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A man with short brown hair and a light beard, wearing blue medical scrubs over a white t-shirt, is smiling slightly at the camera. He is holding a blue pen in his right hand and writing on a white clipboard held in his left hand. The background is a solid light blue.

1

Introduction

The Clinical Scribe Accelerator Training (CSAT) Platform

Welcome! This manual is designed to provide you with a take-home tool that complements **ScribeConnect's STAGE I Clinical Scribe Accelerator Training Course (CSAT-Course STAGE I)**. This manual can also be used as a standalone textbook for current medical team members interested in learning more about the roles and responsibilities of a Clinical Scribe in the Family Practice setting. Whether you use this manual as a supplemental- or standalone product is up to you! If you use this manual as a standalone

tool and become interested in learning more about the CSAT Course, you can find information and discounted access at www.scribeACCELERATOR.com. Information on STAGE II and III CSAT Certification can also be found on the CSAT website (www.scribeACCELERATOR.com).

STAGE I: Classroom Training

The Joint Commission (TJC), an independent health care accreditation and certification organization⁶⁴, provides general guidelines on the education, training, and use of documentation assistants in the clinical practice (Clinical Scribes)⁵⁵. These guidelines suggest that documentation assistants receive education or training in the following **minimum core competencies**⁵⁵:

- Medical Terminology
- Health Insurance Portability and Accountability Act of 1996 (**HIPAA**)
- Principles of billing, coding, and reimbursement
- Electronic Medical Record (**EMR**) navigation and functionality
- Computerized order entry, clinical decision support, and proper methods for pending orders for authentication and submission.

In accordance with TJC's guidelines⁵⁵, ScribeConnect's PHASE I CSAT Course and Manual are divided into four modules that cover the **General, Medical, Financial, and Legal** aspects of medical documentation, which we term the **"Four Pillars of Medical Documentation"**^{66,67}.

Importantly, ScribeConnect's CSAT Platform is dedicated to a commitment of excellence in Clinical Scribe Documentation that exceeds TJC's minimum guidelines. Unlike other scribe training resources, CSAT Materials use a proprietary **research-based approach** to provide education, training, and certification in medical documentation that are **academically-driven**, in accordance with the most up-to-date medical documentation research and standards^{30,41,65-101}.

ScribeConnect's full **STAGE I CSAT Platform** includes the CSAT **Manual**, **Course**, **Workbook**, and STAGE I **Examination/Certification**. Each of these materials can be used as standalone resources; however, they are designed to complement one another, and we recommend using them all together. For each of the four CSAT STAGE I Modules, we suggest first reading through the module in this CSAT Manual, then covering the module in the CSAT Course while using the CSAT Workbook to reinforce the key terms and concepts in the course module. The Manual, Course, and Module will provide opportunities for Review and Assessment at the end of each chapter to help you assess your understanding of the key terms and concepts covered in the chapter. The entire STAGE I training can be followed by the STAGE I CSAT Examination to receive CSAT STAGE I Certification.

A score of 95% or greater is required to earn **ScribeConnect's STAGE I CSAT Certification**. CSAT participants who do not receive a passing score of 95% or greater on a final training examination are offered the option to take an alternative final examination. Information on alternative final examination testing can be found at www.scribeACCELERATOR.com.

STAGE II: EHR Training

In accordance with The Joint Commission's guidelines for Clinical Scribes⁵⁵, the CSAT STAGE I platform provides basic training and education on EMR navigation and use (in addition to medical terminology, HIPAA, and coding and billing principles). However, there are currently 400 different electronic health and medical record software systems in existence¹⁰² and these systems vary widely in their navigation, interface, and functionality (among other criteria)¹⁰³⁻¹⁰⁹. For this reason, **we strongly recommend that STAGE I CSAT certification be followed by 16 - 24 hours of training on how to use your facility's Electronic Health Record (EHR) system for documentation**¹¹⁰.

EHR-specific training can provide an initial opportunity to apply the information covered in the STAGE I CSAT Course and Manual to an active, work-like, time-sensitive environment while also learning to navigate and chart within your facility's specific EHR system.

EHR-specific training provides an initial opportunity to apply the information covered in the CSAT STAGE I Course and Manual to an active, work-like, time-sensitive environment, while also learning to navigate and chart within your facility's EHR system. The **STAGE II CSAT Platform** currently provides EHR-specific training and certification in a limited number of in-

house settings for a limited number of EHR systems. You can visit the CSAT STAGE II website (www.scribeACCELERATOR.com) to determine whether STAGE II CSAT Certification is offered for your facility's EHR system. If STAGE II CSAT Certification is not available to you currently, we recommend you contact your administration staff for information on how to receive this training. You may also find information and training materials available in the Resource tab of the CSAT website at: www.scribeACCELERATOR.com.

STAGE III: Workflow Training

The **Primary Role of a Clinical Scribe is to provide “real-time” documentation services in the clinical setting under the direct supervision of a licensed provider such as a physician, physician’s assistant, or nurse practitioner**^{10,50,55,66,67,111,112}. The scribe role is clerical in nature; however, the role of the scribe extends far beyond simple documentation^{9,10,46,50,66,67,113,114}. A Clinical Scribe must document with efficiency (speed), accuracy, and absolute thoroughness.

Research demonstrates that the success of new Clinical Scribe roles and programs depends critically on sound integration of new Clinical Scribes into the existing clinical workflow^{5,9,30,41,47,100,101}. This seems to be true regardless of whether the Clinical Scribe role is assumed by an individual with previous clinical experience (such a nurse or Medical Assistant (MA)), or by an individual with purely clerical training (as occurs in a “pure-scribe” model)^{8,9,113,115-118}.

ScribeConnect’s STAGE I CSAT Materials are uniquely designed to prepare Clinical Scribes for successful integration into the clinical setting. This is achieved through CSAT’s proprietary emphasis on **Subject Information and Critical Thinking Skills** (as addressed below), which prepare new Clinical Scribes for successful integration into the existing clinical workflow.

We further recommend that STAGE I and II CSAT Certification be followed by **STAGE III Workflow Training and Certification**, in accordance with current research findings^{5,9,47,55,113}. The **STAGE III CSAT Platform** currently provides workflow training and certification in a limited number of in-house settings for a limited number of EHR systems. You can visit the CSAT STAGE III website (www.scribeACCELERATOR.com) to determine whether STAGE III CSAT Certification is offered for your facility’s EHR system in a nearby location.

Workflow training provides new Clinical Scribes with an opportunity to observe, model, and receive real-time instruction and feedback from experienced Clinical Scribes or Scribe Trainers while applying content and concepts covered in STAGES I and II to the clinical setting.

If STAGE III CSAT Certification is not available to you currently, we recommend pursuing a clinical training program that provides one-on-one “real time” training in the clinical setting, in accordance with current research suggestions^{5,9,46,47,55,113}. We suggest working up to 5 clinical shifts with an experienced Clinical Scribe or scribe trainer^{66,67}. Workflow training (which is often termed “Clinical” or “Bedside” Training) provides an opportunity for a new scribe to observe, model, and receive real-time instruction and feedback from an experienced Clinical Scribe or Scribe Trainer.

The Workflow Training phase also enables new Clinical Scribes to apply primary content and conceptual information covered in the CSAT STAGE I and II Materials to the clinical setting with efficiency and meaning. Additional information and resources^{5,46,47,55,113} available to support independent Workflow Training programs can be found under the resources tab of the ScribeConnect website at: www.scribeACCELERATOR.com.

STAGE IV: Clinical Evaluation

In accordance with Joint Commission guidelines and research best practices, we also recommend all new scribes undergo a 90-day **Evaluation Period (CSAT STAGE IV)** that uses regulated assessment tools to monitor each Clinical Scribe’s continued progress toward independent performance objectives^{5,30,41,55,66,67,100,101}. CSAT STAGE IV information and resources are available under the resources tab at www.scribeACCELERATOR.com.

ScribeConnect’s SC Smarts: Subject Knowledge & Critical Thinking Skills

As identified above, the primary role of a Clinical Scribe is to provide “real-time” documentation services in the clinical setting under the direct supervision of a licensed provider such as a physician, physician’s assistant, or nurse practitioner^{10,50,55,111,112}. The scribe role is clerical in nature; however, the Clinical Scribe role extends far beyond simple documentation^{9,10,30,41,46,50,66,67,100,101,113,114}. A Clinical Scribe must be able “think on his or her feet” (literally) and document with efficiency (speed), accuracy, and absolute thoroughness. These core competencies require strong command of the **Subject Knowledge and Information** identified in this manual, as well as the ability to apply the subject knowledge conceptually and practically to the Clinical Scribe role within the clinical environment^{30,41,100,101}. Strong **Critical Thinking Skills**²⁸ are essential to Clinical Scribe success on an *individual level* – when new scribes transition from the “classroom setting” to the

clinical environment – and on a *systems level* – when integrating new Scribe roles into an existing clinical workflow^{9,30,41,100,101}. ScribeConnect-Certified Clinical Scribes demonstrate *both* strong command of the **Subject Knowledge** presented in the CSAT platform *and* solid **Critical Thinking Skills**, as addressed below. Therefore, ScribeConnect scribes have the **SC Smarts** that are required for Clinical Scribe success!

Success as a Clinical Scribe Requires Knowledge and Thinking Skills:

- **Subject Knowledge & Information**
 - ▶ Content information covered in this manual
- **Critical Thinking Skills**
 - ▶ Problem Solving
 - ▶ Communication

ScribeConnect-Certified Clinical Scribes demonstrate *both* strong command of the **Subject Knowledge** presented in the CSAT platform *and* solid **Critical Thinking Skills**. Therefore, ScribeConnect scribes have the SC Smarts that are required for success!

Subject Knowledge: The Four Pillars of Medical Documentation

At its core, the role of a Clinical Scribe requires strong command of the **Subject Knowledge and Information** related to medical terminology and charting, HIPAA, coding, billing, reimbursement, and EMR navigation^{9,30,41,55,100,101,115}. In accordance with the above research guidelines, ScribeConnect's PHASE I CSAT Platform is divided into four modules that cover what we term “the Four Pillars of Medical Documentation.”

The “**Four Pillars of Medical Documentation**”^{66,67} include the following:

- **General Aspects** of clinical documentation
- **Medical Aspects** of clinical documentation
- **Financial Aspects** of clinical documentation
- **Legal Aspects** of clinical documentation

This CSAT Manual Systematically Covers the 4 Pillars of Medical Documentation as follows:

- **Module I – General Introduction:**
 - ▶ We provide a general introduction to the clinical scribe role
 - ▶ We address important skills that are required for successful scribe integration
 - ▶ We review important policies and regulations that pertain to clinical scribes
- **Module II – Medical Aspects:**
 - ▶ We review the medical record and its different components and formats
 - ▶ We introduce pertinent medical terminology
 - ▶ We review important medical findings, services, studies, and procedures
- **Module III – Financial Aspects:**
 - ▶ We highlight important regulations that shape the healthcare environment
 - ▶ We review important aspects of medical coding and billing
 - ▶ We focus on Evaluation & Management (E/M) Service Guidelines, which are commonly used to submit reimbursement claims for service payments.
- **Module IV – Legal Aspects:**
 - ▶ We review important regulations that legally apply to the clinical scribe role
 - ▶ We introduce the concept of the Legal Medical Record (LMR)

Clinical Scribe success depends fundamentally on a strong command of the primary content information identified above. However, scribe success also depends critically on the ability to *apply* this primary information to medical documentation, EHR use, and to the dynamic scribe role within the clinical setting. Therefore, scribe success also requires strong **Critical Thinking Skills**, as addressed below.

Critical Thinking Skills

The Clinical Scribe role extends far beyond the clerical responsibilities conveyed in this Manual. Scribes must literally be able to “think on their feet” in the clinical setting. Therefore, the intellectual capacity of a Clinical Scribe requires more than just primary and conceptual intelligence. **Critical Thinking Skills** – including strong **Communication** & **Problem Solving** Skills are requisites for scribe success^{5,9,41,47,57,66,67}.

Critical Thinking can be defined broadly as a disciplined and active process that involves: conceptualization-, application-, analysis-, synthesis-, and evaluation of information [gathered through] observation, experience, reflection, reasoning, [and] communication [in order to] guide action⁵⁴.

This extremely broad and lengthy definition of Critical Thinking, can be simplified into five general steps, as outlined below.

Critical Thinking generally involves 5 steps:

1. Gathering and Applying Information (in the clinical setting) through:

- Direct Training
- Observation
- Experience
- Reflection
- Reasoning
- Self-Assessment
- Communication (such as constructive criticism and formal evaluations)^{5,9,30}

2. Assessing and Evaluating Information and its Applications through:

- Conceptualization
- Application
- Analysis
- Synthesis
- Evaluation

3. Communication (as outlined below)

4. Problem-Solving (as outlined below)

5. Improving or Updating Information and Application Processes

- Through action
- Through Assessment & Reassessment

Although critical thinking skills require effective communication, critical thinking is fundamentally an independent process. Like the Clinical Scribe role, Critical Thinking is “self-directed, self-disciplined, self-monitored, and self-corrective²⁹.” You are responsible for applying your critical thinking skills to the clinical setting.

Although Critical Thinking involves the **Acquisition of Subject Knowledge and Information** (as identified above), it more potently pertains to the **Application** of that information. The PHASE I CSAT platform provides opportunities to practice applying Subject Knowledge to the clinical setting *conceptually*; however, most of the application process occurs during PHASES II – IV Training, and while working independently as a Clinical Scribe.

Like the Clinical Scribe role, Critical Thinking is:

- **Self-directed²⁹**
- **Self-disciplined²⁹**
- **Self-monitored^{5,29}**
- **Self-corrective²⁹**

Below, we offer a more in-depth introduction to the importance of Critical Thinking in the Clinical Scribe Role. We have designed the CSAT platform to help highlight opportunities to practice Critical Thinking Skills during PHASE I training, and we also highlight situations in which it will be beneficial and important to apply Critical Thinking Skills during your role as an Independent Clinical Scribe.



SuperScribe Tip: Critical Thinking in Clinical Practice

The Critical Thinking Skills outlined in this section are CRITICAL for successful scribe integration into the clinical setting (for new scribes and new scribe programs alike)⁹. However, these skills are not unique to the scribe role; the assessment, communication, and problem-solving skills outlined in this section provide a foundation for successful conduct in any setting and in regard to any problem.

Moreover, the **Assessment**, **Communication**, and **Problem-Solving** processes outlined below closely parallel the provider’s **Medical Decision Making process**, in which:

- Problems and questions are clearly identified and articulated
- Subjective and Objective information are obtained, synthesized, and **assessed**
- Information is **communicated** with others (ex: the patient and specialists)
- **Problems are methodically solved** by:
 - ▶ Identifying all possible causes for each problem
 - ▶ Methodically conducting studies to accept or reject each possible cause
 - ▶ Selecting the most likely cause and Implementing a Solution
 - ▶ Identifying measurable outcomes to assess the solution’s efficacy
 - ▶ Identifying a specific reassessment plan

Critical Thinking Skills: Assessment & Evaluation

In addition to acquiring and applying primary content (Subject Information), successful Clinical Scribes must be able to **Assess and Evaluate** their personal strengths and weakness as a Clinical Scribe⁴¹. This ability is fundamental to scribe growth. Many facilities provide structured processes for evaluating scribe progress and productivity; however, honest self-appraisal can be equally important, and requires an ability to independently acquire information on job productivity. As addressed above, this information can be acquired through observation, reflection, reasoning, and through communication^{29,54}.

Independent Clinical Scribes may also need to **Assess and Evaluate** how effectively a new scribe role is being implemented or integrated into the clinical workflow⁹. Here, independent self-assessment can provide an important first step toward effective **Communication** and eventually enable effective **Problem Solving**, as addressed below.

