Scribes...old concept-new role

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In light of the many challenges today’s physicians face, their managers are dusting off the old concept of “scribes”. Some providers find that the use of scribes helps them meet increased time demands while maintaining the good quality of care they desire to deliver. Scribes working in healthcare today are assisting physicians with duties that include all aspects of a patient’s visit.

According to the information paper, Use of Scribes, developed by the members of the Emergency Medicine Practice Committee, scribes were used as early as the 1970s during the implementation of electronic records. Scribes’ education and training vary. Some scribes are registered nurses, others are pre-med students, and in some cases, medical assistants. With regards to the electronic health records, physicians have expressed concerns such as, “The focus seems to be on reimbursement instead of the provision of quality care” and “My productivity has decreased, and I am not able to capture the information that I was before we were using the computer documentation.” Due to these and other frustrations, the use of scribes to assist providers with medical record documentation is gaining popularity. According to Lewis in Medical Economics, a scribe can assist physicians by:

- transcribing details of the physical exam
- recording physician’s consultations with patient, family members and others
- navigating the electronic health record
- documenting procedures performed
- checking the progress of and reviewing lab, x-rays, et cetera
- recording physician-dictated diagnoses, prescriptions and instructions for patient discharge and follow-up

Risk Management Commentary

The Joint Commission (TJC) does not support the use of scribes to enter orders for physicians or practitioners due to the additional risk added to the process. Organizations that choose to use scribes are required to demonstrate compliance with a number of TJC’s standards in Human Resources, Information Management, Leadership and Rights and Responsibilities of the Individual.

The TJC standards referenced above include but are not limited to:

- A job description that recognizes the unlicensed status and clearly defines the qualifications and extent of the responsibilities (HR.01.02.01, HR.01.02.05)
• Orientation and training specific to the organization and role (HR.01.04.01, HR.01.05.03)

• Competency assessment and performance evaluations (HR.01.06.01, HR.01.07.01)

• If the scribe is employed by the physician, all non-employee HR standards also apply (HR.01.02.05 EP 7, HR.01.07.01 EP5)

• If the scribe is provided through a contract then the contract standard also applies (LD.01.03.09)

• Scribes must meet all information management, HIPAA, HITECH, confidentiality and patient rights standards as do other hospital personnel (IM.02.01.01., IM.02.01.03, IM.02.02.01, RI.01.01.01)

The CMS directs that scribed documentation services include the following:

• Who performed the service
• Who recorded the service
• Qualifications of each person
• Signed and dated by both the physician and the scribeiv.

Organizations should also review the requirements of third party payers as they may have specific guidelines for the documentation completed by scribes. As the prevalence of scribes increases, the potential for expanded legal guidance grows.

**Risk Management Suggestions:**

The implementation of new or revised processes in an organization such as the hiring of scribes presents new challenges and risk exposures that should be considered and managed appropriately.

Prior to hiring scribes, organizations shouldv

• Review individual state law to ensure compliance and proper use of scribes by physician extenders
• Orient and train the scribes specific to the organization and role
• Complete competency assessment and performance evaluations
• Restrict the use of verbal orders to scribes or by scribes
• Require identification to reduce confusion by patients
• Require all entries in the medical record are signed and dated
• Require providers to review information prior to authentication
• Develop a contingency plan in the event scribe is not available

Today’s healthcare environment of increased regulations, documentation incentives and reimbursement requirements continue to impact providers and organizations. Organizations and providers are searching for resources that will allow them to provide safe quality care while meeting the demands required by multiple regulatory sources.

Scribes may have a new role in healthcare. By applying sound risk management principles to their practices, scribes may enhance a physician’s efficiency and improve patient safety efforts at the same time.

MAG Mutual Risk Management and Patient Safety Consultants invite our policyholders’ questions. If you wish to discuss issues related to this article, or have other questions please call us at 1-800-282-4882, and ask for Risk Management.
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