Improved Healthcare & Increased Productivity with Remote Scribing

SCRIBE | EMR
See More Patients, Do Less Typing

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Introduction

Over the past decade, healthcare has seen a paradigm shift towards going digital. Remote Medical Scribing is one of the results of such a shift. Medical scribes, working remotely, listen to the doctor-patient interaction during a clinical visit, and make a comprehensive medical note, including all the relevant details and leaving out the unnecessary bits of a casual conversation.

Remote scribes, working in a highly secure HIPAA-compliant office, prepare the medical note in real-time. With technology in place, clinicians receive a well-structured document without having to dictate the summary of the clinical visit. The healthcare provider can quickly review the note and approve all the orders, prescriptions, or referrals placed by the scribe.

Healthcare providers usually are not fluent in working on technology-driven EMRs, which they require to access the patient's data and process it. It is tedious, time-taking, and cumbersome for a clinician to work on a computer, doing clerical and administrative tasks. It is why these medical frontline warriors need backend support to help them focus on what they do the best and deliver the healthcare that they wish to.

This white paper discusses how healthcare has evolved from using transcription services to remote scribing, showcasing the qualitative and tangible benefits of having a medical scribe. This white paper highlights how remote scribing has been helping doctors to increase their productivity and see more patients with improved healthcare offerings and streamlined Revenue Cycle Management (RCM).

Additionally, the white paper highlights how facilities providing medical scribe services ensure that their systems and processes are HIPAA compliant through their stringent mechanism in place, avoiding any breach of privacy.

EMR expertise, strong listening skills, quick typing speed, and basic medical knowledge of a medical scribe help the doctor to spare consuming time on data entry. Instead, the provider can then focus on medical decision making. Highlighting the benefits of medical scribes, we strongly recommend to the Primary Care, Urgent Care, Specialists, and Emergency Services alike to arrange for remote scribing services.

History

The Advent of Digitization in Healthcare

In 2009, the federal HITECH Act in the United States offered a provision for incentivizing healthcare providers to adopt the usage of Electronic Health Records (EHRs). These software tools and platforms were supposed to simplify patient record-keeping.

A year later, the Affordable Care Act (ACA), also referred to as Obamacare, came into existence in 2010. The law brought a paradigm shift in medical services towards increased access to healthcare and how healthcare functioned. Consequently, more patients could now see a doctor or a clinician. Approximately 6.3 million Americans were actively signed up for health insurance through the ACA coverage at the end of 2014. The numbers increased to 10.2 million by June 2015.

The Gallup survey highlighted how the percentage of American adults lacking health insurance decreased from 18% in December 2013 to 11.9% in the first quarter of 2015. The surge in the number of people getting insurance coverage steered healthcare into the world of digitization. The initial purpose of simplifying patient record-keeping extended to streamlining the insurance processes.

It implied that the healthcare provider had to document the clinical visit in a manner that the staff can easily code and bill and the insurance provider can conveniently comprehend and approve the claim.

Bottleneck Issues with Technology

With all the significant improvements that digitization brought, including preparing e-medical charts and streamlining filing and approval of insurances, it also presented unique challenges in terms of

documenting the medical information. Notably, clinicians began reporting feeling burdened by the administrative and clerical demands of EMRs.