Helpful questions for self-assessment can include:

- How do I feel I am performing as a scribe?
- Do I feel confident in my work?
- Do I feel capable of managing my responsibilities as a Clinical Scribe?
 - ▶ If not, why might this be?
 - ▶ Who could I discuss this problem with?
 - ▶ How can I find a solution to this problem?
- What questions or challenges am I currently faced with in my role as a Clinical Scribe?
 - ▶ How can I find answers or solutions to these questions or challenges?
 - ▶ Why might these challenges be occurring?
 - ▶ Who could I discuss these questions or challenges with?
 - ▶ What could I do differently to improve?
- What feedback am I receiving from the providers I work with?
- Am I responsive to the feedback I receive?

Critical Thinking Skills: Communication

Open **Communication** is a fundamental component of **Critical Thinking**²⁷. Communication is also key to successful scribe integration – at the individual level (for new individuals entering into the Clinical Scribe role for the first time)^{41,46,47,66} and at the systems level (for successful integration of new scribe programs or roles into the clinical setting)^{9,67}.

Strong Communication requires an ability to:

- Clearly and precisely formulate and articulate questions and problems²⁹
- Honestly identify – and take ownership – when things are not working⁹
- Receive constructive criticism⁹

Strong **Communication** begins with the ability to clearly and precisely formulate and articulate questions and problems²⁹. This requires self-assessment: clearly identifying questions and problems *independently* before communicating these questions and problems with others through appropriate channels. **Strong communication requires an honest ability to identify, take ownership, and communicate when things are not working, and requires an ability to receiving constructive criticism**⁹. Communication can be time-sensitive in the clinical setting, so it can be important to identify how and when to appropriately engage in communication.

The following questions can be important to establish – with your Scribe Supervisor and/or with the Provider(s) you are working with – before starting your first shift as a Clinical Scribe:

- What should I do if I encounter a question or challenge during my shift that needs to be addressed immediately?
 - ▶ Are there designated individuals I should communicate with?
 - ▶ Are there designated times for communication (after the patient encounter? At the end of a shift? Are certain times better than others?)
- What should I do if I encounter a question, challenge, or problem during my shift that is not immediate, but that I cannot solve independently?
 - ▶ What resources are available to me for independent Problem Solving?
 - ▶ Who can I communicate with (another Scribe? A Scribe Supervisor? A Human Resources Staff Member? A Provider or Facility Administrator?)
 - ▶ What are the best ways for me to communicate challenges that I encounter (Direct Personal Communication? Telephone Call? Text Message? E-Mail?)
 - ▶ When should I communicate questions or problems I encounter? (Immediately after they occur? Within a week? At regularly-scheduled Meetings?)
 - ▶ Are there any existing communication procedures I should be aware of?

Critical Thinking Skills: Problem Solving

Within the context of Critical Thinking, **Problem Solving** involves a stepwise process that utilizes the **Scientific Method**¹⁻⁴ and closely parallels the **Medical Decision-Making (MDM)** Process outlined in Chapter 2 and Module II of the CSAT PHASE I Platform. This process begins with **gathering, assessing, and interpreting relevant information**²⁶⁻²⁹. Information can be gathered through observation, reflection, reasoning, self-assessment, feedback, and communication (both direct and indirect)^{27-29,54}, and should be assessed within the context of the clinical experience²⁶. Proper assessment also involves identifying and communicating questions and problems (as addressed above)²⁹.

After gathering all relevant information and identifying existing problems or questions, we recommend **identifying and assessing all workable solutions to each problem**^{26,28,29} using the following process²⁶: First, identify all unstated assumptions, values, and biases associated with

each possible solution. Next, identify all possible outcomes and effects associated with each solution. Examine each possible solution in relation to supporting evidence and existing experience. “Rule out” solutions that are not reasonable or workable within your experiential context. Next, identify the values and outcomes that are important for a solution to produce. It may be helpful to rank or order the remaining possible solutions based on these values or outcomes. Finally, select the solution that most closely aligns with the values and outcomes you identified. Remember to remain open-minded regarding alternative solutions²⁹.

Problem Solving involves a methodical stepwise process that uses the Scientific Method¹⁻⁴ and parallels **Medical Decision Making** Processes addressed in Module III:

- **Gather, Assess, & Interpret Relevant Information**²⁶⁻²⁹
 - ▶ Based on observation, reflection, reason, self-assessment, and communication
 - ▶ Clearly articulate all questions and problems²⁹
- **Identify all workable solutions**^{26,28,29}
 - ▶ Remain open-minded regarding alternative solutions²⁹
 - ▶ Identify unstated assumptions, values, and biases for each possible solution²⁶
 - ▶ Identify logical possible outcomes associated with each possible solution²⁶
 - ▶ Examine each solution within the context of the experience in relation to supporting evidence and previous experience²⁶
 - ▶ Rule Out solutions that are not reasonable or workable
 - ▶ Identify values or outcomes that are important for a solution to produce
 - ▶ Rank or order possible solutions based on identified values or outcomes
 - ▶ Select the solution that most closely aligns with the most important values or outcomes identified

This stepwise Problem Solving process may seem vague. **Assessment Question #5** is designed to help you conceptualize how this Problem-Solving Process may apply within the Clinical Scribe Role.

Critical Thinking Skills: Select, Implement, Assess, & Reassess (Update)

Critical Thinking and Problem Solving are ongoing processes, and do not end when a solution has been selected. Problem Solving and Critical Thinking alike are both equally concerned with the way in which a solution is **Implemented**. After selecting one solution to implement, it can be helpful to identify an **Assessment Plan** with **measurable outcomes** that can be used to assess whether the selected solution does indeed solve the original problem. For example, if a clinic is not able to schedule Clinical Scribes for all providers, the clinical administrators or providers may choose to hire and train 1 – 2 additional Clinical Scribes. After choosing to implement this solution, the clinic may set a measurable goal (outcome) of achieving full provider coverage within 2 months' time.

Next, it can be helpful to **identify how the measurable outcomes will be Assessed**. In the above example, the clinic may choose to sample the provider- and scribe schedules in 2 months' time to identify whether complete scribe coverage has been achieved.

The final step in this process would be to **develop a Reassessment Plan**. In the above example, the clinic's administrators or providers may choose to schedule a meeting in 2 months' time to discuss the outcome of the solution they selected. This meeting will provide an opportunity to discuss their solution's outcome, assess its effectiveness, identify whether any new changes need to be made, and address any new questions or problems.

Critical Thinking and Problem Solving are ongoing processes²⁸. **Selecting, Implementing, Reassessing, and Updating Solutions** are all important and follow stepwise processes:

- **Implement A Solution**
 - ▶ Develop a methodical stepwise plan for how the solution will be implemented
- **Assessment Plan**
 - ▶ Develop a plan for how the solution will be assessed
 - ▶ Identify measurable outcome goals that the solution should achieve
 - ▶ Identify **how** the measurable outcomes will be assessed
 - ▶ Identify **when** the selected outcomes will be measured
 - ▶ Identify **when and how** the outcome measures will be assessed (and by **who**)
- **Reassessment**
 - ▶ Identify who will be involved in reassessment, and when/where/how reassessment will occur
 - ▶ Assess whether the solution has met its identified outcome goals
 - ▶ Identify any new problems or questions, and discuss new solutions

Critical Thinking & Integration: Tying It All Together

Scribes do not work in isolation. Scribes work one-on-one with clinical providers, and also become part of a team of medical professionals. Successful integration of new scribes and new scribe roles into an existing medical team requires teamwork, adaptability, open communication, and mutual trust and respect among all team members^{5,9,41,46,47}. While some of these traits – such as resilience and adaptability – may be inherent, others – such as the ability to cultivate trust and respect with a provider – may take time.

Ultimately, the goals of this manual and of the ScribeConnect CSAT platform are to provide you with more than instructional training on scribe efficiency. Our goal at ScribeConnect is to provide you with the foundational tools you will need to integrate an excellent scribe program into your current workflow. We hope that the resources we provide in this manual, in the CSAT Course and Workbook, and in the online supplementary resources will help you develop **ScribeConnect's attitude of confidence, professionalism, reliability, and service**. By cultivating a **culture of employee excellence**, we aim to cultivate a role each employee can take pride in.

Note on this Manual as a Learning Tool

At ScribeConnect, we believe our focus on Critical Thinking skills sets us apart from other scribe companies and service providers. Throughout this CSAT manual, you will encounter sections and exercises dedicated to helping you understand the importance of strong Critical Thinking Skills within the clinical setting. These sections will also provide guidance on ways in which you can succeed as a Clinical Scribe by applying your critical thinking skills.

Throughout this Manual, you will find key **Subject Information (Terms and Concepts)** bolded and underlined. You will also find **SuperScribe Tip-** and **SuperScribe Application Boxes** that are designed to help you conceptualize how you will apply the Subject Knowledge conveyed in the manual to your role as a Clinical Scribe.

At the end of each chapter, you will find a **“Review & Assessment”** section. The **“Review”** sections are designed to reinforce the key terms and concepts presented in each chapter. The **“Assessment”** questions are designed to help you assess and develop your **Subject Knowledge** and **Critical Thinking Skills**. Accordingly, some of the ASSESSMENT questions have straightforward answers that can be identified in the preceding chapter. However, you may need to use outside sources or refer to other areas of the CSAT Manual to answer some of the ASSESSMENT questions, or to understand the question conceptually. Furthermore, many ASSESSMENT questions will ask you to apply the Subject Information covered in a chapter to the clinical setting or to the Clinical Scribe role. Some such questions are designed with specific responses or solutions in mind; however, some questions are not.

In your role as a Clinical Scribe, you are likely to encounter many new situations that require you to think on your feet and use outside resources. The ASSESSMENT questions are therefore designed to help you anticipate some such situations, and to practice applying the **Critical Thinking** and **Problem Solving Skills** identified above to new problems and situations that you may encounter as a Clinical Scribe.



SuperScribe Tip:

Throughout this Manual you will note SuperScribe Boxes that serve as conceptual tools, helping you to integrate primary content information presented in various modules and chapters together, forming a greater understanding of their relevance. SuperScribe boxes also help facilitate Critical Thinking Skills. We encourage you to familiarize yourself with all the information emphasized within each SuperScribe box.

We believe each chapter assessment will provide a learning tool within itself, and we encourage you to complete each chapter assessment to the best of your ability prior to covering that chapter in the CSAT Course. Our veteran scribes have found the CSAT Course to be both challenging and rewarding. We believe the time and effort you invest into Course preparation will enhance your ability to learn during your training, thereby enhancing your ability to succeed as a ScribeConnect Clinical Scribe. **Good luck, and welcome again to ScribeConnect!**



SuperScribe Tip: Know How You Learn!

The **VARK (Visual, Aural, Reading/Writing, Kinesthetic) Guide to Learning Styles** provides a questionnaire that can help identify what learning modalities you are most receptive to²⁰⁻²³. Understanding your VARK Learning Style can help you take control of your CSAT experience, and can also help you better understand others, including the provider you work with, your fellow Clinical Scribes and Scribe Supervisor, and the patients you see with your provider.

- Take the VARK Questionnaire at: <http://vark-learn.com/the-vark-questionnaire/?p=results>
- What style of learner are you? You can find information on each VARK Modality at: <http://vark-learn.com/introduction-to-vark/the-vark-modalities/>
- What strategies are suggested for your VARK Learning Preference(s)?
- See: <http://vark-learn.com/strategies/>

Review & Assessment

Recommended Resources

1. The Joint Commission. Documentation Assistance Provided by Scribes: What guidelines should be followed when physicians or other licensed independent practitioners use scribes to assist with documentation? *Perspectives® Newsletter: The Official Newsletter of The Joint Commission*. 2018;38(8)¹.
2. Joint Commission's 2018 Statement on "Documentation Assistance provided by scribes¹." Includes suggested guidelines for scribe education, training, regulation, and use:
 - ▶ https://www.jointcommission.org/standards_information/jcfaqdetails.aspx?StandardsFAQId=1809

Review

1. The Joint Commission (**TJC**), an independent healthcare accrediting agency, suggest that documentation assistants (Medical Scribes) receive education or training in the following **minimum core competencies**¹:
 - Medical Terminology
 - Health Insurance Portability and Accountability Act of 1996 (**HIPAA**)
 - Principles of billing, coding, and reimbursement
 - Electronic Medical Record (**EMR**) navigation and functionality
 - Computerized order entry, clinical decision support, and proper methods for pending orders for authentication and submission.
2. ScribeConnect's CSAT Platform provides education that extends beyond TJC's minimum competencies. We cover what we term "**The Four Pillars of Medical Documentation**," which refer to the four main aspects of medical documentation:
 - a. General
 - b. Medical
 - c. Coding
 - d. Legal

The four modules in the CSAT platform provide primary **Subject (Content) Information** on each of the “Four Pillars.”

3. The Scribe role is clerical in nature; however, a scribe is much more than a secretary¹⁻⁹. Scribes must demonstrate proficient **Subject Knowledge** of the “four pillars” of medical documentation. Scribes must also be able to “**think on their feet**” and apply this knowledge to the active and dynamic Clinical Scribe Role while working one-on-one with a Provider, and as part of a team of medical professionals within the clinical setting. This second component of the scribe role requires **Critical Thinking Skills**, as addressed below.
4. PHASE I of the ScribeConnect CSAT Platform focuses on Subject Knowledge that is fundamental to the scribe role and includes Critical Thinking Applications. However, scribes are encouraged to follow PHASE I training with EHR-Specific Training (PHASE II), Workflow Training (PHASE III), and a 90-day evaluation period (PHASE IV)^{1,3,9-11}.
 - I. **EHR-Specific Training (PHASE II)**: 16 – 24 hours of training on how to use your facility’s **Electronic Health Record (EHR) system** for documentation.
 - II. **Workflow Training (PHASE III)**: Up to 5 shifts of one-on-one “real time” training with an experienced Clinical Scribe or Scribe Trainer in the clinical setting. This provides new Clinical Scribes with an opportunity to observe, model, and receive real-time instruction and feedback from experienced Clinical Scribes while applying content and concepts covered in STAGES I and II to the clinical environment.
 - III. **90-Day Evaluation Period (PHASE IV)**: “Probationary” evaluation phase that uses regulated assessment tools to monitor each Clinical Scribe’s continued progress toward independent performance objectives.
5. **SC Smarts**: Success as a Clinical Scribe requires **Subject Knowledge** & **Critical Thinking Skills**:
 - **Subject Knowledge and Information**: Content information. All Clinical Scribes should demonstrate strong command of the Four Pillars of Medical Documentation, which are covered in CSAT’s STAGE I Platform.
 - **Critical Thinking Skills**: Broad and dynamic term that involves:
 - ▶ Assessment & Evaluation
 - ▶ Communication
 - ▶ Problem-Solving
 - ▶ Implementing a Solution (Improvement)
 - ▶ Reassessment

6. Critical Thinking I: **Assessment & Evaluation**

- a. Successful Scribes assess their **personal strengths and weaknesses as a Scribe**⁹⁻¹¹.
- b. Independent Clinical Scribes may also need to Assess & Evaluate **how effectively the new Scribe role is being implemented into the clinical workflow**⁵.

