The Use of Scribes in the Emergency Department

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Scribes have been around as a profession for as long as there has been written language. In ancient times, scribes were learned men (and specially trained women) tasked with the important job of chronicling their civilization’s history, stories, and work. In Ancient Egypt, scribes, or “sesh,” were educated in the arts of writing and arithmetic, for use in teaching and commerce. In Mesopotamia, scribes, or “dubusar,” were trained in a “tablet house” and worked on practical matters, such as administrative and accounting functions, as well as artistic matters, including writing such literary works as the Epic of Gilgamesh.

As societies evolved with written history, the work of scribes evolved with them. In more modern times, the work of scribes could involve copying books, or secretarial duties, such as taking dictation and the keeping of business or judicial records for nobility, cities, or temples. With the advent of the printing press, traditional scribes were forced to evolve into more specialized professionals, such as journalists, accountants, typists, and even lawyers and public servants (Wikipedia, 2012).

In more recent times, the profession of scribes has made a resurgence in the medical world. Though the exact history is unclear, some of the earliest documented scribe programs began in Nevada and Texas, and multiple subsequent companies and programs were developed from their template (Wikipedia, ER Scribes, 2012). As physicians face increasing burdens of administrative work in an increasingly regulated field, more physicians have begun exploring the use of medical scribes who choose to commit to the profession as full-time medical scribes. There are dedicated secondary education programs where certification can be gained through vocational schools, community colleges, or state universities. There are also online certification courses, full-time associate’s degrees, and even bachelor’s degrees for those interested in careers in human resources and hospital administration of medical scribing. Increasingly, medical labor companies themselves hire and train prospective ED scribes in how to be an effective scribe.

What Do Scribes Do?

ED scribes perform a variety of functions with the ultimate goal of maximizing the physician’s workflow efficiency. Emergency physicians are faced with a tremendous cognitive load, often requiring moment-to-moment decisions and actions to move patient care forward. Each additional task, from ordering tests to documenting the history and physical exam, adds a level of complexity to the healthcare setting, increases patient ED length of stay, and increases the risk of medical errors by creating more opportunity for the physician to miss something. The constant interruptions in an emergency physician’s workflow put patient care at risk.

Studies have shown that the time spent by the average emergency physician in charting, documenting, and using an electronic medical record (EMR), to be roughly 30%-40% of the overall time on shift. A well-trained ED scribe can be a tremendous resource by helping to record all of the documentation and related workflow management tasks. The scribe follows the emergency physician into patient’s rooms, documenting pertinent positive and negative elements of the history and physical exam findings as dictated by the physician. They document vital signs and keep track of lab values and radiology results. They can pull pertinent past medical records, enter discharge information, compose work excuse notes, and even handle other documentations to be signed off by the physician.

Scribes can document when consultants were paged and called back, enter findings from re-exams, and limit interruptions by taking information from support staff in the department to the emergency physician. In sum, by handling these adjunct tasks for which physicians have been traditionally responsible, the scribe frees the physician to increase patient contact time, give more thought to complex cases, better manage patient flow through the department, and increase productivity to see more patients.

Scribes are also trained in risk management to avoid potential documentation pitfalls (e.g., when to document “worst headache of my life” and, perhaps more importantly, when not to). They are often trained in billing and coding issues related to documentation so they can give the chart an appropriate level of completion to ensure appropriate billing for a patient encounter. They also focus on pertinent details that the physician can overlook on a busy shift, such as documenting procedures, rechecks, and critical care time.

How Much Do Scribes Cost?

Figures for scribe costs vary widely and depend on the labor arrangements at individual sites. Some physicians elect to hire and train scribes on an individual basis, where the hired scribes will work exclusively with that physician. Some physicians (depending on practice environment factors such as ED volume, EMR availability, ED culture, reimbursement, etc.) elect to have multiple simultaneous scribes to help them manage high patient throughput as safely as possible. Many ED physician groups will contract with medical scribe companies that train their scribes in-house and deploy them to the physician group to cover an agreed-upon number of physician slots.

