categories," he says, "ENT, orthopedics, and urgent care.

"We're starting to pick up a fair number of primary care, pediatrics, and rheumatology practices," he adds. "We're getting 1 or 2 new requests on a daily basis."

The Future of Medicine?

Are medical scribes the next big thing in healthcare? Perhaps. The groundswell of support is growing, vendors maintain.

Three years ago, ScribeAmerica had 1000 onsite scribes in clinics and EDs across the country. Today, it has 3600 scribes in outpatient practices and EDs.

"In the outpatient realm, we anticipate these numbers will double in the next year," Murphy says. "We'll probably have 7000 scribes, or so we're hoping, by the end of 2014."

Physicians Angels' business is also booming. The firm is hiring about 25 people a month in India to be virtual scribes and says it still can't meet the US demand.

"We're well over 100 scribes right now because we're adding them on an almost daily basis," Shariff says. "By the end of this year, we'll have about 350."

Before the scribes finish their training, they are spoken for, he says. There is a mounting backlog of requests.

Shariff offers this perspective on scribe industry growth:

"The majority of our doctors are specialists, which is reflective of the overall economy in healthcare," he says. "Forty percent or more of all doctors are specialists. We're just starting to see primary care doctors come to see us.

"Primary care physicians have been slow to move in this direction. Why? They're not as cash-rich. Surgical specialists pulling in $400,000-$500,000 a year see a faster drop in their bookings and ancillary services when they move to an EHR, and they have the liquidity to experiment with something different.

"Primary care doctors tend to move a little slower because they don't think about numbers in the same way. They think of scribes as an expense. They don't look at scribes as profit and income."

Large health systems often display a similar outlook, Shariff has found.

"As more and more big health systems are gobbling up physician practices, they have dissuaded their doctors from using scribes," he says. "They keep coming back to the fact that scribes are more people whom they have to hire. That's where they're stuck. A lot of them have hiring freezes."

Meanwhile, he says, "the small groups around these big health systems are back to full productivity because we're supporting them with scribes, and we know that their volumes have picked up significantly as a result."

However, Shariff believes that the case for scribes will be made from within.

"Doctors in the large health systems are being asked to take pay cuts and give up certain benefits and privileges because of the cash crunch," he points out. "They are the ones who are starting to push for scribes on our behalf."

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