7. Critical Thinking II: **Communication**. Strong communication requires the ability to:

- a. Clearly and precisely formulate and articulate questions and problems¹²
 - i. Beginning with self-assessment, then in communication with others
- b. Honestly identify – and take ownership – when things are not working⁵
- c. Receive constructive criticism⁵
- d. Identify or Define proper communication channels, including:
 - ▶ What information should be communicated
 - ▶ When to communicate questions and problems
 - ▶ Who specific questions and problems should be communicated to
 - ▶ How specific questions and problems should be communicated (in person, by phone/ text/e-mail, through written evaluation, at meetings)

8. Critical Thinking III: **Problem Solving** involves uses the **Scientific Method**¹³⁻¹⁶ and parallels **Medical Decision Making** Processes addressed in Module III. This process involves:

- **Gathering, Assessing, & Interpreting Relevant Information**^{12,17-19}
 - ▶ Based on observation, reflection, reason, self-assessment, feedback, and communication^{12,18-20}
 - ▶ Clearly articulating all questions and problems¹²
- **Identifying all workable solutions**^{12,17,19}
 - ▶ Remain open-minded regarding alternative solutions⁶
 - ▶ Identify unstated assumptions, values, and biases for each possible solution¹⁷
 - ▶ Identify logical possible outcomes associated with each possible solution¹⁷
 - ▶ Examine each solution within the context of the experience in relation to supporting evidence and previous experience¹⁷
 - ▶ Rule Out solutions that are not reasonable or workable
 - ▶ Identify values or outcomes that are important for a solution to produce

- ▶ Rank or order possible solutions based on identified values or outcomes
 - ▶ Select the solution that most closely aligns with the most important values or outcomes identified
9. Critical Thinking IV: **Selection, Implementation, and Assessment/Reassessment**¹⁹ are ongoing stepwise processes:
- **Implement A Solution**
 - ▶ Develop a methodical stepwise plan for how the solution will be implemented
 - **Assessment Plan**
 - ▶ Develop a plan for how the solution will be assessed
 - ▶ Identify measurable outcome goals that the solution should achieve
 - ▶ Identify **how** the measurable outcomes will be assessed
 - ▶ Identify **when** the selected outcomes will be measured
 - ▶ Identify **when and how** the outcome measures will be assessed (and by **who**)
 - **Reassessment**
 - ▶ Identify who will be involved in reassessment, and when/where/how reassessment will occur
 - ▶ Assess whether the solution has met its identified outcome goals
10. Identify any new problems or questions, and discuss new solutions Appendix A.I contains resources that can help promote smooth integration of new clinical scribes and scribe roles into the existing clinical workflow. These resources are also available under the resources tab of the CSAT website (www.scribeACCELERATOR.com).
11. **ScribeConnect's Culture of Excellence** is founded on an attitude of confidence, professionalism, reliability, and service. All ScribeConnect employees are individually and collectively dedicated to providing physicians and health care administrators with Clinical Scribe services that maintain our commitment of efficiency, accuracy, and satisfaction.

Assessment

1. What are the “Four Pillars” of medical documentation?
 - a. _____
 - b. _____
 - c. _____
 - d. _____
2. The Introduction presents four different phases of Clinical Scribe Accelerated Training (CSAT). What are the four different phases of Clinical Scribe Training? What Phase(s) of Training does this CSAT Workbook assist in? Do you have a plan in place to receive the Training Phases that are not provided in this CSAT phase?
 - a. _____
 - b. _____
 - c. _____
 - d. _____
3. ScribeConnect Scribes are SC Smart! What do the S and C in “SC Smart” stand for?
 - a. _____
 - b. _____
4. The “Critical Thinking Skills: Problem Solving” section in this chapter states that “within the context of Critical Thinking, **Problem Solving** involves a methodical stepwise process that utilizes the **Scientific Method**¹³⁻¹⁶ and closely parallels the **Medical Decision-Making (MDM)** Process outlined in Module III of the CSAT PHASE I Platform.
 - a. What is Medical Decision-Making and how does it parallel the Problem-Solving process identified above?

5. Review the Scribe Integration Resources in Appendix A.I and online (under the resources tab at www.scribeACCELERATOR.com) that are available to promote successful integration of new clinical scribes and scribe roles into an existing clinical workflow.
 - a. Identify 5 takeaway points from these resources that you can apply to your integration into the clinical setting and workflow at your facility when you begin your new role as a clinical scribe.
6. You are a new clinical scribe and when you work with Dr. J. you feel unable to keep up with his fast pace. You do not have this problem when working with other providers.
 - a. What can you do if you encounter this problem when you begin working as a Clinical Scribe?
 - b. Who can you discuss this problem with?
 - c. Are there communication processes already in place that you can follow to address this issue?
 - d. Through self-assessment and communication with your Scribe Supervisor, you identify that this problem occurs because Dr. J. sees many patients per shift relative to other providers, and your pace as a new scribe is still relatively slow. What are 3 possible solutions to this problem?
 - e. What are some possible assumptions and limitations associated with the 3 solutions you identified above?
 - f. What possible outcomes might be associated with these possible solutions?
 - g. Your scribe supervisor tells you that the most important outcomes for scribe assessment are: provider satisfaction; provider efficiency (number of patients seen per shift); charting accuracy and efficiency; patient wait times; and patient-centered care. Are any of the solutions you identified more- or less likely to produce these desired outcomes?
 - h. Based on your responses above, which solution of the ones you identified would be most likely to be selected and implemented?
 - i. How would you implement the solution you suggested?
 - j. How, when, and with whom would you assess and reassess the success of the solution you implemented?

7. The **VARK (Visual, Aural, Reading/Writing, Kinesthetic) Guide to Learning Styles** provides a questionnaire that can help identify what learning modalities you are most receptive to²¹⁻²⁴. Understanding your VARK Learning Style can help you take control of your CSAT experience, and can also help you better understand others, including the provider you work with, your fellow Clinical Scribes and Scribe Supervisor, and the patients you see with your provider.
- a. Take the VARK Questionnaire on the VARK Website (<http://vark-learn.com/the-vark-questionnaire/?p=results>).
 - b. What style of learner are you according to the Questionnaire? (You can find more information on each of the VARK Modalities at: <http://vark-learn.com/introduction-to-vark/the-vark-modalities/>)
 - c. What strategies are suggested for your VARK Learning Preference(s) (<http://vark-learn.com/strategies/>)?
 - d. How can you use this information to help advance your CSAT experience and your ability to perform as a successful independent Clinical Scribe?



2

The Scribe Role

The Clinical Scribe Role At First Glance

In the preceding chapters, you will receive formal and conceptual definitions and descriptions of the Clinical Scribe role. This role – while clerical in nature – extends beyond secretarial duties^{9,10,46,50,66,67,113,114}, and varies according to the preferences and policies of the specific healthcare facility and provider utilizing scribe services^{41,55}.

The Joint Commission (TJC, a major health care accreditation and regulation agency⁶⁴), states that **Clinical Scribes** may be unlicensed-, certified- (medical assistants (MAs) or technicians), or licensed (certified nursing assistants (CNAs), registered nurses (RNs)) individuals who **provide documentation assistance** to physicians (MDs) or other licensed independent practitioners (such as physician's assistants (PAs) or licensed nurse practitioners (LPNs)), **consistent with the roles and responsibilities defined in the scribe job description, and within the scope of the scribe's certification or licensure**⁵⁵. This definition is quite broad; what do scribe actually do?

In general, clinical scribes **work one-on-one with a medical care provider during each shift to perform “real time” documentation**^{10,50,55,66,67,111,112}. Typically, scribes enter into the patient room with the provider and document the patient-provider encounter using the facility's electronic health record (EHR) system. However, a provider may also choose to enter a patient's room independently, dictating documentation instructions to a scribe at a desktop setting shortly after the patient encounter^{5,41}. Alternatively, some providers may choose to work with more than one scribe per shift¹¹³.

The determination of whether the scribe will enter the patient room or remain at a nearby desktop setting largely depends upon the preferences of the facility and physician^{5,41}. In any case, the primary role of the scribe is to **provide “real-time” documentation services in the clinical setting under the direction of the provider**^{55,57}. This function allows the provider to devote more time and attention to patient interaction, seeing more patients per shift, decreasing patient wait times, increasing documentation accuracy and efficiency, and improving provider and patient satisfaction in the Family Practice setting^{9,34-41} and in general^{5,10,34-36,39,41-52}.



SuperScribe Tip:

By providing “real-time” documentation services in the clinical setting under the direction of the provider, **Clinical Scribes allow providers to devote more time and attention to patient interaction, see more patients per shift, decrease patient wait times, increase documentation accuracy and efficiency, and improve provider and patient satisfaction** in the Family Practice setting^{9,34-41} and in general^{5,10,34-36,39,41-52}.

What is an Electronic Health Record (EHR)?

The terms **Electronic Medical Record (EMR)** and **Electronic Health Record (EHR)** may be used interchangeably in many medical settings^{120,121}; however, their exact definitions are important to understand:

- **Electronic Medical Record (EMR)** constitutes the patient’s health record relative to just one facility (including provider notes from all of a patient’s visits at one particular facility, such as the patient’s primary care clinic)¹²¹
 - ▶ This is the electronic version of the patient’s paper chart which was previously kept within the facility prior to changes in policy regulations regarding storage of electronic health information¹²¹⁻¹²³, which are addressed further in Module III.
- **Electronic Health Record (EHR)** is “a summary of health events (usually drawn from several EMRs) and may consist of the elements that are eventually shared in a national EHR¹²¹.” The EHR thus constitutes the patient’s entire health record, which is easily transferable between medical facilities and other sources^{104,124}.
 - ▶ The EHR contains provider notes from all of the patient’s provider visits, which may not be limited to one facility. This may include notes from the patient’s pediatrician, orthopedist, psychiatrist, obstetrician or gynecologist, urgent or emergency care provider(s), and any other applicable providers the patient may receive care from in his or her lifetime
 - ▶ In accordance with policy regulations that will be addressed in Module III, a patient’s EHR may be defined as the patient’s EMR, which is transferable between multiple facilities and sources.

- We will be using the term EHR throughout the manual for the sake of consistency.

As a Clinical Scribe in the Family Practice setting, you will interact with the EMR and EHR of each patient your provider sees, accessing a compilation of each patient's individual medical records from various settings and sources; these may range from primary care physician encounters to emergency department visits.

Scribe Functions

Though the scribe role is clerical in nature, there are many clerical services that scribes are prohibited from performing. In 2011, The Joint Commission (TJC, a major health care accreditation and regulation agency⁶⁴) recognized scribe use across various settings and provided guidelines to help regulate this use¹¹². These guidelines were the first of their kind to be issued by a regulatory agency, and identified **permissible and non-permissible scribe functions**. We have outlined these functions below, as adopted from the Joint Commission (2011) and from Campbell, Case, & Crocker's foundational review article, which drew from TJC to provide similar practice guidelines for clinical scribes (2012)¹¹¹.

PERMISSIBLE SCRIBE FUNCTIONS:

- Capture and document information from the patient-provider encounter to enter into the electronic health record (EHR) in the provider's words, and under the provider's direction, including:
 - ▶ **Chief Complaint (CC)**: the patient's subjective reason for the encounter
 - ▶ **History of Present Illness (HPI)**: the patient's subjective description of pertinent information related to the reason for the encounter
 - ▶ Patient's **Past, Family, and Social Histories (PFSH)**, including surgical history and medication list
 - ▶ **Review of Systems (ROS)**: the patient's subjective responses to the provider's review of patient symptoms by body system
 - ▶ **Physical Examination (PE)**, as conducted and dictated by the provider.
- Assist the provider in navigating the EHR.
- Enter information into the EHR as directed by the provider
 - ▶ Ex: Laboratory and radiology findings, consultation results, progress reports, etc.
- Locate and obtain past patient files from Medical Records, electronic databases, and external institutions within the EHR.

- Retrieve laboratory and radiology results.
- Respond to messages on behalf of the provider, as directed by the provider.
- Research information requested by the provider.
- Document various aspects of **Medical Decision Making (MDM)** as directed by the provider; this includes:
 - ▶ Medical necessity (addressed in Modules III & IV)
 - ▶ Review of diagnostic studies
 - ▶ Clinical course note
 - ▶ Differential Diagnoses
 - ▶ Final Impression/Definitive Diagnoses
 - ▶ Patient Follow-Up Instructions
 - ▶ Prescriptions
- Provide patient comfort measures; this includes:
 - ▶ Providing blankets or water to the patient, with permission of patient's nurse or provider.

NON-PERMISSIBLE FUNCTIONS:

- Direct patient contact*.
- Clinical assistance in the performance of any encounter procedures outside of documentation; this includes*:
 - ▶ Physical Examinations
 - ▶ Pelvic Examinations
 - ▶ Screenings
 - ▶ Immunizations
 - ▶ Any other procedures
- Participate in the Medical Decision Making process in any way outside of documentation.
- Contribute to determination of patient care outside of documentation.
- Retrieve, obtain, or administer medication*.
- Handle clinical specimens, including blood, urine, feces, or tissue*.

- Disclose HIPAA-protected patient information with anyone not directly responsible for patient care³¹, including:
 - ▶ The patient
 - ▶ Family members
 - ▶ Medical Personnel
 - ▶ Note: HIPAA refers to the Health Insurance Portability and Accountability Act, as addressed in chapter 5.
- Work outside the scope of practice as defined by The Joint Commission⁵⁵, Centers for Medicare & Medicaid Services (CMS)^{125,126}, health care facility policy, and other regulated agencies.
- Work outside the scope of the job description provided by the healthcare organization⁵⁵.
- *Pertains to clinical scribes without other clinical certifications or licensure. Clinical scribes who *do* hold other clinical certifications or licensure may be able to provide clinical assistance within the scope of their certification or licensure, if permitted within the clinical scribe job description, as dictated by each individual healthcare facility.

The Clinical Scribe Role: Guidelines & Regulations

In 2018, The Joint Commission issued new guidelines on clinical scribe use⁵⁵. These guidelines identify **Clinical Scribes** as **unlicensed-, certified-** (medical assistants (MAs) or technicians), **or licensed** (certified nursing assistants (CNAs), registered nurses (RNs)) **individuals who provide documentation assistance to physicians (MDs) or other licensed independent practitioners** (such as physician's assistants (PAs) or licensed nurse practitioners (LPNs)), **consistent with the roles and responsibilities defined in the scribe job**

description, and within the scope of the scribe's certification or licensure⁵⁵. TJC's guidelines for scribe training and education are identified above in the introduction, and formally, the Joint Commission now defers regulation of scribe roles and responsibilities to the organization or facility utilizing clinical scribes⁵⁵.

Despite their deferral of scribe regulation to the individual healthcare entity⁵⁵, TJC *does* provide some updated guidelines for all organizations using clinical scribes consider in order to ensure clarity regarding scribe role(s) and responsibilities⁵⁵. These guidelines (outlined below) are based on TJC's extensive review of the literature and learning visits to two organizations using clinical scribes⁵⁵. TJC's guidelines are also in accordance with *our* command of the research literature^{5,9,10,34,35,39,41,46,47,115,119,127} and years of industry experience^{30,41,57,100,101,110} here at ScribeConnect.

Joint Commission's 2018 Guidelines for Scribe Use

- **Job Description**⁵⁵: All organizations utilizing personnel to provide documentation assistance must have job descriptions that define the minimum qualifications to perform this function and the allowable scope of activities that can be performed.
 - Job descriptions should specify **assessment plans** for:
 - **Job performance**^{41,55,57,66,67,110,128}
 - **Job/regulation compliance**⁵⁷



SuperScribe Tip:

The Check-box bullets in this section (☐) enable you to use this section as an assessment tool. Check off the boxes that apply to you when completed!

- Job descriptions should **specify the scope of permissible operations** allowed to Clinical Scribes who hold other clinical certifications or licensing (such as MAs, technicians, CNAs, and RNs)^{3,77}.
- **Clinical Policies and Procedures**⁵⁵: Each organization should develop a policy/procedure regarding processes associated with personnel providing documentation assistance.