For example, one ED group may elect to have scribes hired only for the 10 a.m. to 10 p.m. shift on weekdays, while another group may elect to hire full 24/7 coverage for their emergency department. These physician groups will negotiate contract prices with the medical scribe company, which can vary widely based on numerous factors including number of emergency departments covered, quantity of scribe coverage per emergency department, personnel training quality, etc. Some larger emergency medicine groups have developed their own in-house scribe programs rather than contract with an outside company.

Scribes themselves typically earn an estimated $9.25/hour (depending on the business arrangement). The medical scribe profession will likely evolve over time as scribe programs mature and as demand goes up (or down, depending on the national health care climate), and scribes will likely find many different employment options. Some may offer benefits, while others may be more akin to independent contract arrangements. No literature is available on the current state of total average scribe program costs, but this will likely be an area of active research in ED operations.

I’m an ED Director — Should I Invest in a Scribe Program?

The answer is, “It depends.” There are costs and benefits to employing scribes in an emergency department. Each group has to make an assessment if the costs outweigh the benefits of scribe programs. The authors believe that costs are outweighed by the benefits, but some are nonmonetary benefits that can be difficult to measure objectively.

Costs of Implementing a Scribe Program

The costs of implementing a scribe program can be categorized as direct and indirect costs. Among direct costs, the biggest cost in employing medical scribes is the personnel cost in wages and training (including likely turnover, given that many scribes are premedical students who will eventually move on to pursue other career options). Scribes are typically paid $8-$10/hour without benefits, though scribe companies bill emergency medicine groups in the range of $25/hour for full-service scribe programs.

Furthermore, there are costs associated with equipment and tech support needed by scribes in EMR systems (Meyer, H. “The Doctor (and His Scribe) Will See You Now.” Dec. 2010. H&HN [hnmag.com]). For example, you will likely need enough desktop computers to have one per shift plus two backups (in case of technical difficulties) and uniform costs (which are often covered by scribe companies).

Indirect costs are more subtle and related to risk management. It is important that scribes are incorporated in risk management strategies as part of their professional training. One can imagine how it might be dangerous for a scribe

Learning Objectives

After reading this article, the emergency physician should be able to:

- Describe what functions a scribe performs in an emergency department.
- Discuss the benefits of implementing a scribe program.
- Explain the risks and costs of having scribes in an ED.

CME Questionnaire Available Online

The CME test and evaluation form based on this article are located online at www.ACEP.org/focuson.

The participant should, in order, review the learning objectives, read the article, and complete the CME post-test/evaluation form to receive credit.

The deadline for this CME activity is available through March 31, 2015.

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to document a child as “lethargic” based on what a parent describes, when the child may appear well on day 1, only to have the parent return on day 3 with a truly lethargic child.

While there have been no known cases of such discrepancy from misdocumentation by scribes to date, this is a potential risk that emergency physicians need to consider. Another indirect cost is the actual slowing of physician workflow related to scribe incompetence. For example, a scribe who has difficulty composing a coherent note requires the physician to either revise or rewrite every scribe note. Thorough scribe training and experience mostly mitigates this cost, but in some cases it may be necessary to terminate the scribe.

Money Benefits of a Scribe Program

There are several monetary benefits that can be categorized as either direct or indirect.

Direct benefits are those that directly increase revenue as a direct result of having scribes, including:

- Potential for increased patient volume throughput (e.g., instead of seeing 4.2 patients/hour, physicians might see 2.25 patients/hour). For example, at one hospital in Miami, they were seeing 4,771 patients in November 2008 with an average ED length of stay of 381 minutes, prior to hiring scribes. After implementing a scribe program, by December 2010 they had jumped to a monthly volume of 6,700 patients with an average ED length of stay of 284 minutes, or a 25% reduction in time (Meyer).
- Increased RVU/hour (patient as a result of more robust documentation).
- Increased compliance with core measure documentation and the ensuing improvement in reimbursement as dictated by CMS for the coming years.
- For hospitals using EMRs, which will be most of them with the new national mandate, scribes document in real time and allow physicians to leave on time at the end of a shift.
- For hospitals with EMRs, it takes physicians approximately 30% longer to chart compared to paper charting (Meyer), but scribes can make EMR charting faster.