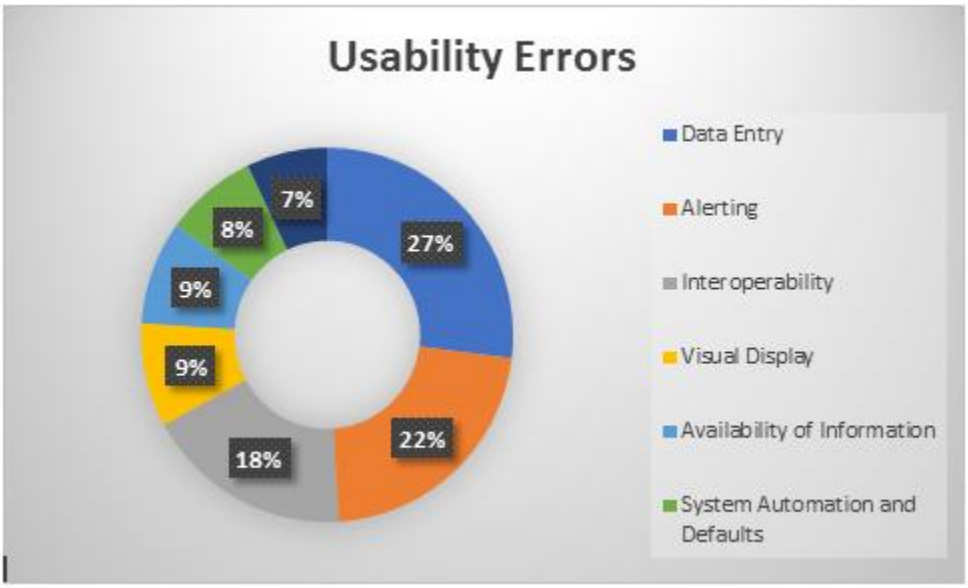

Image: Common issues while using EMR
Source: https://www.truenorthitg.com/ehr-usability-issues/

The documentation of the clinical visit and other work on the EHR/EMR felt so cumbersome and proved time-consuming that it became a primary cause of physician burnout. These challenges gave a tempestuous boon to the medical transcription & scribing industry, which otherwise was present since 1970s.

From Transcription to Remote Scribing

The use of Electronic Medical Records (EMRs) started late 1960s but only became popular in the early 1990s, gradually giving birth to the industry of Medical Transcription. Remote assistance in the form of medical transcriptionists came into being well before HITECH Act and ACA. A doctor would dictate the summary of all the clinical encounters of the day, compile them, and send it to a medical transcriptionist or a vendor providing the service. However, the transcription service could only offer limited support as it was not being provided in real-time.

Further, a doctor had to spend an additional couple of hours to dictate all the patients seen by him in the day. It meant that the turnaround time for the files was 24-48 hours. A transcriptionist would require noting down word-for-word what the provider dictated, which sometimes proved difficult to understand

due to different accents, faulty mice setting, or choppy audio. And it left the scope of a plenty of errors. Longer dictation with technical glitches and higher scope of manual error required another person for QC to sit over the top of a medical transcriptionist, making the files take longer to process.

The concept of having a medical scribe taking notes of doctor-patient interaction during a clinical visit was thought of as a great idea that could resolve a lot of issues. However, having a third person present in the room, who is actually not a clinician, did not appeal to the doctors and patients alike. Hence, remote scribing was brought into existence on the pattern of remote transcription, with the difference being in real-time documentation.

Benefits for Remote Scribing

Transcription vs. Remote Scribing

Documenting on EMR or dictating takes a lot of time for a healthcare provider. These tasks can divert their focus off the patients' care. A medical scribe spares the doctor from spending any time on entering the data. Instead, the scribe empowers the provider to focus on the patient and deliver quality healthcare. Where a transcriptionist requires all the inputs from the doctor, a medical scribe searches the history of a patient using the EMR and pre-chart the medical note before the visit starts, saving a lot of time in giving back the updated information to the provider.

Major points highlighting the benefits of Remote Scribing over Transcription are highlighted below:

	Transcription	Remote Scribing
1.	Turnaround time of files: 24-48 hours	Real-time documentation
2.	The medical note is prepared word-for-word as the doctor dictates.	The medical note, including the HPI and Assessment & Plan, is prepared as a summary while the visit is going on, without any delay.
3.	Relatively higher error rate with proofreading done by a professional appointed for Quality Control (QC)	Less scope of error with Proofreading done immediately by the provider.

4.	Transcriptionist cannot help the provider with placing referrals or orders	A medical scribe can also help the provider with sending prescriptions and placing referrals and orders for lab-work.
5.	Doctors might spend 1-2 hours to dictate	No separate dictation time required
6.	Does not create any impact on the quality of healthcare provided	Significant positive impact on the quality of healthcare provided as the doctor is completely focused on the patient and not on computer

Addressing the Issues

With the advent of Obamacare and other affordable policies, more people sign up for insurance coverage every year, resulting in constant increment in access to healthcare. It implies the provider treats more patients on every passing day. With increased number of patients now seen in a day, a clinician is bound to have stress that would impact its quality of healthcare offering.

Following are the issues that remote scribing strives to address, which concerns healthcare across the United States and all over the world.