Policies may include:

- Proper **log-in procedures** (such as prohibition of documentation assistants from using the physician or licensed independent provider (LIP)'s log-in)
- **Scope of documentation** entry.
- Requirements for **physician review of information and orders** entered by the documentation assistant
- Policies regarding **order entry and submission processes** completed by the clinical scribe
- Policies regarding the **scope of practice** for clinical scribes who hold other clinical certifications or licensing (such as medical assistants (MAs), technicians, certified nursing assistants (CNAs), and registered nurses (RNs))^{57,110}.
- **Training & Competency Regulations**⁵⁵:
 - Organizations utilizing Clinical Scribes **MUST** provide **orientation**⁵⁵
 - Organizations utilizing Clinical Scribes **MUST**⁵⁵ provide **ongoing training** and education regarding the scribe role^{41,55,57,66,67,110}
 - Organizations that contract for Clinic Scribe services **MUST** ensure that the **quality of the service** is the same regardless of whether it is provided directly or through a contractual agreement.
 - Regardless of whether an organization uses an “in-house” or contracted scribe program, the organization should ensure all Clinical Scribes meet the Joint Commission’s minimum training and competency guidelines (outlined above and in the Introduction).



SuperScribe Tip: Joint Commission “MUSTs”

The Joint Commission provides liberal suggestions regarding the clinical scribe role; however, TJC emphasizes three components of scribe training & competency as being mandatory:

- **Orientation**⁵⁵
 - **Ongoing training and education** to the role⁵⁵
 - **Equal competency** among “in-house” and “contracted” scribe standards⁵⁵
-
- **Order Entry**: All types of personnel performing documentation assistance may, at the direction of a physician or another licensed independent practitioner (LIP), enter orders into the electronic medical record (EMR), according Joint Commission guidelines, if this is allowed by the healthcare facility at which the Clinical Scribe works, and outlined in the Clinical Scribe job description.
 - ▶ Clinical Scribes who do enter orders into the EMR are encouraged to use a **“repeat-back” process** while entering orders, especially for new medication orders
 - ▶ Clinical scribes who are not authorized to submit orders should **leave the order as pending** for a certified or licensed personnel to activate or submit the orders after verification.
 - ▶ Transcribing orders into the EMR while providing documentation assistance is not considered a verbal order. **Verbal orders** differ in that they are expected to be acted upon immediately by individuals who are practicing within the scope of their licensure, certification, or practice in accordance with law and regulation as well as with organization policy.



SuperScribe Tip: Order Entry

The Joint Commission currently allows each healthcare organization to decide whether clinical scribes who are licensed or certified to enter orders into the electronic medical record (EMR) will be permitted to do so (under the direction of the provider).

- TJC suggests that authorized scribes who do enter orders into the EMR use a “repeat-back” process to ensure accurate order entry, especially for new medications.
- For clinical scribes who are not authorized to submit orders, TJC suggests scribes leave orders pending for certified or licensed personnel to verify and activate or submit.

Implementation Policies and Procedures⁵⁷

Research and experience demonstrate that successful integration of new scribe roles and programs into the clinical environment and workflow depend critically on **strong communication and teamwork** between clinical scribes, providers, patients, and other clinical team members^{5,9,41,57}. In accordance with these findings, we suggest each organization using clinical scribes develop specific policies and procedures regarding implementation of new scribes into the clinical environment, and communication policies therein.

We suggest each organization develop a **plan for introducing new scribes and scribe roles into the existing clinical environment**. This plan should include:

- **Training sessions for all providers** working with scribes⁵ that address:
 - How to effectively work with a scribe⁵
 - Important compliance and regulatory expectations⁵
 - The organization's job description for clinical scribes⁵⁷
 - Organizational policies regarding the scope of permissible and non-permissible scribe functions⁵⁷
 - Rationale for new documentation workflow⁵
- **Training sessions for all medical team members** that address the suggested criteria above (in the context of the medical team)⁵⁷
- **Facilitation sessions that introduce clinical providers and staff with clinical scribes** and scribe program leadership *before* clinical scribes are implemented into the clinical environment⁵⁷
- **Attention to scribe-specific job equipment and requirements**, including:
 - **Uniform**/dress wear policies
 - Purchasing high-functioning **mobile computers and workstations** for scribe use (as well as backup power cords and batteries, and ensuring adequate access to electrical outlets)^{5,57}
 - Working with an electronic health record specialist or analyst to develop unique **login profiles and documentation templates** (as appropriate) for scribes. It is recommended that scribe profiles mirror the provider view, but include security limitations that reinforce compliance with organizational regulations, such as preventing a scribe from signing or closing a note without provider review⁵.

- Evaluation of the physical layout of the clinic to identify or create designated **scribe workspaces** (within the clinic, and within each patient room) ^{4,77}
- Gradual **introduction of clinical scribes into the clinical setting**, which should include:
 - Identifying and forming **strong communication lines and plans** between provider- and scribe leaders and leadership (as addressed further below).
 - **“Shadowing” phase** in which scribe leaders shadow leading providers
 - Identifying **“best implementation & use” practices** to highlight how scribes can best be implemented and used in the facility’s clinical environment
 - **Evaluation of scribe work stations** within the context of the clinical workflow
 - **Policies regarding scribe-patient introduction**, that address how scribes will be introduced to patients, and by whom
 - **Martel et al. (2018) suggest patients be informed of scribe use and role prior to their encounter with the provider, and be offered the right to see the provider without a clinical scribe present.**
 - **Initial implementation phase**, in which lead scribes work with lead providers
- Plan for implementation of new scribes into the clinical environment until fully desired coverage (of clinical providers with clinical scribes) is achieved
- **Clear timeline for implementation.**
 - ▶ Martel et al. (2018) note that while implementing new scribe programs into their healthcare facilities, their **pre-introduction timeline** (including clinic assessment and preparation before actually introducing scribes into the clinical environment) *“expanded from a few weeks within the first program expansions to between 8 and 12 weeks as the program matured so clinic staff could fully understand planned changes, make physical plant modifications, learn new documentation styles (note types and subspecialty “language”), and hire and train new scribes5.”*

Communication Policies and Procedures



SuperScribe Tip: Implementation Resources

In 2007, an academic inner-city hospital in Minnesota successfully implemented an “in-house” medical scribe program in 9 non-resident-supported clinics of different specialties, with medical scribes (with no clinical duties) supporting both physicians and advanced practice providers. The implementation process is outlined and discussed in Martel *et al.*’s 2018 research article titled: **“Developing a Medical Scribe Program at an Academic Hospital: The Hennepin County Medical Center Experience,”** which was published in *The Joint Commission Journal on Quality and Patient Safety*⁵. We strongly recommend all scribe leadership read this article and its supplementary materials!

The importance of communication is addressed in the Introduction of this module as a fundamental component of critical thought. Research and experiential findings demonstrate that **strong communication is key to successful integration of new scribe roles and programs** into the clinical environment and workflow^{5,9,41,47,57}. Accordingly, we suggest each organization using clinical scribes develop **specific communication policies** and protocols, some of which are identified above in the section on integration.

We further suggest communication guidelines be developed to provide instructions for scribes and physicians on how to address **issues that arise during a clinical shift** (within the first 1 – 3 months of new scribe integration into the clinical environment). For example:

- ❑ **If a scribe struggles to keep pace with a provider**, how will this be addressed? How can the scribe communicate this (and to who)? What resources are available to a scribe who encounters this situation?
- ❑ **If a scribe requires documentation assistance or clarification** during the patient encounter, how can this be obtained?
 - ▶ The Joint Commission suggests clinical scribes use a **“repeat-back” process** when entering orders into an EMR under the direction of a provider⁵⁵.
 - ▶ The “repeat-back” process may also enable scribes to clarify other documentation entries, such as unclear physical examination findings.
 - ▶ Alternatively, a provider may prefer not to interact with the clinical scribe in the patient room, and may designate a time to “check in” with his or her scribe *after* the patient encounter.

- **If a provider feels that some aspect of clinical scribe use is not working** for him/her, how will this be addressed? Who should the provider communicate this to, and what options are available for finding a solution?



SuperScribe Tip: Implementation Resources

In 2014, researchers interviewed providers, patients, and scribes on their perceptions and experiences with clinical scribes used at six different health systems in which medical assistant and nursing roles were extended to include in-visit documentation. The experiences were very positive overall, and **open communication** - including the ability to discuss “things [that] weren’t working” and receive constructive criticism – were identified as important to positive scribe experiences. Yan *et al.* published the findings in their 2016 research article: **“Physician, Scribe, and Patient Perspectives on Clinical Scribes in Primary Care⁹.”** We suggest all scribe leadership read this article!

Review & Assessment

Recommended Resources

1. Martel ML, Imdieke BH, Holm KM, et al. Developing a Medical Scribe Program at an Academic Hospital: The Hennepin County Medical Center Experience. *Joint Commission journal on quality and patient safety / Joint Commission Resources*. 2018;44(5):238-249.
 - Academic inner-city hospital in MN successfully implemented an “in-house” medical scribe program in 9 non-resident-supported clinics of different specialties, with medical scribes (no clinical duties) supporting physicians and advanced practitioners.
 - Implementation process is outlined and discussed in article & supplementary material
 - [https://www.jointcommissionjournal.com/article/S1553-7250\(17\)30432-4/fulltext](https://www.jointcommissionjournal.com/article/S1553-7250(17)30432-4/fulltext)
2. Yan C, Rose S, Rothberg MB, Mercer MB, Goodman K, Misra-Hebert AD. Physician, Scribe, and Patient Perspectives on Clinical Scribes in Primary Care. *J Gen Intern Med*. 2016;31(9):990-995.
 - Qualitative study in which researchers interviewed providers, patients, and scribes at 13 different primary care clinics on their perceptions and experiences with clinical scribes used at 6 different health systems in which medical assistant and nursing roles were extended to include documentation
 - Provides informative overview of helpful attributes, barriers, and limitations found to help or hinder successful implementation of new scribe role(s)
 - https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4978677/pdf/11606_2016_Article_3719.pdf

Review

1. **The Scribe Role:** Scribes work one-on-one with providers to perform “real time” documentation. Scribes enter patient rooms with the provider and capture pertinent information from each patient encounter to enter into each patient chart within the facility’s electronic health record (EHR) system. This is done under the direction of the provider. From a provider’s standpoint, scribes interact with the EHR system *for* the providers, enabling the providers to increase face time spent with the patients, and focus their attention on medical decision-making processes.

2. In brief, scribes help providers ensure and improve:
 - Patient care and satisfaction, by improving documentation
 - Patient wait times and throughput
 - Number of patients seen per provider shift
 - Depth and accuracy of documentation
 - Legal protection
 - Provider's personal satisfaction
3. The terms Electronic Medical Record (EMR) and Electronic Health Record (EHR) may be used interchangeably in some medical settings; however, their exact definitions are important to understand:
 - **Electronic Medical Record (EMR)** constitutes the patient's health record relative to just one facility (including provider notes from all of a patient's visits at one particular facility, such as the patient's primary care clinic)²⁵.
 - **Electronic Health Record (EHR)** "a summary of health events (usually drawn from several EMRs) and may consist of the elements that are eventually shared in a national EHR²⁵." The EHR thus constitutes the patient's entire health record, which is easily transferrable between medical facilities and other sources^{26,27}.
4. The Joint Commission (TJC) identifies Clinical Scribes as **unlicensed-, certified-** (medical assistants (MAs) or technicians), **or licensed** (certified nursing assistants (CNAs), registered nurses (RNs)) **individuals who provide documentation assistance to physicians (MDs) or other licensed independent practitioners** (such as physician's assistants (PAs) or licensed nurse practitioners (LPNs)), **consistent with the roles and responsibilities defined in the scribe job description, and within the scope of the scribe's certification or licensure**¹.
5. The Joint Commission issued guidelines that identify **permissible and non-permissible scribe functions**. Below are several examples of TJC's permissible- and non-permissible scribe functions that are important to understand^{1,28}:
 - **Permissible Scribe Functions**
 - ▶ Capture and document information from the patient-provider encounter to enter into the electronic health record (EHR) in the provider's words, and under the provider's direction

- ▶ Assist the provider in navigating the EHR
 - ▶ Locate and obtain past patient files from Medical Records, electronic databases, and external institutions within the EHR
 - ▶ Retrieve laboratory and radiology results
 - ▶ Document various aspects of **Medical Decision Making (MDM)** as directed by the provider
 - **Non-Permissible Scribe Functions**
 - ▶ Direct patient contact
 - ▶ Clinical assistance in the performance of any encounter procedures outside of the scope of the scribe job description, as dictated by the facility in accordance with the scribe's certification and licensure
 - ▶ Contribute to determination of patient care outside of documentation
 - ▶ Disclose HIPAA-protected patient information with anyone not directly responsible for patient care²⁹
 - ▶ Work outside the scope of the job description provided by the healthcare organization¹
6. In 2018, the Joint Commission published updated guidelines for clinical scribe use¹:
- **Job Description**¹: All organizations utilizing personnel to provide documentation assistance must have job descriptions that define the minimum qualifications to perform this function and the allowable scope of activities that can be performed¹. Job descriptions should specify assessment plans for job performance and job regulation compliance^{1,9-11,30-32} and specify the scope of permissible operations allowed to clinical scribes who hold other clinical certifications or licensing^{3,77}.
 - **Clinical Policies and Procedures**¹: Each organization should develop a policy/procedure regarding processes associated with personnel providing documentation assistance. These may include: log-in procedures; scope of documentation entry; requirements for physician review of information and orders entered by scribes; policies regarding order entry and submission processes; and policies regarding scope of practice for scribes who hold additional clinical certifications or licensing.
 - **Training & Competency Regulations**¹: Organizations utilizing clinical scribes **MUST** provide **orientation** and **ongoing training and education** regarding the scribe role^{1,9-11,31,32}.

- **Order Entry¹:** All personnel performing documentation assistance may, at the direction of a physician or another licensed independent practitioner (LIP), enter orders into the electronic medical record (EMR), according Joint Commission guidelines, if this is allowed by the healthcare facility at which the Clinical Scribe works, and outlined in the Clinical Scribe job description. Transcribing orders into the EMR while providing documentation assistance is not considered a verbal order.
7. Clinical Scribes who enter orders into the EMR are encouraged to use a **“repeat-back” process** while entering orders, especially for new medication orders. Clinical scribes who are not authorized to submit orders should **leave the order as pended** for a certified or licensed personnel to activate or submit the orders after verification.
 8. Based on an extensive literature review and years of industry experience, ScribeConnect recommends the following **Implementation Policies and Procedures^{3,5,32}**:
 - **Training sessions for all providers** working with scribes³
 - **Training sessions for all medical team members** that address the suggested criteria above (in the context of the medical team)³²
 - **Facilitation sessions that introduce clinical providers and staff with clinical scribes** and scribe program leadership *before* clinical scribes are implemented into the clinical environment³²
 - **Attention to scribe-specific job equipment and requirements**
 - Gradual **introduction of clinical scribes into the clinical setting**
 - Plan for implementation of new scribes into the clinical environment until fully desired coverage (of clinical providers with clinical scribes) is achieved
 - **Clear timeline for implementation**
 9. ScribeConnect suggest communication guidelines be developed to provide instructions for scribes and physicians on how to address **issues that arise during a clinical shift** (within the first 1 – 3 months of new scribe integration into the clinical environment), such as:
 - **If a scribe struggles to keep pace with a provider**, how will this be addressed?
 - **If a scribe requires documentation assistance or clarification** during the patient encounter, how can this be obtained?
 - **If a provider feels that some aspect of clinical scribe use is not working** for him/her, how will this be addressed?

