Medical Scribes: A Provider Focused Investment
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Purpose: We started the Trauma Scribe Pilot Program in response to feedback from our division’s attending surgeons, Advanced Practice Providers, and residents regarding the burdens and high demands of documentation in a modern Level I Trauma Center. Juggling direct patient care and clinical decision making with the never ending, behind the scenes work of Electronic Medical Records led to our providers sacrificing time with patients and staying late after their shifts to complete notes. With the hope of alleviating some of the burdensome documentation duties associated with these daily notes, a full-time medical scribe was hired by the department with the initial goal of creating more time for providers to work directly with patients, collaborate with colleagues, and take care of themselves. While there has been an increasing demand for scribes around the country in a variety of medical fields including Emergency Medicine, we believe that our pilot program provided the first fully devoted scribe to an Inpatient Trauma and Critical Care Surgery department in the country. This session explores the process of starting the program and the challenges that were met along the way in addition to a qualitative and quantitative review of the new scribe program’s progress. It is our hope that trauma departments around the country can learn from our use of scribes, as it provided significant performance improvements for our team at a very low cost.

Resources: In order to accomplish this project, we created a pilot program through our organization’s budgetary process. We performed a needs analysis, researched the topic, and submitted a proposal. Our overall anticipated budget was estimated around $30,000 per year as a scribe’s salary starts around $13 per hour. On-boarding and maintenance costs of the scribe were significantly less than other providers (attending surgeon, advanced practice providers). Through collaboration with other hospital department with pre-existing scribe programs, the Department of Trauma & Acute Surgery was able to hire a scribe with some previous experience and training. With the help of the providers, the scribe was trained to meet the department’s documentation standards and learn the inpatient hospital flow. It was necessary for the scribe to complete any Epic, HIPPA or related trainings that are required of other department providers.

Description: The trauma scribe worked 40 hours per week, arriving each day before morning rounds and leaving in the late afternoon. Duties included preparing daily progress notes and discharge summaries for all of the providers working on the acute care unit during rounds in addition to traveling to the emergency department to document all incoming trauma activations and prepare the H&P admission notes. In addition to these regular daily duties, the scribe picked up additional administrative tasks such as answering phone calls in the provider workroom, relaying pages, updating patient lists, and training incoming residents on department workflow and documentation standards. After six months, the scribe trained a new hire over a course of 3 weeks and was subsequently replaced without significant disruption. We are currently looking to hire additional scribes for evening shifts and are considering a collaboration with the hospital’s emergency department to share some of the benefits of our scribes.

Effectiveness: The scribe positively affected documentation proficiency in our department, providing a 5% increase in billing levels for progress notes and an 8% increase in billing levels for discharge summaries than during the same date period of the year prior. 11 providers within the department including attending surgeons, advanced practice providers, and residents completed a qualitative survey regarding their time with the scribe. They reported decreased charting time by over two hours per day in addition to improved documentation accuracy, completeness, and standardization. Providers also reported improved workplace and team satisfaction, positive impacts to their patients’ experiences under their care, and increased capacity to connect with their patients. All participants agreed that they enjoyed working with the scribe and they support expanding the scribe program.

Lessons Learned: As can be seen in the results of the study, hiring a full-time scribe for the department filled many of the gaps that previously existed in our documentation workflow during admissions, rounding, and discharging while simultaneously improving the general quality of the notes. In serving as a flexible advocate and resource for our department's providers, the scribe's role was consistently changing, being able to take on new projects as they came up. In this way, the scribe’s role is still continuing to evolve in our department. The biggest challenge of starting the program
was confronting ingrained habits and notions regarding good documentation. It required flexibility from the providers to implement a new resource into their daily routine. While this is still sometimes an ongoing battle, the scribe did push us to start new conversations regarding the practice and qualities of complete documentation.

**Conclusions:** While there are many approaches to improve documentation efficiency and increase reimbursements in a trauma department, the results of our pilot program suggest that a full-time department scribe confronted the complex challenges associated with electronic medical records and billing by simply giving the providers more hands-on support. This support translated into an improved workplace environment, additional opportunities for providers to connect with their patients, more opportunities for residents to participate directly in patient care, and continuity among the healthcare team while proficiently completing notes at the same time. In this sense, the scribe was a clear way for our department to invest in its providers, their needs, and their goals. In a time when healthcare provider burnout and turnover are costing hospitals exorbitant amounts of money and risking patient outcomes, the results of our program suggest that the addition of a scribe can confront these larger issues.