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Remote Scribes – Decreasing Physician Burnout

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Introduction

With the advent and development of digital technology, remote services have gained a foothold in every industry. And healthcare is no exception. Remote Medical Scribing is one of the services that brewed due to requirement of the clinicians to create a high-quality medical chart of a patient in real-time. Notably, clinicians have reported feeling burdened by the reporting demands of EHRs—responsibilities that take away from their time and focus on patients. These burdens are so weighty that they have become a chief cause of physician burnout.

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 a well-structured document without a clinician 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.

This white paper discusses how remote medical scribes can:

- Decrease physician burnout,
- Improve their clinical interaction with the patient,
- Help them to leave the facility on time that allows them to spend some quality time at home.
- Overall enhance physician satisfaction

This white paper highlights how remote scribing has been helping doctors to increase their productivity and see more patients with improved healthcare offerings.

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.

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Remote Scribes Decreasing Physicians Burden

Reducing EMR Data Entry Burden

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. 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. 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.

How It Works

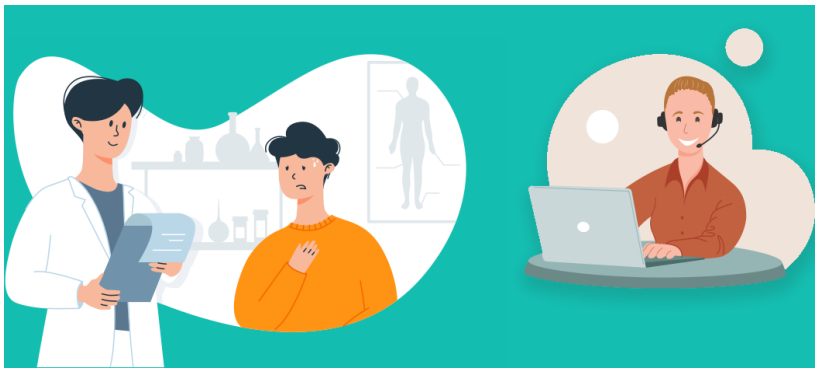
- The primary medical scribe has credentials to enter into the EMR remotely.
- Scribes prep charts ahead of time to complete as much pre-visit work as they can.
- Clinicians log into a telemedicine application for 2-way communication with their scribe.

The Constant Communication

A. Just before the visit, the clinician will inform the remote scribe about the patient to be seen. It is when the Remote Scribe will confirm and verbalize any important patient notes.

B. The provider enters the room. And the scribe begins documenting the clinically significant information from the Clinician-Patient conversation, placing the relevant aspects of the narrative and exam into the appropriate sections of the EMR.

C. While the clinical encounter is in progress, the scribe simultaneously orders labs/scans and prepares prescriptions & referrals to be sent as directed by the provider.



D. After the visit ends, the clinician reviews the chart and signs it, transmitting any order, referral, or prescription that has been placed.

Remote Scribes offer the following benefits to clinicians while working with them remotely:

- **Real-time Documentation**: The medical note, including the HPI and Assessment & Plan, is prepared as a summary while the visit is going on, without any delay.
- **Less Scope of Error**: Proofreading can be done immediately by the provider.
- **More than Entering a Narrative**: A medical scribe can also help the provider with sending prescriptions and placing referrals and orders for lab-work.
- **No Extra Time spent:** No separate dictation time required
- **Improved Healthcare Offerings**: Significant positive impact on the quality of healthcare provided as the doctor is completely focused on the patient and not on computer
- **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.

Improving the Quality of Patient Encounter

Obamacare and other affordable insurance policies have lead to more people signing up for insurance coverage every year. This has resulted in easy access to healthcare, leading to more number of appointments in a day for a healthcare provider. A clinician runs the risk of compromising its quality of healthcare offering with increased number of patients seen in a day.

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.

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.

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.

Decreasing Physician Burnout

Practically, a healthcare provider 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.

Eliminating Burnout

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.

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.

In the times of Covid-19

Physicians, during the pandemic, have been constantly making life and death decisions. However, along with the huge workload with Covid-19 spread, it is the added responsibility of the administrative work has taken a toll on physician’s health and wellbeing.

Physician who have used remote scribing services have had different experience altogether. Their remote scribe would document the symptoms and treatment plan thoroughly within a couple of minutes after the visit. This medical note required minimal proofreading, due to which the physician could spend more time with the patient and could see more number of patients in a day. Remote scribes reduced the time spent by physician on documentation to less than half-an-hour throughout a day.

This increase in efficiency with documentation leads to a decrease in burnout. Healthcare providers have felt that remote scribing has played a critical role in allowing them to focus on and taking good care of their patients during 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

The digitization of healthcare promises significant improvement, including more efficient and more personalized care at lower costs, but it has also brought challenges to the industry. Notably, clinicians have reported feeling burdened by the reporting demands of EHRs—responsibilities that take away from their time and focus on patients. These burdens are so weighty that they have become a chief cause of physician burnout. 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.

Medical scribes have been associated with decreased physician EHR documentation burden, increased work efficiency, and improved clinical interactions. Real-time clinical documentation done by a remote scribe will help physicians to combat burnout by eliminating the administrative burden related to EMR charting and data entry post visits. Remote medical scribes empower physicians to:

- Focus on the patient and not on computer;
- Leave EMR data entry to their scribe.
- Get detailed medical information of the patient within minutes of the visit.
- Gain quality time and improved engagement with the patient.

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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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