10. In 2007, an academic inner-city hospital in Minnesota successfully implemented an “in-house” medical scribe program in 9 non-resident-supported clinics of different specialties, with medical scribes (with no clinical duties) supporting both physicians and advanced practice providers. The implementation process is outlined and discussed in Martel *et al.*'s 2018 research article titled: **“Developing a Medical Scribe Program at an Academic Hospital: The Hennepin County Medical Center Experience,”** which was published in *The Joint Commission Journal on Quality and Patient Safety*³. This article can be accessed online at: [https://www.jointcommissionjournal.com/article/S1553-7250\(17\)30432-4/fulltext](https://www.jointcommissionjournal.com/article/S1553-7250(17)30432-4/fulltext). We strongly recommend all scribe leadership read this article and its supplementary materials!
11. In 2014, a group of researchers conducted a qualitative study in which providers, patients, and scribes were interviewed over the course of one year on their perceptions and experiences with clinical scribes used at 13 different primary care clinics in which medical assistant (MA) and nursing roles were extended to include in-visit documentation. The researchers (Yan *et al.*) published their findings in the 2016 research article: **“Physician, Scribe, and Patient Perspectives on Clinical Scribes in Primary Care”**⁵. The article provides an informative overview of helpful attributes as well as barriers and limitations found to help or hinder successful implementation of new scribe role(s) into the existing clinical workflow (and influence positive perceptions of new scribe roles). The article is accessible online at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4978677/pdf/11606_2016_Article_3719.pdf. We suggest all independent clinical scribes and scribe leadership read this article!

Assessment

1. What is a scribe?
2. Describe the scribe role:
3. What is the difference between EMR vs EHR? What EHR system does your facility use?
4. This chapter mentions The Joint Commission. What is The Joint Commission? You may need to conduct outside research or read ahead in the manual to answer this question.
5. Identify 5 permissible scribe functions
 - a. _____
 - b. _____
 - c. _____
 - d. _____
6. Identify 5 non-permissible scribe functions
 - a. _____
 - b. _____
 - c. _____
 - d. _____
7. Identify 5 mandatory scribe functions
 - a. _____
 - b. _____
 - c. _____
 - d. _____
8. How will you receive the information you need to meet the 5 mandatory scribe functions identified above?

9. How would you respond if you were working with a provider who asked you to perform one of the non-permissible scribe functions identified above?
10. How would you respond if you observed another scribe performing one of the non-permissible scribe functions identified above?
11. What are some implementation policies and procedure that ScribeConnect suggest?
12. What are some issues that should be addressed during the first 1 – 3 months of new scribe integration into the clinical environment?
13. Identify 5 vocabulary words presented in this chapter that you are unfamiliar with; look up the definitions for these words:
14. Review point #8 suggests reading Martel *et al.*'s 2018 research article, "**Developing a Medical Scribe Program at an Academic Hospital: The Hennepin County Medical Center Experience**³," which can be accessed online at: [https://www.jointcommissionjournal.com/article/S1553-7250\(17\)30432-4/fulltext](https://www.jointcommissionjournal.com/article/S1553-7250(17)30432-4/fulltext). Read this article and its supplementary material. What are 5 implementation policies, processes, or procedures that Martel et al., used in their scribe program that you can apply to your own scribe program or to your role as an independent clinical scribe?
15. Review point #9 suggests reading Yan *et al.*'s 2016 research article, "**Physician, Scribe, and Patient Perspectives on Clinical Scribes in Primary Care**⁵," which can be accessed online at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4978677/pdf/11606_2016_Article_3719.pdf. Read this article. What are 5 attributes that Yan et al., identified that were helpful in facilitating smooth integration of the new clinical scribe role into the existing clinical workflow? How can you use these 5 attributes in your own role as an independent clinical scribe? What are 5 barriers/limitations that Yan et al. identify? How can you avoid- or prepare to overcome these barriers/limitations?



3

Clinical Work Flow

Workflow in the Clinical Environment

By understanding how patients flow into and out of the Family Practice clinic, you can anticipate the “next step” in a patient’s care. This will enable you to match pace with – or stay ahead of – the provider you are working with. Below, we will walk through a patient’s encounter at the clinic. Please note that implementing a new scribe program into the Family Practice setting will alter the pre-existing work flow, as addressed in chapter 1⁹.

Prior to the Patient’s Appointment

In the Family Practice setting, each patient’s appointment is scheduled in advance. Prior to the patient’s appointment, the patient will likely receive a telephone- or e-mail reminder of his or her appointment.

Most facilities ask their patients to arrive 15 minutes prior to the scheduled appointment time. During this time, patients will be asked to complete paperwork that provides or updates information on the patient’s **Personal, Family, and Social History (PFSH)**, which is defined further in Module II. In most Family Practice settings, scribes and staff members work together to update this information into the patient’s chart^{9,10,41,56}.

Patient Registration and Room Assignment

On the day of a patient’s appointment, a patient typically enters the clinic, signs in, and is checked onto the schedule, indicating that patient’s presence in the facility to the facility’s staff⁵⁶. The schedule is usually contained within a virtual setting, such as on a screen in the facility’s EHR system; however, the schedule may exist in a physical form in the facility⁵⁶.

A patient may be asked to wait in a lobby area until he or she is assigned to a room. **Patient wait times are important in the Family Practice setting**^{129,130}. Many Family Practice clinics have a goal for the **provider to see each patient within 15 minutes after the patient’s arrival**⁴¹.

Many facilities have staff members who are responsible for helping the patient navigate through the facility, escorting the patient to- and from his or her assigned room. They may also be responsible for updating patient’s whereabouts on a department tracking board, reviewing a patient’s chart, alerting the provider when a patient returns from radiology (for example), and updating the provider on general progress in patient course.

Medical Assistants (MAs) & Pre-Provider Assessment & Care

Many facilities have **Medical Assistants (MAs)** or nurses who conduct initial patient assessments prior to the patient-provider encounter. The certification and role of the nurse or MA may vary by facility. Typically, MAs perform routine tasks and procedures such as **measuring patient vital signs, obtaining a brief patient history** including the **History of Present Illness (HPI)** and **review of patient symptoms by body system (ROS)**, **administering medications and injections, collecting and preparing tissue for laboratory testing**, and **recording information into the patient's EMR¹⁰⁻¹³**. Information is often documented within the patient's EMR, and made accessible to the provider, scribe, and other members of the medical team by the MA. Module II addresses all of these medical documentation components in greater depth.



SuperScribe Tip: Care Team Providers with Dual Roles, Certification, or Licensing

In some cases, one staff member may perform multiple roles⁸⁻¹⁴ identified above. For example, a **Medical Assistant (MA)** may be responsible for:

- Rooming a patient
- Obtaining vital signs
- Obtaining subjective portions of the patient's electronic medical record, including:
 - ▶ **History of Present Illness (HPI)**
 - ▶ **Review of Symptoms (ROS)**
- Recording information into the patient's **electronic medical record (EMR)**
- **Providing follow-up instructions.**

Some of these roles overlap with those of a clinical scribe. You yourself may already have certification as an MA or nursing staff member and may now be preparing to also play the role of a clinical scribe⁸⁻¹⁴. Chapter 1 addresses issues related to duality of care team providers serving as clinical scribes.

VITAL SIGNS: Vital signs are measures of various physiological statistics, used to assess basic body functions, and patient status. **The primary four vital signs are: body temperature, blood pressure, pulse rate (or heart rate), and respiratory rate**¹³¹⁻¹³⁴. Although only the primary four vital signs have been officially universally adopted, some organizations include other measurements as “additional vital signs”^{41,131-134}. For example, many Emergency Medicine Service (EMS) agencies use pulse oximetry and blood glucose level as fifth and sixth vital signs, while the **Veterans Administration (VA)** includes a pain rating (on a 0-10 pain scale) as a “fifth vital sign.” Other settings also include oxygen saturation or pupil size; the number of vital signs obtained may vary dependent upon the site in which the scribe works.

The Patient Encounter

Obtaining the History & Physical Examination (H&P)

In many settings, the provider will review the nurse or MA's notes prior to the patient encounter. The scribe will be responsible for documenting the provider's review of these notes. The provider may direct the scribe to include pertinent information from the nurse or MA's notes into the provider's note.

After reviewing the existing documentation on the patient, the provider and scribe enter the room and obtain and document the **history and physical exam (H&P)** respectively. The provider will then discuss the **plan of care** or **workup plan** with the patient, and the scribe will document this discussion^{62,63}. The H&P and Workup Plan are addressed in further detail below in the section on the patient chart.

The Patient Workup

Following the initial patient-provider encounter, diagnostic studies, including laboratory studies, small procedures, and radiology studies may ensue. Depending on the facility's regulations, the clinical scribe may place or pend orders for diagnostic studies⁵⁵. In some cases, a facility may not have direct means to provide certain diagnostic studies, such as imaging studies or procedures. In these cases, the scribe may – under the direction of the physician and within his or her certification – help coordinate patient care by coordinating, documenting, and providing the patient with referrals and follow up instructions⁵⁵.

For studies that are obtained in-house, the scribe may track the progress of these orders for each

patient, alerting the provider when results return, and documenting result findings into each patient's chart⁵⁵. In some cases, a scribe may need to call the lab for an update on the progress of a particular diagnostic study; however, in most cases, the scribe can track progress of orders on the facility's EHR through the scribe's computerized workstation.

If applicable, the scribe will return with the provider into the patient room to document any repeat encounters, in which the provider may discuss diagnostic findings with the patient, and update the patient of the care plan^{41,55,56,62,63}.



SuperScribe Tip: Looking Ahead

Module III covers requirements providers must meet to receive reimbursement for quality care rendered to Medicare patients. These requirements include **meaningful use of certified electronic health record technology** and **enhancing coordination of care and patient and clinician shared decision-making**^{62,63}. By documenting when a provider discusses the care plan with the patient, you can help document your provider's compliance with reimbursement standards, ensuring s/he will qualify for the reimbursement s/he deserves.

Patient Charting: Overview

The provider note may be conceptually divided into two portions – **the subjective portion**, which is based on *subjective information provided by the patient* (such as the patient histories) – and **the objective portion**, which is based on the *provider's objective* findings, and primarily includes the physical examination and diagnostic findings^{53,65,135}. We provide a brief overview of these portions below. Module II provides a more in-depth look.

HISTORY & PHYSICAL EXAMINATION (H&P): The H&P encompasses the patient history, including the Chief Complaint (**CC**); History of Present Illness (**HPI**); Past, Family, and Social History (**PFSH**); Review of Systems (**ROS**); and the Physical Examination (**PE**)^{53,65}. This constitutes the **Subjective** and **Objective** portions of the chart in which the provider gathers information required to formulate the *Differential Diagnosis* (described below).

SUBJECTIVE: Arising from *the patient's* perception of his or her state and not necessarily observed by the provider. The subjective portions of the patient chart – the **CC, HPI, PFSH, and ROS** ("pt histories") – are documented according to *the patient's subjective* declaration^{53,65}.

OBJECTIVE: Perceptible to persons other than the affected individual; independent of individual perception^{53,65}. Based on the provider's factual observations and findings on the **Physical Examination (PE)** and from **Diagnostic Findings**, including laboratory, radiology, and procedural studies. The *PE* and *diagnostic findings* constitute the objective portion of the patient chart^{53,65}.

ASSESSMENT AND PLAN (A&P): The final portion of the chart that constitutes the provider's medical decision-making process (MDM), including the patient problem list and a discussion of the differential diagnoses and supporting history and exam findings for each problem (**the assessment**), and **the plan** for continued care for each identified problem or diagnosis^{53,56,65}. This may also be referred to as the **Impression and Plan (I&P)**, and may be used to dictate a portion of the patient summary instructions^{56,65}.



SuperScribe Tip: SOAP NOTE

Patient notes that are structured or organized into **S**ubjective information, **O**bjective findings, provider **A**ssessment, and care **P**lan are termed **SOAP Notes**⁵³. Because this structure is widely used, most electronic health record systems format the electronic medical note accordingly. Dr. Patricia Pearce and colleagues discuss this phenomenon in depth (with EMR images) in their 2018 article “The essential SOAP note in an EHR age⁶⁵.” We suggest reading this article (www.ncbi.nlm.nih.gov/pubmed/26795838), as well as Lew & Ghassemzadeh's 3-pg overview of “SOAP Notes” published online in StatPearls (www.ncbi.nlm.nih.gov/books/NBK482263)⁵³.

Medical Decision Making (MDM): Arriving at the Assessment & Plan (A&P)

Like the decision-making process described in the “Critical Thinking” section in the Introduction, the provider will use pertinent positive findings from the H&P and diagnostic findings to identify a list of all possible diagnoses (termed the **differential diagnosis**), and will discuss pertinent results and plans with the patient until a **definitive diagnosis** has been identified^{17,136,137}. The definitive diagnosis is then used to formulate a care plan and patient summary instructions with and for the patient^{17,56,136,137}. The provider's medical decision-making process is typically dictated by the provider and documented in the Assessment portion of the patient chart (see below).

Differential Diagnosis (DD, DDx):

The distinguishing of a disease or condition from others presenting with similar symptoms. The DD may refer to a list of all possible definitive diagnoses that could be contributing to the *Chief Complaint* or patient *Problem(s)*, from least to most likely, and includes the possibility of other less likely diagnoses that may harm the patient⁵³. The DD also refers to the systematic process by which the provider narrows the range of possible explanations for a patient's problem¹³⁶, and so includes the provider's thought process behind the list⁵³. For billing and coding requirements, the DD is often directly linked to the *Patient Problem List* and to pertinent signs and symptoms in the H&P⁶⁵.

**SuperScribe Tip: DDx in Primary Care**

In the family practice setting, an annual physical examination or routine check-up may not include a chief complaint and may not warrant differential or definitive diagnoses. Module II addresses the way in which these presentations can be properly documented in the EHR⁶⁵.

Definitive Diagnosis:

Fully developed identification of a decisive disease from its signs and symptoms; identification of the nature and cause of a patient illness, problem, or clinical presentation¹³⁸⁻¹⁴⁰; associated with specific diagnostic codes^{140,141}.

Looking Ahead: Medical Decision Making (MDM) and Medical Complexity

The complexity of a patient's problem(s) dictates the complexity of the differential diagnosis and medical decision making process, and contributes to the **complexity of care rendered to the patient**. This **medical complexity** dictates the way a patient's encounter can be coded, billed, and reimbursed (as addressed in Module III)¹⁴². Therefore, thorough and accurate documentation can significantly impact the reimbursement your provider receives.

Patient Assessment & Plan / Impression & Plan (A&P/I&P)

After formulating differential and definitive diagnoses, the provider will discuss diagnostic findings with the patient and discuss the final **Assessment/Impression and Plan (A&P / I&P)**. The scribe will document the A&P/I&P, as addressed below.

Assessment / Impression

The **Assessment** portion of a patient's chart documents a synthesis of pertinent positive and negative findings in the subjective and objective portions of the patient's workup, including the patient histories and physical examination (H&P) and diagnostic results (laboratory-, radiology-, and procedural findings)^{53,65}. The Assessment includes the patient **Problem List**, which lists all patient problems in order of importance, and is often used to generate the final definitive diagnosis/es and plan⁵³. The Assessment also includes the **Differential Diagnosis** (which lists different possible diagnoses from least- to most likely), and the provider's thought process behind this list⁵³. Other diagnoses that could potentially harm the patient but are less likely are also discussed⁵³. We describe the provider's **Medical Decision Making (MDM)** process above; this will typically be documented and discussed in-depth in the provider's Assessment⁵³.

Plan

The **Plan** portion of the A&P/I&P delineates and matches each diagnosis (or problem) with items for planning care, including: who will do what; to what degree; and when⁶⁵. Specifically, the plan "details the need for additional testing and consultation with other clinicians to address the patient's illnesses" or **Problems**, and includes additional steps needed to treat the patient⁵³.