- **Reduced Quality of the patient encounter**

  With physicians having to spend 5-7 minutes of a 15-minute appointment looking at the computer and not on the patient, the interaction appears blunt without any visible display of care from the provider.

- **Loss of Revenue for the clinician**

  Physicians increase the time-slot of their appointments to compensate for the time lost while working on computer. Or they try to take extra hours of break to finish documenting or dictating charts. It leads to fewer patients seen in a day, which directly impacts the revenue generation.

- **Clinician Burnout**

  Practically, a clinician takes 5-7 minutes, on average, to document a medical note on EMR in a raw manner. Considering conservatively that a healthcare provider sees 15 patients in a day, he is spending 75-105 minutes in a day that is approximately 2 hours. This finding is consistent with the research studies that have indicated that the physicians, not using scribe services, spend nearly 2 to 3 additional hours per day charting in EMRs and doing data entry.

This additional workload is frustrating for the clinicians, who are usually not familiar or comfortable working with technologically advanced tools. After a busy day at the office, they want to spend some quality time at home with their families. The time spent on documentation prevents physicians from having this leisure, resulting in burnout.

Qualitative Benefits

With the increasing use of remote scribing and growing awareness, patients have started trusting the process and are less concerned about the breach of privacy, a finding that was confirmed in a study done in 2018. The report indicated that nearly 80% of the participating patients trusted their healthcare provider and were not concerned with privacy issues. In fact, other studies are reporting increased patient satisfaction, having their doctor's attention entirely to themselves.

Medical scribes have empowered physicians to enhance their work efficiency by noting down HPI and Assessment & Plan as a well-organized narrative. By the end of the visit, the only thing that doctor has to do is review and sign the orders using a click, and the entire discussion during the appointment is saved and updated in the EMR. And the prescriptions, lab orders, or referrals are sent to the concerned faculty. Medical scribes, offering real-time clinical documentation, help healthcare providers in combating burnout by eliminating their administrative burden post visits.

They allow clinicians to:

- Focus entirely on the patient, not on computer.
- Leave EMR data entry for their scribes.
- Review detailed and updated patient's medical information within minutes of the visit.
- Gain quality time and experience improved engagements with the patient.

Real-time Documentation

Using telemedicine applications, bi-directional audio allows remote medical scribes to document the narrative of the encounter and track quality measures in real-time, completely eliminating charting by the physician.

Avoiding Burnout

A medical scribe takes a lot of pressure off the healthcare provider by cutting down his/her administrative burden. The provider not only stays in a relaxed state of mind throughout the day but also is able to leave the facility on time, spending much needed time with his family, which helps him/her to avoid burnout.

Seamless Medical Charting

The vendor providing remote scribing services will always assign a dedicated expert medical scribe for a particular provider. Professional scribes quickly learn the working style and individual requirements of the clinician, making very few errors and meeting high approval rates. They are experts on working with technologically advanced and robust tools, which allows them to offer updated medical information seamlessly. Hence, remote scribing easily integrates into the provider's existing workflow.

HIPAA Compliance

Medical scribes have access to the patient's data via EMR. HIPAA compliance for using these platforms is essential for safeguarding the sensitive information of the patient. Medical scribes working remotely comply with all HIPAA rules. They work from a secured facility where personal portable electronic devices are prohibited inside the working area. And all computers are equipped with restricted downloading limited access to the Internet.

Improved Patient Interactions

With the scribe documenting relevant medical details comprehensively, the physician is free from all its clerical duties. The healthcare provider can then focus exclusively on what he does the best, i.e., listen to the patient's issues and offer the best treatment in a manner that he intends to deliver. A prospective study in 2013 showed improvements in physician–patient interaction in a Cardiology clinic with enhanced patient satisfaction.

Tangible Benefits

Apart from qualitative offerings mentioned above, remote scribing creates a positive measurable impact on the healthcare facility. From seeing more number of patients to improved revenue, here are the following tangible benefits of having remote scribing services.

Streamlining Processes

Having been trained to listen and accurately chart, a medical scribe offers high-quality EMR charting that allows optimal coding and billing. The medical note is prepared in a manner that the insurance provider can easily comprehend and approve the claim, resulting in faster reimbursement and improved Revenue Cycle Management (RCM).

