Policy: Use of Medical Scribes

ORGANIZATIONAL: Affects two or more departments.							
Folder	Organizational Choices: Health Information Mgmt			**Sub-Folder** (If Applicable)	**n/a**		
Original Effective Date	11/1/2019	**Scope**	*What departments does this policy apply to? State "All" as is may apply to the entire organization.* *All*				
Approved (Approver/Date)	MDRC: 2/20/2020; MEC: 2/25/2020						
Last Reviewed/ Revised Date	2/25/2020	**OSHA Category** (If Applicable)	Not Applicable	**Standard** (If Applicable)	*n/a*	**Number of pages**	5

PURPOSE:
To define the use of scribes by Southeast Health physicians/providers to ensure medical record completion fully and accurately reflects the patient's care and in accordance with federal, state, accreditation requirements. The primary goal of utilizing a scribe is to increase the efficiency and productivity of the provider while enhancing the patient experience.

GUIDELINES:

- Scribes must agree to adhere to the Southeast Health *Use of Medical Scribes* policy and sign the Southeast Health Scribe Agreement (see Appendix A) prior to performing scribe services.
- Scribes are present during performance of clinical services provided by a physician or licensed independent practitioner and document at the time of the encounter, on behalf of that provider, verbatim the services and observations of the provider without applying any clinical insight or interpretation. "The scribe does not act independently, but simply documents the physician's dictation and/or activities during the visit" (WPS/Medicare, 2011).
- A scribed note must accurately reflect the service provided on the specific date of service.
- A scribe's note may be handwritten, dictated, or created/typed directly in the EHR.
- Scribed documentation must insert an attestation that clearly provides the name of the scribe (with credentials when applicable), their role (i.e., scribe), and the provider of the service. EX: This note has been scribed by Firstname Last, CMSP, in the presence of and under the direction of Dr. John Smith.
- Scribes are required to notify the provider of any alerts triggered by the EHR; all alerts must be addressed by the provider.
- Providers and scribes are required to document in compliance with all federal, state, and local laws, as well as with internal policy and Medical Staff Bylaws and Rules and Regulations.

- The provider is ultimately responsible for all documentation and must attest that the scribed note accurately reflects services provided. EX: I, Dr. John Smith, have reviewed and agree with the above documentation.
- All documentation must bear an appropriate authentication, to include signature (may be electronic), along with date and time of signature. Authentication may not be delegated.
- Charges are never submitted for services provided by a scribe. Charges may only be submitted for services performed by the provider or clinical staff according to privileges.
- Failure to comply with this policy may result in corrective and/or disciplinary action (see Compliance section below).

PROCEDURE:

Definitions:

Scribe – an individual present during a provider's performance of a clinical service and documents on behalf of the provider everything verbalized during the course of the service. Any individual serving as a scribe must not be providing care to the patient in any clinical capacity and is not permitted to interject personal observations or impressions.

Verbatim – capturing in documentation the exact words stated.

Process:

1. Any individual who desires to serve as a scribe must review the Southeast Health *Use of Medical Scribes* policy and sign a Southeast Health Scribe Agreement. The requesting provider must also sign the Agreement, which is then submitted to their respective Southeast Health Practice Manager for sign-off.
2. The scribe will meet with the HIM Director to receive instruction in how to adhere with the documentation and signature elements and requirements of the Southeast Health *Use of Medical Scribes* policy, including insertion of the scribe attestation. The HIM Director will sign the Scribe Agreement and submit a copy to Human Resources.
3. A scribe may not begin performing services as a scribe until the Agreement is finalized.
4. Once approved, the scribe will accompany the provider into the exam or procedure room and document verbatim services described by the provider directly into the medical record.
5. The scribe must alert the provider of any alerts that arise during generation of documentation.
6. Once the note is complete, the scribe will apply their attestation and forward to the provider.
7. The provider is required to review the documentation for accuracy, make any required revisions or addenda, and then authenticate (electronically sign) the documentation by insertion of the provider attestation.
8. If a scribe changes departments, a revised scribe agreement should be submitted to the new practice manager and to HIM.