Many plans are Problem-Oriented^{6,7} and include the following information for each Problem⁵³:

- Which testing (if any) is needed (laboratory studies, radiology, procedures, etc.)
- Rationale for each test that is suggested to resolve diagnostic ambiguity
- Next step in the care plan, dependent on whether testing is positive or negative
- Any required therapy (such as medications)
- Any required referrals or consultations with specialists
- Patient education and counseling
- Documentation that the plan was discussed with the patient

The Plan concludes with specific follow-up instructions or a return clinic appointment⁶⁵, similar to the Reassessment Plan identified in the section on Critical Thinking Skills in the Introduction.

Patient Summary Instructions

Patient-centered care is important for reimbursement payments and focuses on including the patient in the Medical Decision Making process and discussing the Assessment and Plan with the patient^{15,17,59}. To promote this, most EHRs have a final section for **Patient Summary or Discharge Instructions (PSI)**. Like the A&P/I&P, PSI provide a summary of the patient's visit and instructions for follow-up care. These instructions may include information on medication changes, orders for laboratory and radiology follow-up, referrals to medical specialists, and brief information on **patient education**. Many times, the PSI are synonymous with the A&P; however, in a format that is made accessible to the patient. The patient summary instructions are often available in template format on the EHR and many EHRs can pull this information automatically from the A&P⁵⁶. The scribe can help document these specific instructions into the patient's chart, and ensure that information automatically pulled from the A&P into the Patient Summary Instructions by the EHR is authentic and accurate. Another medical staff member may be responsible for printing the patient instructions and providing them to the patient at checkout⁵⁶.



SuperScribe Tip: Patient Summary Instructions

Many EHRs contain spaces for clinical notes to be entered that can only be viewed by the provider or care team. In the Family Practice setting, these notes may include sensitive information. If this information is entered into the EHR system incorrectly, it may be automatically pulled into the Patient Summary Instructions. Therefore, as a scribe, it can be helpful to review the patient summary instructions to ensure that all information therein is authentic, accurate, and meant to be seen by the patient⁵⁶.

Assessment/Impression & Plan Altogether

Oftentimes the Assessment/Impression and Plan are documented together in one section of the patient chart, and are indistinguishable from one another. However, some EHRs (or providers) may document these as separate portions in the patient note. Please refer to your facility's specifications to determine how these portions will be documented within your clinic's EHR.

Looking Ahead: Problem-Oriented Charting (POC)

Many providers, healthcare facilities, and electronic health record systems (EHRs) use what is termed **“Problem-Oriented Charting” (POC)**, in which data is organized around individual medical problems⁵⁻⁷. In EHRs, these problems are usually found (and documented) in the patient **Problem List**. Problem oriented charting (POC) consists of 4 components^{6,7}:

- A database or collection of all information known about a patient
- A patient **problem list**
- An **initial plan** for each problem
- A daily up-to-date progress note in SOAP format.

One advantage of problem-oriented charting is that the Assessment and Plan documentation originate in the patient **Problem List** and are thus directly linked to specific conditions⁵⁻⁷. This charting style meets reimbursement criteria for risk adjustment documentation (addressed in Module III) by ensuring that each A&P note is directly linked to each condition, and that each condition is appropriately addressed during each patient visit^{5,6,141,143}.

A Problem-Oriented A&P may use the following structure:

“Problem 1, Differential Diagnosis, Discussion, Plan for Problem 1.

Problem 2, Differential Diagnosis, Discussion, Plan for Problem 2.

Repeat for additional problems53.”

Problem oriented charting is addressed more thoroughly in Chapter 6 of Module II.



SuperScribe Tip: Problem-Oriented Charting (POC)

Many providers, healthcare facilities, and EHRs use **Problem-Oriented Charting (POC)**⁵⁻⁷, in which Assessment & Plan (A&P/I&P) documentation originates in the patient problem list⁵⁻⁷.

Here are actions you can take to help ensure accurate electronic POC documentation:

- Ensure each patient’s Problem List is accurate and up to date
- Notify your provider if a patient problem exists that has not been addressed in >1 yr.
- Ensure the Problem List accurately transfers into other areas of the chart, such as Patient Summary Instructions and Patient Education Information.

Review & Assessment

Recommended Resources

1. Chowdhry SM, Mishuris RG, Mann D. Problem-oriented charting: A review. *Int J Med Inform.* 2017;103:95-102⁶.
 - Reviews **Problem-Oriented Charting (POC)** – in which patient data is organized by diagnosis or problem (from patient Problem List). Provides suggestions for use and figures of Problem List in EPIC, the most common POC-oriented EHR.
 - <https://www.sciencedirect.com/science/article/pii/S1386505617301041?via%3Dihub>
2. Weed LL. Medical Records That Guide and Teach. *New England Journal of Medicine.* 1968;278(12):652-657⁷.
 - Original conceptualization of **problem-oriented charting** in light of clerical burden posed by chronologically-sequenced charting practices that organized data based on origin (radiology/lab/medications/doctor's notes, etc.)
 - [http://imed.stanford.edu/curriculum/session17/content/NEJM%20-%20Medical%20record%20that%20guide%20and%20teach%20\(Weed%20-%201968\).pdf](http://imed.stanford.edu/curriculum/session17/content/NEJM%20-%20Medical%20record%20that%20guide%20and%20teach%20(Weed%20-%201968).pdf)

Review

1. In general, a patient's flow through the clinic at a Family Practice facility includes:
 - Patient Check-In & Registration
 - Nurse or Medical Assistant (MA) Assessment
 - ▶ Patient vital signs obtained
 - Provider Assessment
 - ▶ Obtaining the H&P: History of present illness (HPI) & Physical Examination(PE)
 - Diagnostic Workup:
 - ▶ This may include laboratory and radiology studies and procedures
 - ▶ A follow-up appointment may be scheduled to review these findings
 - Patient Summary Instructions

2. **PATIENT WAIT TIMES** are important in the Family Practice setting; most Family Practice facilities have a goal for the provider to see each patient within 15 minutes after the patient's arrival to the facility.
3. **MEDICAL ASSISTANTS (MAs)** perform routine tasks and procedures such as measuring patient vital signs, obtaining a brief patient history including the **History of Present Illness (HPI)** and review of patient symptoms by body system (**Review of Systems, ROS**), administering medications and injections, collecting and preparing tissue for laboratory testing, and recording information into the patient's EMR.
4. **VITAL SIGNS** are measures of various physiological statistics used to assess basic body functions and patient status. **The primary four vital signs are:**
 - Body temperature
 - Blood pressure
 - Pulse rate (or heart rate)
 - Respiratory rate.
5. Patient charts are often categorized into **subjective** and **objective** portions (together termed the H&P), followed by the **assessment** and **plan**. This will be covered in-depth in Module II, and is reviewed briefly below.
 - **SUBJECTIVE:** Arising out of – or identified by – *the patient's* perception of his or her own states, and not observable by the examiner. The subjective portions of the patient chart – the *CC, HPI, PFSH, and ROS* – are to be documented according to *the patient (subject's)* declaration.
 - **OBJECTIVE:** Perceptible to persons other than the affected individual and independent of individual thought or perception. Based on factual observations and findings identified by the provider on the *Physical Examination (PE)*, and from *diagnostic findings*, including laboratory, radiology, and procedural studies. The *PE* and *diagnostic findings* constitute the objective portion of the patient chart.
 - **ASSESSMENT AND PLAN (A&P):** The final portion of the chart that constitutes the provider's medical decision-making process, including a discussion of the differential diagnosis and supporting history and exam findings (the *assessment*), and the *plan* for continued care. This may also be referred to as the *Impression and Plan (I&P)*.

6. Patient notes that are structured or organized into **S**ubjective information, **O**bjective findings, provider **A**ssessment, and care **P**lan are termed **SOAP Notes**³³. Because this structure is widely used, most electronic health record systems format the electronic medical note accordingly.
 - a. Dr. Patricia Pearce and colleagues discuss this phenomenon in depth (with EMR images) in their 2018 article “The essential SOAP note in an EHR age³⁴.” We suggest reading this article (www.ncbi.nlm.nih.gov/pubmed/26795838).
 - b. Lew & Ghassemzadeh’s 3-pg overview of “SOAP Notes” published online in StatPearls (www.ncbi.nlm.nih.gov/books/NBK482263) also provides helpful information; we suggest reading this as well³³.
7. The physician’s **Medical Decision Making (MDM)** process is often documented in the medical record. This process enables the physician to synthesize pertinent positive and negative findings from the patient’s workup (including the H&P as well as diagnostic findings) to develop a list of all possible diagnoses (termed the **differential diagnoses**), and discuss pertinent results and plans with the patient until a final **definitive diagnosis** is identified³⁵⁻³⁷.
 - a. The definitive diagnosis is then used to formulate a care plan and patient summary instructions with and for the patient³⁵⁻³⁸.
 - b. The provider’s medical decision-making process is typically dictated by the provider and documented in the Assessment portion of the patient chart.
8. **DIFFERENTIAL DIAGNOSIS (DD, DDx)** often refers to a list of all possible definitive diagnoses that could be contributing to the *Chief Complaint* or patient *Problem(s)*, from least to most likely, and includes the possibility of other less likely diagnoses that may harm the patient³³.
9. **DEFINITIVE DIAGNOSIS**: The fully developed identification of a decisive disease from its signs and symptoms; identification of the nature and cause of a patient illness, problem, or clinical presentation³⁹⁻⁴¹, associated with specific diagnostic codes^{41,42}.
10. The scribe is often responsible for documenting the **Patient Summary Instructions** into the **provider note** within the patient’s **electronic medical record (EMR)**. Scribes also help prepare Patient Summary Instruction paperwork under the provider’s instructions.

Assessment

1. Describe the patient flow through the facility during a patient encounter. How does patient flow through the facility in which you will work differ from that described in this chapter?
2. Identify 4 individuals (besides yourself) who are part of the medical team and will interact with the patient during the patient encounter. Provide a brief description of each role:
3. How will you identify these individuals when you are working with them in the clinical setting?
4. Prior to seeing a patient, your provider asks to see the patient's vital signs. What are 4 "primary" vital signs?
 - a. _____
 - b. _____
 - c. _____
 - d. _____
5. How will you know where to find each patient's vital signs?
6. What does the term "subjective" mean, in reference to medical documentation?
7. Identify 4 subjective portions of the patient's chart that you will document as a scribe:
 - a. _____
 - b. _____
 - c. _____
 - d. _____
8. How do you determine what information to document in the subjective portions of the patient's chart?
9. What does the term "objective" mean, in reference to medical documentation?
10. Identify the objective portion of the chart that you will document during the initial patient-provider assessment:
11. What is the "Assessment and Plan?"

12. How will you know when the provider is dictating information for you to document in the “assessment and plan” section of the provider note?
13. Your provider instructs you that a patient will need a work note, a referral for a physical therapist, and instructions to follow up for a return appointment in 1 month. What does this mean? Where and how would you document this information?



4

A Typical Scribe Shift

A Typical Scribe Shift

Now that we've reviewed the patient flow into- and out of- the clinic, let's focus in on the scribe's role within this medical environment. In chapter 1, we covered **primary content information related to the scribe role**; we provided a brief definition and description of the scribe role, along with permissible, non-permissible, and mandatory scribe functions.

Now let's walk through a typical scribe shift to develop a conceptual understanding of the scribe role. Such an understanding will help you conceptualize the primary information conveyed in the following modules.

Monthly Shift Assignments

After the provider's schedule has been made available, the scribe will be assigned to work specific shifts with specific providers. A scribe typically only works with one provider per shift, but may work with several different providers over the course of several shifts.

Review Provider Preferences

At ScribeConnect, we encourage each facility to develop **Provider Preference Documents** that outline the specific charting-, documentation-, and scribe use preferences for each provider at a given facility⁵⁷. These documents may include information such as

- *Dr. O. prefers to call out physical exam findings in the rooms; prefers scribes to "repeat back" order entries; dictates the A&P for scribes to transcribe*
- *Dr. P. prefers to discuss physical exam findings with the scribe after the patient encounter (at her work station). Prefers scribes to pend orders. Prefers to enter her own A&P into the chart. Wants scribes to update her on problems in the problem list that have not been addressed in a yr. Wants scribes to review A&P and notify her if documentation and terminology do not qualify for reimbursement.*

Examples of these documents can be found in Appendix A.II and in the resources tab of the CSAT website. Scribe supervisors are encouraged to make these documents available to all scribes. Upon receiving the scribe schedule, we encourage each scribe to review the provider(s) that s/he is scheduled to work with for each shift, and review the provider's specific charting preferences.

Arrival: 30 Minutes Prior to Each Shift Start

Efficient preparation prior to the start of each clinical shift enables each scribe to assess the work pace and flow for the shift and formulate an initial assessment of time management requirements for that shift.

We suggest scribes arrive 30 minutes prior to the start of each shift to clock-in, log on to the scribe workstation, and log on to the facility's **Electronic Health Record (EHR)** system.

In the Family Practice setting, most patient appointments are scheduled in advance, so a schedule for all patient appointments on a particular day can be reviewed prior to the start of each day or shift after logging in to the facility's EHR. Arriving early enables each scribe to prepare the patient charts for the day, as addressed below.

Pre-Charting

In the Family Practice setting, providers (and scribes) see between 20–30 patients per day and spend 10–20 minutes in each patient room^{41,56,144-148}. This fast pace requires clerical preparation and “pre-charting” prior to each shift^{41,56,57}. **Pre-charting** typically constitutes preparing each patient's Electronic Medical Record (EMR) within the facility's EHR system, reviewing previous charting that may be pertinent to the patient's present encounter, verifying the patient's PFSH, pulling up laboratory and radiology findings in cases where the patient is presenting for follow-up, and updating preventative healthcare measures^{56,57}. This critical preparation time enables the scribe to work at – or ahead of – the provider's pace during each shift, maximizing the service each scribe provides to the provider.



SuperScribe Tip: Pre-Charting

Family Practice scribes are encouraged to arrive 30 min prior to each shift to prepare the patient's charts for the day. This preparation is often termed “**Pre-Charting**”^{56,57} and includes:

- Verifying patient Personal, Family, and Social History (PFSH)
- Pulling up laboratory and radiology findings in cases where the patient is presenting for follow-up
- Updating preventative healthcare measures in the patient's chart.

ScribeSense: Cautionary Notes on Pre-Charting

Although pre-charting can be helpful, it must only be used as a preparatory documentation tool.

- **All pre-charting documentation must be verified by the provider and patient during the patient encounter, and updated for accuracy.**
- A scribe may not use pre-charting to add information into a patient's chart that has not been verified by the provider or patient, as this can hinder quality patient care, impose harm to the patient, and can constitute documentation fraud.
- Modules III and IV of this manual address several aspects of documentation fraud.

In 2015, Donna Vanderpool, MPA, JD, published a helpful article in the *Journal of Innovative Clinical Neuroscience* titled “**EHR Documentation: How to Keep Your Patients Safe, Keep Your Hard-Earned Money, and Stay Out of Court**”¹⁴⁹. This article can be accessed online at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4558790/pdf/icns_12_7-8_34.pdf and we suggest all clinical scribes and scribe supervisors read this article during their Stage I clinical scribe training.