Indirect benefits incurred by cost reductions as a result of having scribes include:

- Medical error reduction leading to decreased costs.
- Medical risk reduction through better documentation. For example, patients will get more thorough discharge instructions. There will be more frequent patient rechecks documented on the chart (since physicians often forget this crucial documentation step).

Nonmonetary Benefits

Many things that have value are not given. Much of the value brought by scribe programs is nonmonetary in nature. Scribe programs tend to increase physician workplace satisfaction by allowing physicians to spend more time on direct patient care and less on documentation and billing issues. They increase patient satisfaction by allowing physicians to have more time giving care and explaining diagnoses and plans of action in detail. Oftentimes, scribes will improve staff satisfaction by assuming tasks formerly reserved for nurses and technicians (e.g., tracking down lab values, informing physicians of updates on radiology results).

Case Study

In our suburban emergency department (approximately ED volume 80,000), we document using a leading EMR system and furnish our scribes with tablet laptops with wireless mice, which they carry with them, all of which requires technical support from time to time.

Our emergency medicine group, which is a large national group, contracts with a scribe company that hires, trains, and schedules scribes to work on the shifts we ask them to work. Initially, we piloted the scribe program on a partial coverage basis during our busiest shift hours, but the results were so positive that we extended coverage for 16 physician-hours a day (we staff 66 hours per day) but elected not to cover our fast-track physician with a scribe because we also employ mid-level providers in the fast track.

We initially launched the scribe program when we had T sheet paper charting. Over the first 6 months of implementation of a scribe program, we had a volume increase of roughly 5%-6%. Our length of stay did not change, but from improved documentation, we noted a level of service improvement of 20%, an RVU/hour improvement of 15% at the site, and significant improvements in both critical care billing and procedure documentation/capture. When we went live with an EMR 21 months later, we would have expected a 20%-30% productivity decrease from the go-live process itself. But with our scribe program, we did not see any productivity decrease.

Overall, our experience with implementing a scribe program was positive. It helped our physicians build throughput capacity, as evidenced by the fact that our monthly volumes increased 20% after scribes were brought on board, but our emergency department length of stay was unchanged.

Our average door-to- doc times have also dramatically decreased from physicians not spending as much time documenting.

There has also been no need to increase physician staffing for this increased volume, nor is there a plan to do so in the short term.

Physicians have welcomed the administrative assistance that allows them to focus more on patient care than documentation. The quality of our charting has, in fact, improved as has the billing level of our charts on average. We document critical care and procedures more often, and spend more time at the bedside performing rechecks.

Some anecdotal evidence suggests that scribes have even helped with core measure compliance. For example, if a pneumonia patient receives antibiotics more than 6 hours after presentation, a scribe provides an extra checkpoint to make sure that the atypical presentation is documented.

On the downside, our physicians do have to go through and proofread the charts, and correct them as necessary. However, that consumes less time than doing all the documentation, especially for physicians who are less adept at typing in an EMR.

In all, most physicians in our group consider the scribe program a worthwhile investment for improving their job satisfaction. As with EMRs, once a scribe program is fully implemented, it is hard to remove it from the ED’s culture.

Summary

Scribes are a significant change to the standard practice patterns of emergency departments. EMRs usually increase the amount of time providers spend documenting patient care, and computerized physician order entry creates new interruptions and workflow impediments. As emergency physicians are required to add more tasks to the list of daily activities during a clinical shift, offloading some of the responsibilities to a personal recording assistant decreases interruptions, increases patient contact time, improves patient satisfaction, and improves physician job satisfaction.

The cost of implementing a scribe program is not inconsequential, and the benefit will vary depending on individual department characteristics. At busy sites with increasing volume, the capacity increase can allow the scribe program to pay for itself with increased average level-of-service billing from improved documentation, slower increase in physician coverage based on improved productivity, and better physician retention/growth stability.