Figure: Remote Scribing Streamlining RCM

Increased Productivity with More Patients

As a medical scribe completes the chart within a couple of minutes after the visit is complete, it significantly eliminates the forced reduction in patient load. Reduced workload allows the provider to see the patient in a relaxed state of mind, showcasing increased productivity.

A study in 2013 reported the positive impact of medical scribes on 4-cardiologists over 65-working hours. It found that the providers were able to see 81 more patients using scribe services. Other studies indicate that a physician can have increased patient visits per day by 20%-50% while offering extra care with the time saved on not needing to document in the EMR.

A retrospective study in 2013 compared the productivity of 10-cardiologists using scribes with 15-cardiologists without scribes. Physicians with scribes saw approximately 10% more patients per hour. This improved productivity resulted in seeing extra 84 new and 423 follow-up patients. Further, 3,029 additional work relative value units (wRVUs) were generated.

Generating Higher Revenue

The retrospective study of 2013, in conclusion, highlighted the increased cardiovascular revenue of $1,348,437 by the physicians using scribes. Physicians with scribes also generated additional revenue of

$24,257 by creating medical notes that were coded at a higher level. Total additional revenue generated was $1,372,694 at a cost of $98,588 for the scribes. Generally speaking, with 20% of increased patients' visits, an individual provider can contribute an extra $125,000-$200,000 in annual revenue for its healthcare facility.

Value for Money

Economical pricing for remote scribing is based on a monthly rate for full-time providers as well as an hourly rate for those providers that must spend parts of their day performing procedures/surgeries. It means that providers can come to an arrangement where they only pay for how much they use the scribing service.

Saving in-house Resources

With vendors providing all the training and tools to the remote scribe, the primary care facility can save its in-house team from tedious administrative duties, such as giving induction and information pertinent to the specific EMR. Additionally, with scribes working remotely, it reduces headcount, payroll, benefits, and the headache of managing employees in general.

In the times of Covid-19

With medical scribes working remotely, the primary care facility has a few less people as a source or recipient of a potential infection. Reduced staff would definitely help a long way to help in mitigating transfer of Covid-19.

Discussion

Hospitals need to run more efficiently at their peak capacities to accommodate the existing, as well as the newly insured patients entering into organized healthcare. It is where remote scribing comes into the picture and can make things happen. By saving the precious time of the provider, a medical scribe allows the physician to see more patients with reduced door-to-doctor time, thus increasing productivity. With real-time comprehensive documentation, a medical scribe empowers the clinician to exclusively focus on what he does the best. Various studies have shown significant increment in revenue generation through the use of scribing services across clinical settings. Vendors, who offer remote scribing services, provide all the training and tools to their medical scribes. It means that the primary care facility can save its in-house resources and associated cost attached with inducting and training a scribe. All these benefits offered by remote scribing ultimately help the doctor to improve the healthcare quality.

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About ScribeEMR

ScribeEMR, guided by passionate and experienced entrepreneurs, strives to provide simple, virtual, and highly effective healthcare solutions to resolve clinical documentation challenges with focus on significantly reducing data entry time of healthcare providers. We offer dedicated medical scribes, medical coders, referral coordinators, and virtual assistants to help primary care facilities to prepare accurate medical charts and perform optimal coding & billing that is easily approved by the insurance.

Offering Efficient & Convenient Medical Charting Solutions

With ScribeEMR, each clinician is individually paired with a dedicated remote medical scribe who listens to each encounter and enters the encounter narrative into your EMR in real-time. This simple reduction in administrative duties increases both the patient experience and chart quality.

Rigorously-trained Scribes

Offering services in 40+ EMR systems, extensive training is provided to all medical scribes in every aspect of clinical documentation, including managing lab orders, diagnostics studies, prescriptions & referrals.

100% Uptime

In the instances, wherein the primary scribe is not available (Illness, vacation, etc.), every provider is assigned a back-up to ensure uninterrupted service.

No Tech Upgrade Required

Our scribes can leverage the providers' existing telemedicine technology to listen to each patient encounter and capture data directly into their EMR system. A provider or its healthcare facility does not need to upgrade its technology.

Stringent HIPAA Compliance

ScribeEMR complies with all HIPAA rules. Personal portable electronic devices are prohibited inside the working area that has limited access to the Internet. All medical scribes and coders attend HIPAA training through our Learning Management System.

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