Scribes can:

- Assist the provider in navigating the EHR

- Locate prior notes, labs, or imaging for the provider to review
- Enter documentation into the EHR for the specific date of service of the encounter under direction of the provider
- Create reminders for the provider through Message Center

Scribes cannot:

- Take or enter any orders
- Translate for patients
- Handle bodily fluids
- Touch patients
- Act independently without direct clinical oversight
- Conduct other duties while serving as a scribe
- Be the final author/signature on a note

NOTE: The patient has the right to refuse having the scribe present. If a scribe is credentialed or licensed for a clinical role with Southeast Health, he or she may act within their scope of duties and/or applicable licensure.

Compliance:

- All Southeast Health representatives, including employees, contracted staff, students, volunteers, credentialed medical staff, and individuals practicing care at Southeast, must comply with this policy and are responsible for ensuring that all other Southeast Health representatives comply with this policy.
- Random audits will be performed of documentation generated by each scribe. At least 10 records per scribe will be reviewed quarterly for compliance by the HIM Department. Results of the audit may determine more frequent monitoring and auditing is needed, to be addressed at the time of the audit. Results will be shared with the Regulatory Compliance Committee.
- Suspected violations of this policy will be reported to the HIM Director, the Compliance Officer, or the Director of Quality for further investigation.
- Individuals who violate this policy will be subject to appropriate disciplinary action, up to and including termination.

REFERENCES:

AHIMA. (2012). Using medical scribes in a physician practice. *Journal of AHIMA, 83*(11), 64-69.

Tenet Health. (2015). Scribes in the hospital provider-based setting. Retrieved September 6, 2019, from: https://www.tenethealth.com/docs/default-source/old-documents/policy---comp-rcc_4-62_scribes_in_the_hospital_provider_based-setting.pdf?sfvrsn=fb002db7_2

University of Rochester – Strong Memorial Hospital. (2018). Use of medical scribes policy. Retrieved September 6, 2019, from

https://www.urmc.rochester.edu/MediaLibraries/URMCMedia/compliance-office/education-tools/documents/Policy-0-3-4-Use-of-Medical-Scribes.pdf

WPS/Medicare. (2011). Guidelines for the use of scribes in medical record documentation. Retrieved September 6, 2019, from https://www.acep.org/globalassets/uploads/uploaded-files/acep/clinical-and-practice-management/resources/reimbursement/wps---guidelines-for-the-use-of-scribes-in-medical-record-documentation.pdf

Attachments: (Label as Appendix A, B, C, etc.)

Appendix A

Southeast Health Scribe Agreement

I hereby certify that I have reviewed the Southeast Health *Use of Medical Scribes* policy. I understand that as a scribe I am:

- Required to be present during the provider's performance of clinical services and document verbatim on behalf of the provider during the course of services
- Not permitted to see the patient in any clinical capacity nor interject my own observations or impressions

Documentation I scribe must clearly provide my name (with credentials when applicable), identify my role as scribe, and state the provider of the service for whom I am scribing.
EX: The above has been scribed by First Last, CMSP, in the presence of and under the direction of Dr. John Smith.

I am aware that documentation in the electronic health record requires use of my own log in and password and that any documentation I generate must be clearly identified as documented by me. Documenting under another individual's log in is prohibited.

If the above-noted scribe is credentialed and licensed for a clinical role with Southeast Health, he or she may act within their scope of duties and applicable licensure.

_____	_____	_____
Scribe Printed Name	Signature	Date

I, the undersigned provider, agree that the scribe identified above will only perform duties as described within the Southeast Health *Use of Medical Scribes* policy. I also agree that I am solely responsible for the accuracy, review, and authentication of all health record information captured and/or entered by the above-named scribe. I will include an attestation that I have reviewed all documentation created by said scribe and agree with its accuracy. EX: I, Dr. John Smith, have reviewed and agree with the above documentation.

_____	_____	_____
Provider Printed Name	Signature	Date

The above-named individual is approved to provide scribe services in accordance with the Southeast Health *Use of Medical Scribes* policy for the above-named provider.

_____	_____	_____
Practice Manager Printed Name	Signature	Date

The above-named individual has received instruction in electronically completing documentation, including application of appropriate signatures, as well as adhering with the Southeast Health *Use of Medical Scribes* policy for the above-named provider.

_____	_____	_____
HIM Director Printed Name	Signature	Date