EMR Scribes: Real-Time Tech Support Boosts Physician Productivity & Reduces “Paper Care” Hassles

February 2011

White Paper

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Executive Summary

Electronic Medical Records (EMR) are a modern-day solution for physicians who too often find themselves multi-tasked, absorbed in mundane administrative details, and unable to enjoy enough quality time with family and friends.

EMR implementation is spreading quickly in the United States. Yet despite the medical community’s hope that EMRs would bring improved workflow efficiencies and patient care, physicians are finding their EMRs, in fact, reduce their productivity. Research shows a physician using an EMR sees, on average, 11.2 patients less per week — a potential revenue loss of up to $3800 per month — than before the adoption of an EMR. While there are many reasons for this — poor design and many EMRs’ inability to meet the needs of specialists — the fact is existing EMRs have not delivered on their promises.

A new trend in healthcare is the adoption of on-site EMR scribes. An on-site EMR scribe is a clinically knowledgeable staffer who follows the physician throughout his or her entire clinic, documenting pertinent details of each patient visit in real-time. Scribes reduce the amount of administrative work a physician must do and can increase gross revenue by up to $2300 per month.

If the idea of hiring an on-site EMR scribe is appealing, virtual EMR scribes offer many of the same benefits of on-site EMR scribes, but cost less. Virtual scribes are located off-site, often in lower cost markets. They do not replace your office staff; rather, they make the best use of your office staff.

The virtual scribe frees up the physician to interact with the patient, handling the ‘paper care,’ while the physician handles the ‘patient care.’ Virtual scribes also alert physicians to missing test results and remind physicians of medication refills and documentation requirements for billing purposes. Virtual scribes are connected remotely to the EMR in the exam room and all data is stored at the physician’s practice.

The leading provider of virtual scribes is Physicians Angels (www.physiciansangels.com). Physicians Angels delivers a scalable, virtual work force that supports medical offices and hospitals with virtual scribes, virtual file room clerks, and other virtual support staff.

Due to Voice over Internet Protocol and other Internet technologies, virtual EMR scribes present a viable and more cost-effective alternative to on-site EMR scribes. Additionally, virtual scribes create a long-term working relationship with the physician, are ‘portable’ from one location to another, and are less expensive. Challenges to using a virtual workforce are primarily technical and communications-focused, and can be overcome easily with proper implementation and adjustment to new processes and procedures.
Background

Ask a physician to define a good day in the office and what are you likely to hear? “I spent 30 percent of my day on administrative tasks”? “I felt rushed and behind schedule, and I barely had any time for lunch”? Unlikely.

Yet, these challenges are all too real for today’s practicing physician. Multitasked, absorbed in mundane administrative work, and unable to enjoy enough quality time at home with family; these are some of the day-to-day issues that lead to unnecessary stress and inefficiencies for medical practitioners. It’s enough to make a physician feel he or she is more like a fast food line cook than a highly-skilled professional serving the public good.

Electronic Medical Records (EMR) are perceived as one solution to this problem. EMR implementation is spreading quickly in the United States. A CDC survey of around 7,000 practices reports 50.7% of those in ambulatory practice had at least a partial EMR in place this year, up from 48.3 percent in 2009.\(^1\) This is fueled in part by the rebates offered in the Health Information Technology for Economic and Clinical Health Act (HITECH) of 2009. Other reasons include the generally accepted advantages of centralized, digital patient records, such as: 1) easier access for physicians and staff, 2) the opportunity for clinical reporting, 3) clinical connectivity across communities and regions, and 4) improved quality of care.

Despite the medical community’s hope that EMRs would bring improved workflow efficiencies and increased patient capacity, many physicians are finding their EMRs, in fact, reduce their productivity and decrease their interactivity with patients. A recent study of 1,000 physicians conducted by athenahealth and Sermo, a professional online community for physicians, indicates that while 81% of physicians have a very favorable/somewhat favorable opinion of EMRs, 54% strongly agree/agree that EMRs slow down the physician during patient exams. And 60% strongly agree/agree that EMRs distract from face-to-face interaction with patients.\(^2\)

Reasons for this include: poor planning and implementation; poor EMR design and time-consuming EMR user interfaces (only 51% of those surveyed by Sermo feel EMRs are designed with physicians in mind);\(^2\) lack of workflow redesign; an EMR’s inability to meet the needs of specialists; and low technology literacy rates among some physicians.

Kaiser Permanente is one large healthcare provider that has spent or obligated large sums – an estimated $2 billion – on new EMR technologies, according to Daniel Essin, MD. However, Essin argues, “the technology has not enabled their providers to see more patients than before; the productivity standard in some areas has been lowered from four visits to three. A number of the practitioners spend several uncompensated hours per day completing the charting that they didn’t have time to do during normal clinic hours.”\(^4\)

EMR Scribes

Because many medical offices and hospitals do not have the time, budget, or expertise to resolve these issues in the short-term, many are adopting what was initially a stop-gap measure, but is becoming now a compelling addition to patient care: EMR scribes. EMR scribes are a new breed of clinical support staff allowing physicians to exceed their pre-EMR productivity levels and positively impact both physician satisfaction and patient care along the way.
Do EMRs deliver comprehensive clinical documentation that key employees in the hospital unit or practice can access without endlessly chasing down medical charts? Yes. Can EMRs correlate clinical information and generate useful reports that would be nearly impossible in a paper-based environment? Absolutely. These facts are not in dispute.

What is in dispute are the advertised benefits of existing EMRs, which have promised greater efficiencies and more productive time for physicians and their staff, but have not delivered. This paper addresses in greater detail the reasons for this. It also studies the business models and efficiencies of several existing EMR scribe service companies operating today.

The Elephant in the Exam Room

Despite the promise of improved efficiencies, the literature about EMR implementation and adoption indicates that current EMR technologies do not meet the needs of physician workflow. A key reason is most EMRs require that a user manage multiple computer programs or screens, checkboxes, and typing – all of which ends up replacing the time a physician spends with patients with time absorbed in administrative matters. This reduces the highest paid individual in the medical practice – the physician – to a clinical data entry clerk for a significant portion of the day.

One of the many disconnects between EMR design and physician workflow is that many EMRs are designed without sufficient end-user input. EMRs that have been designed for, but never adequately tested with, physicians and nurse practitioners have flooded the market. What are quick and simple tasks for a sedentary programmer – e.g., locating and attaching a document, or clicking through checkboxes in a template – are not so quick and simple for the physician, who must perform them while simultaneously examining a patient, writing a prescription refill, and tasking a medical assistant. Moreover, all of these things must be done within an average of 7-10 minutes, if the appointment schedule is to run on time.

The Productivity Dive

In a pre-EMR environment, physicians wrote notes on paper and dictated the rest. This per-patient, paper-based, documentation process typically took the physician an average of 2 minutes to complete. Per-patient EMR documentation, however, has been found to require an average of 3.5 minutes per patient to complete, due to the data entry and cutting and pasting most EMR templates require: a 1.5 minute increase. And some physicians find they are spending even more time than this. Multiple physician clients of practice management firm KarenZupko & Associates – which has worked with thousands of practices nationwide – report that they spend several hours a day completing their EMR documentation. The amount of time required can vary significantly depending on the EMR tool and the efficiency of the overall practice.

Why Does Physician Productivity Matter to EMR Adoption?

Reduced physician productivity leads to fewer patients seen, bigger backlogs, and lower revenues. Physicians are paid per encounter. So, fewer encounters means fewer dollars to cover staff and overhead costs.

In today’s reimbursement climate – when everyone from CMS to managed care plans are reducing payments for physician services – physicians and hospitals cannot afford this hit to their revenue stream.
Now, setting aside the time a physician wastes with data entry into an EMR, what are his or her economic losses? Assuming the EMR adds 1.5 minutes to documentation time, and assuming a conservative average of 15 minutes per appointment, the physician’s productivity is reduced by approximately 11 patients per week – assuming he or she sees around 110 patients/week and works the same number of hours as before EMR implementation.

### EMR Impact on Physician Productivity

**Before a practice has an EMR**

- **Daily patient load (8 hours/day, 15-minute appointment) =** 32
- **Weekly patient load (assumes 3.5 clinic days) =** 112

**After a practice implements an EMR**

- **1.5 additional minutes x 112 patients/week =** 2.8 hours (168 extra minutes)
- **Per week, per physician productivity loss =** 11.2 patients

Using an average reimbursement of $86.00 per visit, assuming one sees 11.2 patients less every week, this is a potential revenue loss of $963.20 per week, or $3,852.80 per month. In today’s reimbursement climate – when everyone from CMS to managed care plans are reducing payments for physician services – physicians and hospitals cannot afford this hit to their revenue stream.

**Enter the EMR Scribe**

To mitigate the productivity dive and workflow challenges associated with EMRs, a new clinical support role is emerging: the **EMR scribe**.

An EMR scribe is a clinically knowledgeable, technically proficient staff person who follows the physician throughout his or her entire clinic, documenting history, examination, and other pertinent details of each patient visit in real-time. As proficient with technology as they are with medical terminology, EMR Scribes free physicians from cumbersome documentation tasks and allow them to work at their highest and best use: treating patients.

Here’s how the process works: A medical assistant or nurse takes the patient’s weight and vital signs and accompanies the patient to an exam room. 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. At the end of the clinic session, the physician reviews the documentation and makes any corrections to the scribe’s documentation and signs off.
The physician-scribe relationship goes beyond transcription. 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. They also 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. Many physicians gain a sense of security, knowing that their documentation was completed thoroughly and according to regulations and guidelines.

Scribes are often pre-medical or nursing students who find the experience invaluable to their course of study. Some report that the job of an EMR scribe is one of the best on-the-job-training experiences available. Scribes who work for professional scribe companies such as PhysAssist, Physicians Angels, Scribe America, and ScribeMD are finding that being a scribe is a fulfilling career option.

Emergency Departments Lead the Way

A 2008 study by the Academy of Emergency Medicine demonstrated that only 37% of an emergency physician’s time was spent providing direct patient care. That time dropped to 29% when an EMR was implemented. The hospital emergency department (ED) is a fast-paced clinical setting where there is no time to waste – most certainly not the physician’s. So perhaps it’s no surprise that EMR scribes made their first appearance in the emergency room.

At Loma Linda Medical Center in Los Angeles, CA, physicians were spending too much time documenting and not enough time with the patient, according to Robert Steele, MD, and Chief of Loma Linda’s Emergency Department. “The solution was to take the doctors off the computer and put them at the bedside, and let the scribe do the transcription,” says Steele. “It’s been a huge success. The physicians love it.”

At Loma Linda, Steele said doctors used to spend two minutes with a patient, then take four minutes typing the information into the computer. Now the doctor talks to the patient with the scribe present and summarizes the encounter to the scribe in 30 seconds. While the scribe spends three minutes entering the information into a laptop, the doctor can spend extra time with the patient. Scribes can also prepare discharge forms, so they are ready for the doctor to sign.

Seton Medical Center in San Francisco, CA also has seen a benefit to using scribes. According to Jason Ruben, MD, who has helped Seton’s ED and others start a scribe program, “In our case, an ER scribe program has not only made the change to EMR easier, but has improved the quality and delivery of medical care. This occurs because the physician is better able to concentrate on the patient encounter and spend more time at the bedside. As a result, both patient satisfaction scores and physician job satisfaction increases.”
Many Benefits, Some Drawbacks

Indeed, the primary benefit of scribes is that they increase physician productivity, creating a time savings that allows physicians to increase their patient volume. A 2007 study by Emergency Medicine Scribes Services (www.emscribesystems.com), a third-party ER scribe vendor in Santa Barbara, CA, cited ER physician productivity increases of 15-35%, as measured in relative value units (RVUs) per hour, depending on the EMR system in use.

Other data indicate that a physician sees approximately one additional patient per hour when using a scribe. A study of scribe use in the emergency department indicated that an additional .80 patients can be evaluated in a 10-hour shift, using a scribe, generating 24 (2.4/hour) additional RVUs.²

Assuming the metric of an additional .80 patients per hour, if an emergency department physician works 10 hours per day, 3.5 days per week, this is potentially 28 additional patients per week. Assuming an average reimbursement of $86.77 – Medicare's 2011 allowable for code 99284 (Level 4 emergency services) per visit – this amounts to a potential $2,429.56 per week, or $9,718.42 per month.

Patients not only accept EMR scribes – they are more satisfied with their care experience when scribes are present. According to a study published in The Journal of Urology, patient satisfaction rates were 93% with a scribe versus 87% in the absence of a scribe. This same study indicated that physicians also were more satisfied when scribes were present – citing 69% satisfaction rate versus 19% satisfaction rate without a scribe.³

However, the literature does cite some drawbacks to using scribes. First, scribes can prevent physicians from ever having to interact with EMR technology. Some view this as a ‘crutch’ that allows physicians to continue to ignore new technology at a time when executives and professionals in other industries are using technology on their own, without the help of support staff. This should be considered for those hospitals and medical offices that plan to use scribes to ‘transition’ physicians into the use of a new EMR: the ‘transition’ may never occur.

A rotating workforce is another common problem with scribes. Scribes often leave when they finish nursing school or are accepted to medical school, creating ongoing turnover and training issues. One EMR scribe program chair also cited the challenge of getting physicians to give up control of the chart, which some may not want to do.

And last, as with any new program, if implemented poorly, a scribe program can cost more than it gains in physician productivity and revenue.

Scribes Save $600,000 and Win Over Physicians

The leaders of the ED at Tri-City Medical Center in Oceanside, CA created an initiative that has saved them $600,000, generated a billing increase of 10% per provider per hour, and won over physicians. What did they do? They began to use physician scribes in concert with their electronic medical record (EMR). They have seen a 6.45% increase in productivity based on patients seen per hour. The physicians can focus on the bedside and look at the patient while the scribe enters information into the electronic chart. Scribes prepare the discharge forms, including medication reconciliation, so they are ready for the doctor to sign.

Moving Beyond the ED: Scribes in Medical Offices

Although EMR scribes made their first appearance in the emergency room, medical offices also find advantages to hiring them. Robert Dowling, MD, Medical Director at Urology Associates of North Texas, first experienced scribes in the hospital ED, and then decided to use them in his practice to improve productivity. Dowling explains, “The scribe is at the physician’s hip, listens to the history being elicited, and documents in real-time.”

Dowling adds that the physician dictates the exam to the scribe, who enters it on structured note forms. If the scribe and patient are not the same gender, the scribe stands outside the exam room and listens to the dictation. The scribe returns and documents the counseling. The scribe then enters the orders, including medications, and uses the E&M engine to code, and populate the charge interface. Next, the scribe hands a tablet PC to the physician, who does his or her own embellishment, usually a synopsis and/or communication to the referring provider.

Urologist Neil Baum, MD, New Orleans, LA, also sees benefits. He estimates that he is able to see five or six additional patients each full day in the office. Moreover, his E&M coding has moved from levels 2 and 3, to levels 4 and 5, because the scribe is able to be more thorough in documenting the history and review of systems and in recording the nuances of the physical exam. “The new system can be frustrating in the beginning,” Baum says, “but when you see how efficient you become, you will enjoy the luxury of having a scribe. As a matter of fact, when the scribe is absent or on vacation and I have to use the computer, I realize how invaluable she is and how effective the technique is enhancing my practice.”

A family practice group in Fayetteville, NC, says that by using scribes, its physician partners now earn twice the income of the average family practice physician. Randall Oates, MD, who founded Soapware (http://www.soapware.com), an EHR system development company in Fayetteville, declares, “The bottom line is – and I’ll make it real simple – the family practitioner has only to see one extra patient every three hours to cover the cost of the scribe and the technology.”

Benefits of EMR Scribes

- Improves physician productivity and satisfaction.
- Increases patient satisfaction.
- Can enhance reimbursement due to improved documentation.
- Provides quality control to ensure tests are received and prescriptions refilled.
- Eases the transition into a new EMR.
- Provides support to soon-to-retire physicians who will not use the EMR long-term.

Dollars and Sense

In the private medical office setting, the increase in the number of patients seen per hour can be even higher than the .80 per hour in the ED. Feedback from pilot studies conducted by Physicians Angels, a provider of scribe services, indicates that an average of one additional patient per hour, per physician, can be seen when a scribe is used.

The collective experience of consultants from KarenZupko & Associates is that physician clients who have adopted EMRs can spend even more time per patient completing their encounter documentation. In one ‘worst case’ scenario, the physician was spending an additional 10 minutes per patient. Poor product selection, lack of a solid implementation plan, and insufficient training contributed to the inefficiencies.
For purpose of financial illustration, we have estimated conservatively a scribe’s ability to allow a physician to see one additional patient per hour during an 8-hour clinic day. Assuming a 40/60% mix of new/established patients, the following data projects the potential revenue gain in a private office setting. Although the appropriate level of E&M code will vary by specialty and case mix – and payer mix ultimately will determine reimbursement – we have used 99203 and 99213, and the 2011 Medicare allowable of $102.95 and $68.97, respectively, for this model.

**Per Physician Potential Gross Revenue with a Scribe in a Medical Office**

<table>
<thead>
<tr>
<th>Description</th>
<th>Calculation</th>
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<tbody>
<tr>
<td>Number of additional patients possible per 8 hour clinic</td>
<td>8.0*</td>
</tr>
<tr>
<td>Number of additional patients possible per 3.5 clinics per week</td>
<td>28**</td>
</tr>
<tr>
<td>Gross potential revenue per week</td>
<td>$660.50***</td>
</tr>
<tr>
<td>Additional revenue from ancillary services related to these visits</td>
<td>Varies</td>
</tr>
<tr>
<td>Gross potential revenue per month</td>
<td>$2,311.74</td>
</tr>
</tbody>
</table>

*3.2 new patients (assumed as 99203) and 4.8 established patients (assumed as 99213)  
**11.2 new patients (assumed as 99203) and 16.8 established patients (assumed as 99213)  
***Using 2011 Medicare allowable of $102.95 (99203) and $68.97 (99213).

Due to wide variance in ancillary services by specialty, as well as patient and payer mix, the model does not attempt to estimate the additional revenue from imaging, injections, in-office procedures, diagnostic tests, lab tests, product sales, or other ancillary services that would be recommended for a portion of these 28 additional patients.

To apply this model to a medical office, estimate the percentage of visits that result in an ancillary service being delivered, and the average per-patient reimbursement for such services. Add the product of these to the Gross Potential Revenue Model, and it becomes even more compelling.

To determine the net revenue gain of a scribe, factor in the cost of the scribe and the elimination of some or all transcription costs. Hourly rates for scribes vary. Some articles and reports indicate that starting rates for a new scribe are about $10 per hour, with experienced scribes earning about $14 per hour (plus benefits). But anyone familiar with the wages of hospital and medical staff would agree that this is probably too low to attract bright, tech-literate, clinically capable staff for any length of time. A more generally accepted wage range is $20 to $25 per hour, plus benefits. Assuming that benefits typically add 25% to the hourly wage, the estimated total cost of a scribe can range from $25 to $31.25 per hour—an average of $28.12 per hour.

**Net Per Physician Revenue Gain Using a Scribe in a Medical Office**

<table>
<thead>
<tr>
<th>Description</th>
<th>Calculation</th>
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<tbody>
<tr>
<td>Gross potential reimbursement per week*</td>
<td>$660.50</td>
</tr>
<tr>
<td>Plus: Eliminated transcription expense per week</td>
<td>$375.00</td>
</tr>
<tr>
<td>Less: Cost of scribe for 28 hours per week (Avg. of $28.12/hour)</td>
<td>$(787.36)</td>
</tr>
<tr>
<td>Net potential revenue gain with scribe per week</td>
<td>$248.14</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>Calculation</th>
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</thead>
<tbody>
<tr>
<td>Gross potential reimbursement per month</td>
<td>$2,311.74</td>
</tr>
<tr>
<td>Plus: Eliminated transcription expense per month</td>
<td>$1,500.00</td>
</tr>
<tr>
<td>Less: Cost of scribe for 28 hours per month (Avg. of $28.12/hour)</td>
<td>$(3,149.44)</td>
</tr>
<tr>
<td>Net potential revenue gain with scribe per month:</td>
<td>$662.30</td>
</tr>
</tbody>
</table>

*Assumes transcription is outsourced at $15/hour, and transcriptionist works 25 hours/week per physician.
The preceding model is intentionally conservative and does not take into consideration the additional potential revenue from ancillary services ordered for these additional patients. Depending on an organization’s patient and payer mix, patient volumes and/or average reimbursement per visit may be higher.

Increase Cost Effectiveness, Reduce Turnover, Go Virtual

If the idea of scribes is appealing, virtual scribes offer many of the same benefits of on-site scribes, but cost less. And while virtual scribes require different implementation demands from on-site scribes, they are more efficient and cost-effective in the long term.

Virtual scribes are located off-site, often in lower cost markets. Typically, they do not replace your office staff; rather, they make the highest and best use of your office staff. Here’s how it works:

On-site support staff takes the patient’s weight and vital signs, updates medication information, and leads the patient to an exam room. The virtual scribe ‘meets’ the patient and physician in the exam room, using a Voice over Internet Protocol (VoIP) connection.

The virtual scribe simultaneously listens to the visit through a VoIP connection, completes the EMR template screens, and types the dictation. The physician and virtual scribe communicate in real-time using instant messaging via the physician’s computer.

As with the on-site scribe, the virtual scribe frees up the physician to interact, unencumbered, with the patient. Also, like their on-site counterparts, virtual scribes alert physicians to missing test results and remind physicians of medication refills and documentation requirements for billing purposes.

Once the doctor leaves the room, the virtual scribe finishes up documentation directly in the EMR. The chart is then ready for the physician to review and sign off within 10-15 minutes.

“It boils down to this: virtual scribes have saved us time and money. I can do dictation in half the time. And it costs half as much.” - Christopher Perry, DO

Lower Cost, Longer Term Relationship

Toledo Clinic ENT, a practice with two otolaryngologists and a Nurse Practitioner in Toledo, OH, has been using virtual scribes for over a year. “We used to dictate all of our charts,” says Christopher Perry, DO. “It was very time intensive and also expensive to have everything transcribed. It cost us about $30,000 just for the dictation and we weren’t very happy with the process. The virtual scribe is an alternative that lets us work smarter, not harder. I can do dictation in half the time. And it costs half as much. And although saving money is great, we save time too and can spend more time with our families.”

Virtual scribes deliver all of the same benefits as on-site scribes, but at a lower cost and with greater flexibility and consistency. Additional benefits of virtual scribes are:

- Virtual scribes follow physicians from office location to office location, even when offices are far apart.
- Virtual scribes are part of a team which cover a given medical office, so you never need to worry about vacation or sick days; there is always coverage.
- Virtual scribes do not leave for medical school or residency programs; scribing is their full-time career.
- Virtual scribes don’t require flexible scheduling around their school classes.
Virtual scribes do not need to be full time employees; medical offices can scale up, or scale down, on their use of virtual scribes without ‘hiring and firing.’ Virtual scribes are also more cost effective – typically $10 to $15 per hour, with taxes and benefits already included, as they are leased employees.

Virtual scribes saved Perry $15,000 the first year – plus, he spends 50% less time completing his documentation. “It boils down to this: virtual scribes have saved us time and money,” says Perry.

Privacy is Not Compromised

Virtual scribes are bound by HIPAA rules. During a visit, patients sign a statement that they are aware the practice uses virtual scribes. Additionally, practices are discreet about their virtual staff. A sign is posted in each exam room explaining that the practice uses a virtual scribe. Virtual scribes don’t talk during the visit; they send questions using secure instant messages. This causes little to no disruption during the patient encounter. Virtual scribes are connected remotely to the EMR in the exam room — the EMR is not installed at the off-site office — so, all data is stored at the physician’s practice.

At Chico Orthopaedics & Sports Medicine Clinic in Chico, CA, physicians simply tell patients that someone is listening to the visit and recording it. The physicians report that most patients have no problem with this, and there have been no negative comments so far.

Same with Toledo Clinic ENT: “In my experience using virtual scribes with thousands of patients, no one has really had a problem with it,” says Perry. “If they are a little concerned in the beginning of the visit, after they experience it they say, ‘That’s cool.’ In fact, most patients are very impressed. They feel like ‘this doctor knows what he’s talking about. This is cutting

Meet Healthcare’s Emerging Virtual Workforce

The leading provider of virtual scribes is Toledo, OH-based Physicians Angels (www.physiciansangels.com). Physicians Angels delivers a scalable, virtual work force that supports medical offices and hospitals with virtual scribes, virtual file room clerks, and other virtual support staff.

Founded by otolaryngologist Afser Shariff, MD, Physicians Angels launched in 2010 after several years of developing and testing its concepts. In late 2010, the company had numerous practices in multiple specialties distributed throughout the United States using its service.

Physicians Angels follows a rigorous training and mentoring program for its ‘Angels’ – the term the company uses to describe its virtual scribe employees, all of whom meet the requirements of having transcription or life sciences skills, as well as knowledge of medical terminology. Each recruit receives three months of training, which includes anatomy and physiology, and hands-on training in multiple EMR systems. The company’s virtual scribes are compatible with more than ten different EMR tools, including: AllMeds, Greenway PrimeSuite, eClinicalWorks, Sage Intergy, Practice Fusion, IC Charts, and AdvancedMD. Rigid competency tests assure that Physician Angels scribes have the skills and knowledge to fulfill the virtual scribe role successfully. Additionally, as part of their training, Physician Angels’ scribes observe a colleague for one month, before they can assume independent scribing duties.
Another virtual scribe company is Houston, TX-based Virtual Doctor Scribes (www.virtualdoctorscribes.com), which delivers virtual documentation services to the emergency room market. The company’s scribes are actual medical doctors, allowing a higher level of communication and documentation than can be achieved using non-physicians.

A third company, Australia-based Scribes (www.scribes.net.au) allows businesses in multiple industries, including healthcare, to outsource their office online. However, they are not specifically geared to delivering virtual scribe services and are limited to general transcription, medical-legal reports, medical reports, copy typing, and mail merging.

**Overcoming Virtual Challenges**

The most common challenges to implementing virtual scribes are technical and communications-based. If the Internet connection goes down, your practice could be temporarily disconnected.

Poor connections – typically the result of poor bandwidth in the medical office’s physical location – also can be a barrier – e.g., if the call drops or it is hard to hear for transcription purposes. Another connection problem results if the physician moves too far from the exam room microphone. An investment in high quality microphones, which range in price from $120 - $240, typically resolves this connection problem. Also, because they will never visit your office, working with a virtual scribe may seem impersonal for some. But after a ‘warm-up’ phase of just a few weeks, most physicians find they have a similar bond with their virtual scribe as they would with a physical scribe.

Typically, each of these challenges resolves once physicians and staff become comfortable with the new processes and way of working. Practices find that virtual scribes present a forward-thinking, viable alternative to on-site scribes. This happens quickly in the virtual scribe service implementation process.

<table>
<thead>
<tr>
<th><strong>Comparison of On-Site and Virtual Scribes</strong></th>
</tr>
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<tbody>
<tr>
<td><strong>On-Site Scribe</strong></td>
</tr>
<tr>
<td>Shows up for work in your office each day. Typically, in the exam room during patient visits, but sometimes located outside the exam room using a listening device.</td>
</tr>
<tr>
<td>Asks physicians questions directly, while in the exam room with the patient.</td>
</tr>
<tr>
<td>Not available when sick or on vacation.</td>
</tr>
<tr>
<td>Paid at prevailing, local wages.</td>
</tr>
</tbody>
</table>
Conclusion

A 2010 survey showed that a majority of doctors and patients prefer the use of information technology when it comes to managing their healthcare and have high hopes that new information technologies can provide better service. This appears to reflect the larger trend of public comfort with information technology’s ability to bring greater efficiencies to many fields, from education to government services. However, the proliferation of EMRs in hospitals and medical offices has not delivered on doctors’ and patients’ hopes to date. Instead, most EMRs have created workflow inefficiencies, due to a variety of well-documented implementation and user interface issues.

An EMR scribe can alleviate inefficiencies associated with clinical documentation. Data show EMR scribes improve physician productivity and satisfaction, patient satisfaction, and documentation quality. Scribes also might increase reimbursement, while creating more free time for physicians and their staff to enjoy life outside of the clinic.

Currently, EMR scribes are located predominantly on-site in a hospital or medical office. Virtual scribes present a new and viable alternative to on-site scribes, delivering similar benefits at a lower cost, and with a focus on developing long-term relationships with the growing number of doctors they support.

<table>
<thead>
<tr>
<th>On-Site Scribe</th>
<th>Virtual Scribe</th>
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<tbody>
<tr>
<td>Leaves the job once their nursing or pre-med program ends; recruiting and</td>
<td>Does not leave for medical school or residency programs – the virtual team is</td>
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<td>training lag times result in the physician being without a scribe for periods</td>
<td>a continuous workforce that is always trained in the specialty, and on the</td>
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<td>of time.</td>
<td>physician’s EMR. Scribing is their full-time career, creating a long-term</td>
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<td></td>
<td>relationship with a practice and eliminating the downtime associated with</td>
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<td>staff turnover.</td>
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<tr>
<td>Fixed to a given practice or area, given the limitations and expenses of</td>
<td>“Portable” – i.e., a physician connects with the scribe from any office and</td>
</tr>
<tr>
<td>having on-site scribes move to another city.</td>
<td>can ‘go’ with the physician if he changes practices or hospitals. One group</td>
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<td></td>
<td>of virtual scribes can serve a system of hospitals in a wide region or nationwide – all of them following the same protocols.</td>
</tr>
<tr>
<td>Costs $20 to 25 per hour.</td>
<td>Costs $12 to 15 per hour.</td>
</tr>
<tr>
<td>Benefits package may increase the cost of an on-site scribe by 25%.</td>
<td>Benefits are included in the hourly wage.</td>
</tr>
</tbody>
</table>


Conn J. Getting it in writing: Docs using scribes to ease the transition to EHRs. Modern Healthcare. February 8, 2010.


End notes


$86.00 is rounded from $85.96 – which is the average of the 2011 Medicare allowable for 99203 (new patient, Level 3 - $102.95) and 99213 (established patient, Level 3 - $68.97).