In her article, Vanderpool cites several important federal statements that have been issued regarding the risks EHR documentation can pose in relation to documentation fraud¹⁴⁹. The statements that are applicable to clinical scribes include:

- “False documentation of care is not just bad care; it’s illegal. ...Indications [of medical documentation fraud] include potential ‘cloning’ of medical records [which can] inflate what providers get paid. ...**A patient’s care information must be verified individually to ensure accuracy: it cannot be cut and pasted from a different [medical] record of the patient,** which risks medical errors as well as overpayments,” issued by the U.S. Department of Health and Human Services (DHHS) and the Department of Justice in “A Letter from Obama Administration on hospital billing,” September 24, 2012¹⁵⁰.
- “Generally **it is inappropriate to copy and paste or otherwise document [a medical record] entry that is not derived from a patient encounter at the time of the visit,** unless the provider makes clear notation that the information is copied and pasted from another [medical] record,” issued by the Federation of State Medical Boards (FSMB) in their 2014 “Report on the Committee on Ethics and Professionalism in the Adoption and Uses of Electronic Health Records”¹⁵¹.

Here, we relay Vanderpool’s cautionary advice¹⁴⁹ regarding electronic documentation as it pertains to clinical scribe use of “pre-charting practices” alongside our own suggestions based on years of industry experience.

- **Templates:** While templates can provide helpful documentation prompts, they must be used with caution. Ensure that any template used is appropriate for the patient, as “templates tend to take a one-size-fits-all approach, without regard for age appropriateness, or target patient population¹⁴⁹.”
- **Pre-populating fields:** Some EHRs – and clinical scribes – can populate an entire patient assessment just by selecting a checked box or entering a particular chief complaint or template. In these situations, adherence to the FSMB’s advice above on copy-pasting is equally pertinent to pre-populating medical records:
 - ▶ Generally, pre-populating any medical information into a patient’s medical record is inappropriate if it is not “derived from a patient encounter at the time of the visit,” unless the pre-populated documentation is verified during the encounter or identified as being pre-populated from old documentation¹⁵¹.
 - ▶ Vanderpool offers the following cautionary example on pre-populating medical records: “In one case, the pre-populated data for physical examinations created automated documentation saying female patients had received prostate examinations and male patients had negative pap smears¹⁴⁹!”
 - ▶ Although it may be tempting to pre-populate information into the subjective or objective portions of a patient’s chart based on a patient’s chief complaint, this temptation holds grave risks for inaccurate, harmful, and even fraudulent medical documentation. For example, Dr. Rahmi Mowjood, DO provides the example that: “oftentimes an initial chief complaint can turn out to be misleading or even incorrect once the encounter actually gets underway¹⁵².”

Based on federal statements and regulations, literature review, and industry experience, we at ScribeConnect offer the following guidelines on pre-charting:

- ScribeConnect suggests that pre-charting practices be used to gain an initial familiarity with each patient’s medical record.
- **Pre-Charting can help a clinical scribe note different items of medical documentation that should be attended to- and updated during the encounter.**
- Pre-charting can help a clinical scribe prepare for a patient encounter by pulling up information from old medical records that a provider may benefit from having access to during the patient encounter. This practice does not justify, condone, or promote the pre-population of information from old records into a patient’s medical record prior to the patient encounter. Rather, old information may be prepared so that it is easily accessible if it is needed during the encounter.

Take Initiative: Identify Yourself to the Provider

Upon the provider's arrival to the facility, each scribe will introduce him or herself to the provider and identify him/herself as the scribe assigned to work with the provider for that shift. In cases where the scribe pairing with a provider is new, we suggest the scribe thoroughly review all available **Provider Preference Documents** and initiate a brief conversation with the provider about that provider's preferences relating to scribe use, charting, and documentation style.



SuperScribe Tip: First Shift with a New Provider

When working with a new provider who you have not worked with before, it is appropriate in most cases to initiate a brief discussion with the provider to confirm his or her specific documentation preferences. Initiating such a conversation is the responsibility of the scribe. Scribe initiative and open communication with the provider are critical for cultivating a successful relationship between a provider and a scribe^{9,41}. Strong communication between scribes and providers is also important for successful implementation of new scribe programs^{9,41}.

New Patients May Require Additional Documentation

In the Family Practice setting, most patients will have an established medical record at the facility or clinic, and the provider will most likely be familiar with the patient's **past medical, family, and social history (PFSH)**. Patients who are new to the facility or clinic may require additional charting that the scribe will assist in to provide this background information and documentation. New and returning patients alike may be asked to complete paperwork prior to the provider encounter providing or updating their PFSH, and the scribe may enter this information into the patient's EMR.

Patient Wait Times are Important

Patient wait times are important in the Family Practice setting^{129,130}. Most Family Practice settings have a goal for a provider to see each patient within 15 minutes of the patient's arrival to the facility. The scribe can assist the provider by alerting him or her to each patient's arrival, and providing updates on patient wait times.

The Patient-Provider Encounter

The Initial Encounter

Prior to the patient-provider encounter, a receptionist will enter the patient's **Chief Complaint** into the chart⁵⁶. A nurse or Medical Assistant (MA) may obtain some of the patient's pertinent history before the patient-provider encounter and relay this information to the provider and scribe⁵⁶. The scribe will be responsible for documenting this information into the patient chart.

Upon entering the patient room, the provider will introduce the scribe to the patient. In the case of new scribe programs, the provider may explain the scribe role to the patient^{9,56,57}. The provider may further spend several minutes conversing with the patient in a friendly manner. During this time, the provider may **confirm historical information** obtained by the nurse or MA, and may follow-up on previous patient problems that can be used to update the patient's PFSH and Problem List⁵⁶. **While the provider interacts with the patient, the scribe documents pertinent HPI and ROS information obtained from the patient-provider interaction.**

Following the initial conversational portion of the patient-provider encounter, the provider will perform the **Physical Examination (PE)** and the scribe will document. We suggest scribes verify all unclear physical examination findings with the provider to ensure all pertinent information is accurately captured. This verification process may occur in the patient room during the physical examination or after the patient encounter^{56,57}.

After the physical examination, the provider will **discuss the plan of care with the patient**, which may include laboratory work, radiology studies, and interventions such as medications. The scribe will document this plan into the patient's chart. The scribe will also document that the plan was discussed with the patient, and will document patient agreement with the plan.



SuperScribe Tip: Documenting Patient-Centered Care

Including the patient in the medical decision making process is an important component of **patient-centered care** and is important for delivering quality care¹⁵⁻¹⁹ and for meeting government reimbursement programs (such as the Quality Payment Program¹⁹ addressed in Module III)^{15,16,58-61}. As a scribe, it is important to note and document when your provider includes the patient in the decision-making process; this is typically documented in the A&P.

The entire patient encounter may take up to 20 - 25 minutes for new patients; however, for returning patients, this encounter may take 10 – 20 minutes, depending on the nature of the Family Practice setting^{41,56,144-147}. **Charting speed and efficiency are important for scribe success, and the preparation period prior to the start of each shift enables each scribe to maintain sufficient speed, efficiency, and organization throughout the shift.**

Clerical Work & Upkeep

The scribe will leave the patient room with the provider. After each encounter, the provider may review pertinent documentation elements with the scribe. The provider may ask the scribe to pull up previous Electronic Medical Records (EMRs) of the patient *if the scribe has not done so already*. The provider may also ask the scribe to convey requests to nursing staff members, such as obtaining consult notes from different specialists⁵⁶. Together, the provider and scribe may then enter orders for further diagnostic and therapeutic intervention, such as laboratory studies and medications (depending on facility policy)⁵⁵.



SuperScribe Tip: Designating Time for Scribe-Provider Communication

In many cases, scribes find it helpful to designate an appropriate place and time after each patient encounter to ask the provider for direction or clarification needed relative to charting and documentation. This protocol should be discussed with the provider prior the beginning of the shift, if not identified in the provider's scribe use preferences.

Some providers may see 2-3 patients in a row before pausing for clerical upkeep. Alternatively, some providers may pause for a clerical period in between each patient. These variations will depend upon the provider's preferences. **Familiarizing yourself with each provider's charting and workflow preferences can help you work more seamlessly with each provider.** Preparing and utilizing an organizational system adapted to the provider's preferences will further help you apply **critical thinking skills** to your role as a Clinical Scribe.

Scribe Breaks

Although research demonstrates that employees in the health care setting are more efficient and productive when they take appropriate breaks for meals and rest, the U.S. Department of Labor does not require employees to take meal or rest breaks under federal law¹⁵³⁻¹⁵⁵. Rather, each state is responsible for mandating employee break requirements and regulations¹⁵³⁻¹⁵⁵. The Society for Human Resource Management provides information on each state's requirements regarding rest, meal, and break policies¹⁵⁵. As a clinical scribe, it will be important for you to understand your health care facility's policies on meal, snack, and rest breaks. It is also important for scribes to be mindful of the facility's workflow and ensure scribe breaks do not disrupt the productivity and flow of the provider or medical team. Often the provider him/herself will take a 30-minute break for lunch. We recommend scribes time their breaks to coincide with those of the provider. Scribes are also encouraged to remain hydrated and may communicate with the provider their needs for bathroom use, water breaks, etc.

Shift Completion

The scribe's primary purpose is to provide quality service to the provider. At the end of a shift, ScribeConnect scribes are encouraged to communicate briefly with the provider, asking for feedback on their services if appropriate, and confirming the shift's end with the provider^{66,67}.

The scribe's shift ends after the scribe has properly discarded all documents containing protected health information for all patients, such as new patient forms or laboratory results. The scribe may then log out of the facility's EHR, log off of his or her workstation, return the workstation to its designated area within the facility, and clock-out.

Review & Assessment

Recommended Resources

1. Vanderpool D. EHR DOCUMENTATION: How to Keep Your Patients Safe, Keep Your Hard-Earned Money, and Stay Out of Court. *Innovations in clinical neuroscience*. 2015;12(7-8):34-38⁴³.
 - Helpful article on the regulatory risks of electronic medical documentation.
 - https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4558790/pdf/icns_12_7-8_34.pdf.
2. Provider Preference resources in Appendix A.II
 - Also available in the resources tab of the CSAT website
 - www.scribeACCELERATOR.com

Review

1. Arriving at least 30 minutes prior to the start of each shift enables the scribe to adequately prepare for the shift by:
 - “Pre-charting:” preparing each patient’s **Electronic Medical Record (EMR)** within the facility’s **Electronic Health Record (EHR) System**.
 - Prepare to comply with the provider’s specific preferences related to scribe use, charting, and documentation.
2. Independent scribes and scribe supervisors are encouraged to prepare documents for each provider that outline that provider’s specific documentation preferences. Examples of these documents are available in Appendix A.II and under the resources tab of the CSAT website (www.scribeACCELERATOR.com).
3. “Pre-charting” entails:
 - Preparing each patient’s **Electronic Medical Record (EMR)** within the facility’s **Electronic Health Record (EHR) System**
 - Verifying patient **Personal, Family, and Social History (PFSH)**
 - Reviewing previous charting that may be pertinent to the patient’s present encounter, such as previous laboratory and radiology findings

- Pulling up specific EHR documentation aids that may otherwise take time to pull up and prepare during a shift
 - Updating preventative healthcare measures
4. Scribes are encouraged to demonstrate initiative by identifying themselves to the provider as the scribe assigned to work with the provider for a shift.
 5. New patients may require additional documentation. The scribe may be asked to enter information from new patient documents into the patient's chart.
 6. Patient wait times are important. Most Family Practice settings have a goal for a provider to see each patient within 15 minutes of the patient's arrival to the facility.
 7. Pertinent patient history and subjective documentation criteria may be obtained by a nurse, Medical Assistant (MA), or through patient paperwork provided prior to the patient-provider encounter. The scribe may be responsible for reviewing and updating this information. This information may include the subjective portions of the patient's chart:
 - Chief Complaint (CC)
 - History of Present Illness (HPI)
 - Past, Family, and Social History (PFSH)
 - Review of symptoms by body system (Review of Systems, ROS)
 8. During the initial patient-provider encounter, the scribe will document pertinent information from the patient-provider interaction. This information will include:
 - The subjective portions of the patient's chart:
 - ▶ History of Present Illness (HPI)
 - ▶ Past, Family, and Social History (PFSH)
 - ▶ Review of symptoms by body system (ROS)
 - The objective portions of the patient's chart:
 - ▶ Physical Examination (PE)
 - The plan of care, which may include:
 - ▶ Laboratory studies
 - ▶ Radiology studies
 - ▶ Interventions, such as medications
 - ▶ Procedures

- The patient's agreement and consent with the provider's plan.
9. In 2015, Donna Vanderpool, MPA, JD, published a helpful article in the *Journal of Innovative Clinical Neuroscience* titled “**EHR Documentation: How to Keep Your Patients Safe, Keep Your Hard-Earned Money, and Stay Out of Court**”⁴³. This article can be accessed online at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4558790/pdf/icns_12_7-8_34.pdf and we suggest all clinical scribes and scribe supervisors read this article during their Stage I clinical scribe training.
 10. Many scribes find it helpful to designate an appropriate place and time after each patient encounter to ask the provider for any clarification needed relative to charting and documentation. This should be established prior to starting the shift.
 11. The scribe will document each patient's assessment and plan, as directed by the provider, and may enter the patient's summary instructions into the EMR.
 12. Time management and organization enable practical intelligence; these qualities are critical for a successful shift as an independent scribe.
 - Resources on successful integration of new scribe roles into the existing work flow are available on the CSAT Website under the Resources tab.
 13. Upon completion of each shift, the scribe is responsible for confirming the shift's termination with the provider.
 14. The scribe's primary purpose is to provide quality service to the provider.

Assessment

1. You are scheduled to work an 8am shift with Dr. Smith. What time will you set your alarm to wake up? How will you prepare for this shift?
2. You have not worked with Dr. Smith before. How will you prepare for your first shift?
3. You know you are supposed to take initiative by introducing yourself to Dr. Smith as his or her scribe; how will you identify who Dr. Smith is?
4. Why is it important to arrive early to each shift?
5. What are 4 actions you will take after arriving early to a facility, but prior to seeing your first patient with the provider?
 - a. _____
 - b. _____
 - c. _____
 - d. _____
6. What is “pre-charting” and why is it important? What are three limitations or risks involved in “pre-charting?” How will you avoid these risks in your role as an independent clinical scribe?
7. In 2015, Donna Vanderpool, MPA, JD, published an article on the regulatory risks of electronic medical documentation titled: “EHR Documentation: How to Keep Your Patients Safe, Keep Your Hard-Earned Money, and Stay Out of Court⁴³.” This article can be accessed online at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4558790/pdf/icns_12_7-8_34.pdf. Read this article. What are 5 charting practices identified in this article that pose risk for fraudulent or harmful medical documentation? What are 5 actions you can take to ensure that your own medical documentation services enhance – rather than compromise – the quality of care your provider is able to deliver to his/her patients in light of this article?
8. **While the provider is interacting with the patient, the scribe documents pertinent information from the patient-provider interaction.** The information a scribe obtains and documents during the initial patient encounter corresponds with 5 sections of a patient’s chart. What are these 5 categories of information?
 - a. _____
 - b. _____

- c. _____
- d. _____
- e. _____

HINT: Each category has an acronym that is provided in parentheses throughout the CSAT manual and course; 4 of the 5 categories are subjective information and may be obtained prior to the patient-provider encounter. The 5th category of information is objective and obtained only by the provider.

- 9. Besides the information identified above, what other information will be discussed and documented during the initial patient-provider encounter? HINT: this information would be documented in the “Assessment & Plan” portion of the cart:
- 10. While in the patient room, the provider tells you to document that “reflexes are 2/4 bilaterally.” What does this mean and where would you document this in the chart?
- 11. How would you respond to the above scenario if you were unsure of what the provider has asked you to document, or if you are unsure of where to document this information in the medical record?
- 12. You see one of your patients show up on the schedule. What does this mean, and how do you respond?
- 13. After alerting your provider that your next patient has arrived, the provider asks how long the patient has been waiting. How will you find this information?
- 14. Your shift is scheduled to end at 4p. It is currently 3:50p and your provider decides to take a walk-in patient. You have a night class at 5:00p that you cannot be late for, so staying late is not an option for you. How would you respond?
- 15. View the Provider Preference resources in Appendix A.II (these resources are also available in the resources tab of the CSAT website: www.scribeACCELERATOR.com).
 - a. Do provider preference documents already exist for the providers you will be working with at your facility? If so, print these out and store them in a binder that you can use access during your shifts or save these in an electronic format that is compliant with your facility’s HIPAA policies and that you can access during your shift.
 - b. Review these documents. How will you use these documents to comply with each provider’s documentation preferences during your role as a clinical scribe?

- c. If provider preference documents do not already exist for the providers at your facility, use the resources in Appendix A.II to develop templates that you can use to document the specific preferences of the provider(s) you will work with during your role as a clinical scribe.
- d. How will you develop these documents (if they do not already exist) at your facility, and where will save them? How will you make them accessible to you and other scribes at your facility?

HIPAA

5

**Industry Regulations
(HIPAA & HITECH)**



HIPAA: Health Insurance Portability and Accountability

Providing quality patient care is of utmost importance to all health care providers and organizations across the country. Access to sensitive patient information is a key component of providing such care. Without such access, providers would not be able to adequately assess, diagnose, and treat their patients. However, such access entails ethical responsibilities, including the duty to maintain patient confidentiality and the duty to respect patients' rights.

In 1996, congress enacted the **Health Insurance Portability and Accountability Act (HIPAA)**^{31,156-159}, which included several key health reform laws regarding:

- Health Care Access, Portability, and Renewability
- Prevention of Health Care Fraud and Abuse
- Tax-Related Health Provisions
- Consolidated Omnibus Budget Reconciliation Act (COBRA) Clarification– and other miscellaneous health reform laws.

One of the most important aspects of HIPAA was the pronouncement of the first set of national standards for maintaining the privacy and security of **individually identifiable health information**, as well as the definition of numerous offenses relating to the violation of such standards^{31,156}. These standards have been issued within three separate rules or acts and are enforced by the Office of Civil Rights (OCR), a division of the U.S. Department of Health and Human Services. These acts include:

- 2003 HIPAA Privacy Rule^{24,25,160}
- 2005 HIPAA Security Rule^{25,161,162}
- 2009 Health Information Technology for Economic and Clinical Health (HITECH) Act¹⁶³⁻¹⁶⁵

Each component serves to protect patients' rights regarding individually identifiable health information. Because information is increasingly captured, stored, and transmitted electronically, the above acts specifically protect patient's rights regarding *electronic* forms of individually identifiable information.

As a Clinical Scribe, you will have access to patient's **protected identifiable health information**. It is vital for you to understand your responsibilities in accessing and using this information. Moreover, Clinical Scribes are responsible for understanding and respecting the policies of

HIPAA and of the facility at which the scribe works⁵⁵. Therefore, in addition to introductory training below, **ScribeConnect strongly encourages all clinical scribes to undergo HIPAA and HITCH training at your clinical facility, in compliance with Joint Commission Guidelines⁵⁵.**

HIPAA PRIVACY RULE^{24,25,156,160}

The **HIPAA Privacy Rule** provides national standards for protecting individually identifiable health information and applies to four entities: health plans, healthcare providers, healthcare clearinghouses, and business associates¹⁵⁶. To better understand this description, it can be helpful to understand some terminology that is used in the HIPAA Privacy Rule itself^{24,25,156,160}:

- **“Protected Health Information (PHI)”** refers to individual patient health information that is protected by HIPAA in the ways that it can be used and shared.
- **“Covered Entity”** refers to any healthcare organization that has access to PHI. Covered Entities must comply with HIPAA policies and procedures on handling PHI.

Covered Entities fall under one of four categories^{24,25,156,160}:

- **Health Plans:** Individual and group plans that provide or pay the cost of medical care are covered entities. These include: health, dental, and vision plans; Medicare; Medicaid; Health Maintenance Organizations (HMOs); prescription drug plans; and employer-sponsored health plans. These covered entities are all subject to the HIPAA Privacy Rule.
- **Health Care Providers:** All health care providers who electronically transmit health information are Covered Entities subject to the HIPAA Privacy Rule. This includes individual providers such as physicians and medical staff and institutional providers such as clinics.
- **Health Care Clearinghouses:** Any entity that processes health information received from another entity. This includes billing services and health management information systems.
- **Business Associates:** A person or organization that does not fall under one of the three categories of Covered Entities above but performs certain functions or services involving the use or disclosure of health information *on behalf of a covered entity*^{166,167}. This can include:



SuperScribe Tip:

Clinical Scribe contractors are Business Associates and are subject to HIPAA Regulation.

- ▶ **Clinical Scribes, scribe companies, and scribe contractors**
- ▶ Accounting & Legal services
- ▶ Data aggregation services
- ▶ Health care consulting services
- ▶ Other types of services provided on behalf of a Covered Entity that require the Business Associate to access health information.

All Business Associates are required by HIPAA to execute a Business Associate Agreement, which outlines each party's HIPAA compliance obligations^{166,167}.

Protected Health Information (PHI) ^{24,31,168,169}

What is Protected Health Information?

The **HIPAA Privacy Rule** protects all “**individually identifiable health information**” held or transmitted by a Covered Entity or its Business Associate in any form or media, whether electronic, paper, or oral. The Privacy Rule defines this information as **Protected Health Information** or **PHI**^{24,31,168,169}.

In addition to the information below, information on the HIPAA Privacy Rule (including PHI, the “**Minimum Necessary Principle**,” and administration requirements) can be found at: <https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html>.

PHI includes any information, including demographic data, that relates to the:

- Past, present, or future physical or mental health or condition of the individual
- Provisions of health care to the individual
- Past, present, or future payment for the provision of health care to the individual
- See: <https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html>

To be considered PHI, information must relate to one of the three categories above and must also identify or provide a reasonable basis upon which to identify the individual^{24,31,168,169}. Some of the most common identifiers are:

- Name
- Address
- Name of Employer
- Any Date (birth, admit date, discharge date)

- Telephone or Email Address
- Social Security Number
- Medical Record Number
- Patient ID Number

Use and Disclosure of PHI^{24,25}

There are only two permissible circumstances to use or disclose PHI:

- When PHI is used or disclosed in accordance with the Privacy Rule
- When an individual expressly authorizes use or disclosure of his/her PHI in writing

Permissible Uses/Disclosures under the Privacy Rule^{24,25}

Under the Privacy Rule, Covered Entities or their Business Associates are permitted to use or disclose PHI without the individual's express permission for the following purposes only:

- Provision, coordination, and/or management of an individual's treatment
- Activities related to payment for treatment rendered to the individual
- Activities related to health care operations, including:
 - ▶ Quality assessments
 - ▶ Performance evaluations
 - ▶ Audits
 - ▶ Business planning and administration
 - ▶ Insurance functions
- Incidental uses or disclosures of information, including such scenarios as:
 - ▶ Patient sign-in sheets
 - ▶ Calling out a patient's name in a waiting room
 - ▶ Public interest purposes, such as information relating to communicable diseases
- To provide to the individual him/herself or to a legally identified personal representative

Any use or disclosure of PHI that does not fall under one of these categories may only be conducted *if* **expressly authorized by the individual**, as outlined below.



SuperScribe Tip: Defining “Express” Authorization

In the context of protected health information (PHI), the terms “express” and “expressly” indicate that authorization is freely given by the individual, and not incentivized or coerced^{24,25}.

Individuals must expressly authorize use of their PHI in writing for any of the following reasons:

- Use or access to any psychotherapy notes of a patient
- Any targeted marketing communications
- Disclosures to a life insurer for coverage purposes
- Disclosures to any employer for pre-employment physical purposes
- Any other purpose that does not fall under a permissible category

If a Covered Entity or Business Associate uses or discloses PHI for any purpose that is not outlined above, such action would be a violation of HIPAA and subject to penalties, as described later in this chapter.



SuperScribe Tip: Protecting Patient Information

As a best practice, scribes should always refrain from sharing patient information with anyone who is not directly involved in the patient’s care. Such responsibility should be left to a facility staff-member who can first confirm that a person has legal permission to receive information which may be protected by the HIPAA Privacy Rule.

SuperScribe Applications

- Mr. Brown lives alone; his neighbor has driven him to his appointment and has agreed to wait in the lobby to drive Mr. Brown home after his visit. The neighbor asks you if Mr. Brown is alright, what is going on, and if Mr. Brown has means to pay for this visit. How do you respond?
 - ▶ Unless the neighbor has written identification as Mr. Brown’s legal personal representative you may not share any information about Mr. Brown’s encounter, prognosis, diagnosis, or payment means with the neighbor.

- ▶ You should explain to the neighbor that you are unable to disclose any information concerning Mr. Brown.
- Your neighbor comes into the clinic to be seen by the provider you are working with. The neighbor's sister arrives and asks you how her sister is doing; how do you respond?
 - ▶ You are not allowed to share your neighbor's information with the sister unless she has express written approval from the patient or she is her legal personal representative.
 - ▶ Upon recognizing that you know the patient, you may want to disclose this information to the provider and ask if the provider would still like you to enter the room during the encounter.

The “Minimum Necessary” Principle^{24,25,31-33}

When a Covered Entity or Business Associate is **permitted-** or has **express authorization** to access, use, or disclose PHI, he or she must only access, use, or disclose the minimum amount of patient information that is necessary to fulfill his or her duties. This principle is termed the **“Minimum Necessary Rule,”** and is a key component of the HIPAA Privacy Rule^{24,25,31-33}. Under this rule, Covered Entities are responsible for implementing policies and procedures that reasonably restrict PHI access based on an employee's responsibilities regarding each patient encounter. Therefore, your health care facility is responsible for implementing its policies and procedures regarding PHI. **As an independent clinical scribe, you are responsible for understanding and complying with your facility's policy's and for ensuring that you can receive HIPAA training at your health care facility**⁵⁵. One measure shared by all health care facilities is that in the Electronic Health Record System (EHR), each keystroke and point of access is monitored to ensure that workforce members are using the system appropriately and in accordance with facility policy and the HIPAA Privacy and Security Rules (see next section).

As a rule of thumb all health care workers should only access, use, and disclose the minimum amount of information that is necessary to fulfill the required health care duties at the time the work is being performed. **Once a scribe's job-related requirements for access to patient health information no longer exists, the scribe's permission under the HIPAA Privacy Rule to access such information also terminates.** The only exceptions to this rule apply to the patients themselves and to the health care providers. Patients may view their full medical records at any time if requested through proper channels. Likewise, providers may view as much information as they need to in order to treat their patients to the best of their ability.



SuperScribe Tip: The “Minimum Necessary Rule”

The “**Minimum Necessary Rule**” is a key component of the HIPAA Privacy Rule; it states that any Covered Entity or Business Associate that receives **express authorization** to access, use, or disclose protected health information (PHI) must only access, use, or disclose the **minimum amount of patient information necessary to fulfill its permitted duties**^{24,25,31-33}.

- Example: A secretarial clerk who answers telephone calls and directs patients from the front desk does not require access to each patient’s full medical record to complete his/her secretarial duties.
- The minimum amount of information the secretarial duties would require include the name, status, and location of each patient. Thus, the volunteer would not be permitted to access any other patient information under the HIPAA Privacy Rule.

SuperScribe Applications

- You are working with Dr. A; your neighbor comes in for an appointment, but is seen by Dr. B. The neighbor’s sister asks you how her sister is doing; how do you respond?
 - ▶ You may not access the neighbor’s chart since you are not directly involved in the care of your neighbor and you do not have a job-related purpose to view the chart.
 - ▶ **Remember:** even if you have the ability to view someone’s chart, it would be a violation of HIPAA to view the information out of curiosity or personal gain when viewing such information is not necessary for the purpose of performing your duties as a scribe.
- On your previous shift, you saw a dramatic patient case. Laboratory and radiology studies were ordered to determine a definitive diagnosis. You are dying to learn the patient’s results and diagnoses. Are you permitted to look these up in the patient’s chart during your next shift?
 - ▶ **No.** Once your shift ends or you no longer have a job-related need to know the information you no longer have permission per HIPAA rules to view the information.
 - ▶ **To view a patient’s chart out of curiosity or for personal gain is a violation of the HIPAA Privacy Rule.**

- In the same scenario depicted above, a nurse who saw the patient yesterday asks you to look up the patient's laboratory results. Can you relay this information to her?
 - ▶ **No.** Since you are not currently involved in the direct care of the patient, you may not access the patient's protected health information for yourself or for the nurse. If the nurse is currently involved in the patient's care and has a job-related need to know this information, she must access it herself.
 - ▶ Politely express to the nurse that you are not permitted to access or share this information.
- A patient is returning to the clinic with a unique condition that you are not familiar with. A chest X-ray (CXR) was obtained at the patient's last visit and the provider you are working with seems excited about the CXR findings. Can you show the X-ray findings to another scribe, or ask a nurse to help you identify the unique findings on the CXR for your own learning purposes?
 - ▶ **No.** The CXR contains identifiable information such as the patient's name, medical record number, and/or diagnosis. This is protected health information and you may not share it with anyone who is not directly involved in the patient's care. You may not show the CXR to another scribe. You may not access this PHI for your own personal use.
- Can you take a picture of the X-ray on your cell phone to review after your shift?
 - ▶ **No.** You may not take a picture of the X-ray to show to anyone else or to refer to yourself. No patient information should ever be transmitted, stored, or uploaded to a personal device under any circumstances—including photos or videos.
- While working as a scribe for Dr. Jones you see a patient with a very complex history and unique diagnosis. You want to save the patient's chart so that you can read up on it after your shift. You would like to email yourself the patient's chart. Is this allowed?
 - ▶ **No.** Reproducing any portion of a patient's chart for purposes other than direct patient care is strictly prohibited under the HIPAA Privacy Rule. A scribe may not save, copy, or reproduce any portion of a patient's chart for personal use.

- What if you remove the patient's name?
 - ▶ Even if the patient's name is removed, it is possible the patient's chart contains other information that could be used to identify the patient; this would be protected health information (PHI). In particular, the date associated with the e-mail would confer the date of the patient's visit, which can constitute individually identifiable information.
- What if you only email yourself the History of Present Illness (*HPI*), a subjective portion of the patient's chart – rather than the *entire* chart?
 - ▶ A scribe does not have the right to use a patient's information for personal use, or to use or share a patient's health information in any way that is not related to the scribe's direct contribution to the patient's care.
- You saw 35 patients while working with Dr. Jones today. Dr. Jones said this is the largest volume of patients he has ever seen in one shift. You feel very proud and want to take a screenshot of the day's schedule as a memorandum of your record-breaking efficiency as a scribe. Is this allowed?
 - ▶ **No.** The schedule contains protected health information for each patient you see during a given shift, including personal identifiable information, such as the patient's last name and gender.
 - ▶ The patient tracking sheet – along with any notes used for scribing purposes during a shift – must be properly disposed of at the end of the shift in accordance with the facility's policies and the HIPAA Privacy Rule.
- Another scribe who works at your facility receives strong positive feedback from the providers. You want to review her HPIs to see how they compare to yours; maybe you can learn something. Is this allowed?
 - ▶ **No.** The HPI contains protected health information, which you are not allowed to access unless you are directly involved in the care of that patient.
- Your mother was recently seen in the clinic at which you work. She was given a vague diagnosis and sent home with a prescription, but cannot remember how long she should take the prescription for. She is also unclear on the diagnosis. She asks you to look into her chart to explain her diagnosis and prescription plan to her. Can you do this?

- ▶ **No.** If you are your mother's personal legal representative with written authorization, you may present this written documentation to the secretary outside of your working hours as a scribe. You may then ask for your mother's requests to be met.
- ