The Solution to EHR Documentation Challenges

Anne E. Frunk

Intro Health Care Info Mgmt.

Tennille Gifford

Abstract

Are medical scribes the right choice in health care organizations? Due to widespread adoption of the electronic health record, clinicians are faced with the burden of increased documentation workloads and less face-to-face time with patients, directly impacting clinician satisfaction. With these increasing demands of administrative work and cumbersome charting requirements, medical scribes are often suggested as part of the solution. This paper will discuss using medical scribes in health care organizations and potential benefits and risks of implementation.

Keywords: medical scribes, clinician satisfaction

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Introduction

EHRs are generally regarded as the vehicle that streamlines workflows, improves documentation, and captures patient medical data in various ways to measure quality outcomes and utilization. The medical documentation is considered the "truth" of the patient's electronic medical record, so much so coders and health care professionals will tell you "If it isn't documented, it didn't happen" ("Guidelines for EHR Documentation to Prevent Fraud" n.d.). On the other hand, one could also speculate if it *is* documented, did it happen? "Providers bill on documentation, not necessarily on the care provided" (EHRIntelligence, 2017).

Today, coupled with the electronic medical record, some health care organizations employ sophisticated IT departments that can automate much of workflow and charting requirements mandatory for clinicians. While there may be "less clicks" in some cases needed to document, it brings questions to the degree of thoroughness and credibility. The balance of accuracy and documentation that supports medical necessity presents challenges. Furthermore, at the same time, we are still striving for innovative approaches to accurately depict medical care despite implementation of the electronic medical record.

In this paper we will explore the implementation of EHRs and the use medical scribes, unintended consequences, and "unexpected possibilities" (EHRIntelligence, 2017). The importance of this paper is to demonstrate awareness of obstacles, both good and bad, when using medical scribes and shed light on strategies for not only successful documentation outcomes but strong clinician/scribe relationships.

The Advantages of Medical Scribes in Health Care

With the adoption of EHRs, one of the unanticipated outcomes was the additional burden placed on clinicians of the extra work to maintain accurate and timely documentation. This also impacted clinician satisfaction and productivity. “More than one-half of all US physicians experience burnout, with primary care physicians having one of the highest rates. Among the largest contributors to burnout is a growing clerical workload” (Gidwani, et al., 2017). To help clinicians address this challenge, medical scribes were introduced to mitigate clinician burnout and increase workflow efficiency.

> When working with a scribe, physicians were much more satisfied with how their clinic went, the length of time they spent face-to-face with patients, and the time they spent charting. These findings suggest that scribes may have a protective effect on physicians well-being. Implementation of team documentation is an important component of achieving the Quadruple Aim, a patient-centered approach to care that also emphasizes improving the work life of physicians. Spending less time on documentation frees up the physician to pursue direct clinical care and care coordination, thus enhancing joy of practice and preventing burnout. In academic centers, scribes provide faculty physicians more time to teach medical students and residents (Gidwani, et al., 2017)

While scribes help complete charting on behalf of the provider, they can also assist with coding the patient visit. In smaller health care systems, primary care, or private practices, the clinician is often responsible for accurate coding by choosing proper ICD, CPT and/or HCPCS codes to support medical necessity to the highest degree of specificity. With the implementation of ICD-10-CM and various annual coding updates, it can become difficult for the clinician to appropriately code each patient visit. Because medical scribes are trained in areas of anatomy,

physiology, medical terminology and technical spelling, disease processes, labs, pharmacology, and HIPAA (American Healthcare Documentation Professionals Group, n.d.) they are well on their way to meeting the fundamental education qualifications required of a certified medical coder.

Medical scribes who are also coders have the skills to document in a methodical structure that supports the level of visit or procedure(s) coded. While EHR templates can guide the medical scribe through HPI (history of present illness), ROS (review of systems), physical exam and MDM (medical decision making), *what* to document and capturing key medical information makes the difference of achieving documentation integrity. According to AHIMA (American Health Information Management Association), with the continued advancement of electronic health records (EHRs), there is increasing concern that a potential loss of documentation integrity could lead to compromised patient care, care coordination, and quality reporting and research as well as fraud and abuse (AHIMA, 2007). In addition, inaccurate documentation and billing can result not only in under payments but potential erroneous over payments. Just because a health care organization was reimbursed for a service rendered does not mean they were supposed to be. Furthermore, not only can scribes assist in documentation integrity but also improve the time it takes to close a chart. According to a study conducted by (Gidwani, et al., 2017) “Physician charting efficiency was measured judging by the time it took to complete or close a chart, or the time between a patient encounter and a physician signing the chart note marked by timestamps in the EHR. Medicare clinical documentation guidelines state charts should be closed within 48 hours or less of a patient encounter. Overall, scribes improved the time it took to close a chart” (EHRIntelligence, 2019). Medical scribes have contributed to clinical documentation improvement, clinician satisfaction, as well as supporting successful implementation or switching of EHRs.

There is a long list of considerations when it comes to implementing and/or switching EHRs. However, medical scribes can help reduce disruptive workflow by becoming EHR super users to help guide the clinicians as they become more familiar with the program. Because medical scribes understand the nature of what is required for documentation, they can also test and work out the bugs when rolling out a new EHR.

Ethical Considerations and Risks Using Scribes

While there are many positives to using medical scribes in health care organizations there are also risks. It is important to have a robust training program in place along with policies and procedures to ensure documentation guidelines are followed. While the qualifications mentioned before are essential, it is also important for the medical scribe to be aware of any organizational reporting requirements. Medical scribes should be included and actively involved in conservations with Quality and RCM (Revenue Cycle Management) departments on how to properly enter and capture data. Various grants, quality measures (e.g., HEDIS, PQRS), incentives and annual utilization reporting such as UDS (Uniform Data System) and OSHPD (Office of Statewide Health Planning and Development) are dependent on accurate documentation. When documenting on the behalf of the clinician, medical scribes should also have their own access and documents should identify portions entered by the medical scribe. Like clinicians, medical scribes need to comply with federal and state laws and documentation guidelines.

Because the chart note is the legal record and ultimately the provider is signing off, it is important for the medical scribe to adhere to their training and not input their own observations and impressions. It is also important for the medical scribe to have an understanding of the conversation taking place between the provider and the patient. In some instances, there could

be documentation errors when a medical scribe transcribed what they thought they heard and not what the clinician said. "It is imperative that any and all entries regarding a patient's health information be completed in the presence of and at the direction of the provider" (AHIMA, 2012). In addition, medical scribes should also avoid copying and pasting and carrying forward from previous notes as short cuts. This could be considered "cloning" and the medical record should have differences in each patient encounter. Palmetto GBA states simply changing the date in the EHR without reflecting what occurred during the actual visit is not acceptable (Palmetto GBA, 2018). When in doubt the medical scribe should always ask the clinician for any clarification before finalizing the chart note. With that said, best practice is to have the clinician review the medical record, any alerts, or tasks completed on their behalf.

The clinician and medical scribe relationship is valuable and there needs to be a level of trust and mutual respect between the two. If the clinician does not trust the medical scribe or respect their role, they may not want to use the scribe during their patient visits. This can sometimes be difficult for clinicians as they may not work with the same medical scribe on a daily basis. For clinicians who do not wish to use medical scribes and organizations who employ clinicians whose work hours can vary, it can become a difficult task to manage medical scribe schedules. However, this may not be avoidable and it is a good idea to cross train medical scribes in other areas such as front office, patient education, medical records (HIM) and other clinical/administrative duties. This can benefit the organization but also add value to the role of the medical scribe as well as increases adaptability.

Conclusion

The successful use of medical scribes can vary from one organization to another. It's important to evaluate your scribe program and benefits that it can offer and you can also tweak

different aspects to meet your own organizational needs. Equally important is that we study the effects and set goals as well as monitor metrics. For example, a key metric is reviewing clinical time vs. administrative time. As discussed previously, these metrics coupled with overall clinician/staff satisfaction can improve workflows and reduce clinician\staff burnout.

While the use of scribes may not make sense for all health care organizations, the popularity of medical scribes has skyrocketed. Scribes are currently being used in more than 1,000 hospitals and clinics across 44 states. It is estimated that by 2020, there will be 100,000 scribes in the United States, or 1 scribe for every 9 physicians (Gidwani, et al., 2017). In conclusion, medical scribes are proving to be integral part of providing health care today and going into the future.

References

AHIMA. (2007). Integrity of the Healthcare Record: Best Practices for EHR Documentation (2013 update). Retrieved from http://bok.ahima.org/doc?oid=300257#.XZEfk0ZKjIU.

American Health Information Management Association (AHIMA) is a well-known credible professional association that delivers education and best practices on coding and clinical documentation standards. This particular article describes various scenarios and considerations for data integrity in the medical record. This is a reliable source for understanding a high-level overview of best documentation practices.

AHIMA. (2012). Using Medical Scribes in a Physician Practice. Retrieved from https://library.ahima.org/doc?oid=106220#.XZKst0ZKjIU.

I chose another writing by American Health Information Management Association (AHIMA). This article describes the use of medical scribes in the health care industry and gives examples of their roles and responsibilities. This article also includes the benefits of medical scribes and summarizes different areas they can be helpful. This information was useful in researching how medical scribes can be utilized but also what is required when exploring training programs.

EHRIntelligence. (2017, May 18). EHRs and meaningful use: Unintended consequences, unexpected possibilities. Retrieved from https://ehrintelligence.com/news/ehrs-and-meaningful-use-unintended-consequences-unexpected-possibilities

EHRIntelligence is an online resource for the latest news and product information about EHRs, ICD-10, HIE, and other health IT-related issues facing ambulatory and acute care facilities. It is a hub of multiple resources and current articles. This particular article was useful for my research because it described both the positives and negative consequences of implementation of the electronic medical record. The information outlined was considered when analyzing medical scribes as a remedy and/or risk.

EHRIntelligence. (2019, June 20). Scribes Improve Physician Satisfaction, EHR Clinical Documentation. Retrieved from https://ehrintelligence.com/news/scribes-improve-physician-satisfaction-ehr-clinical-documentation.

This article was used as a resource to explain the beneficial outcomes of using medical scribes in the health care industry to alleviate some of the administrative burdens and provider burnout. The author highlighted different areas of chart completion, more face-to-face time with patients, and findings of improved clinician well-being.

Gidwani, R., Nguyen, C., Kofoed, A., Carragee, C., Rydel, T., Nelligan, I., … Lin, S. (2017, September). Impact of Scribes on Physician Satisfaction, Patient Satisfaction, and Charting Efficiency: A Randomized Controlled Trial. Retrieved September 29, 2019, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5593725/.

The authors are primarily physicians who study primary care and population outcomes. The research described in their studies speaks to actual results and impacts of medical scribes compared to visits without medical scribes. This information was useful in my paper to provide clinical results illustrating the use of medical scribes. It was important that this was written from a clinician’s perception.

Guidelines for EHR Documentation to Prevent Fraud. Appendix B: Case Studies. (n.d.). Retrieved from http://library.ahima.org

Medical Healthcare Documentation Professionals Group. (n.d.). Medical Scribe Training & Implementation Program. Retrieved September 29, 2019, from https://ahdpg.com/services-staffing/medical-scribe-implementation-service/.

The author outlined medical scribe training programs and the potential skill and education requirements. When considering using medical scribes in the health care industry, we also need

to consider what it will take to successfully implement a program. This article highlights the education and skills required to employ a medical scribe as well as various training curriculum.

Palmetto GBA. (2018, May 2). Medical Record Cloning. Retrieved from https://www.palmettogba.com/palmetto/providers.nsf/DocsCat/Providers~Railroad Medicare~EM Help Center~Medical Review~8MKQK88358.

The author of this article, also known as CMS (Centers for Medicare and Medicaid) speaks to documentation integrity and avoidance of committing fraud. The article described documentation risks and gave examples of what not to do when using the electronic medical record. The information provided was another tool to consider for scribe training programs.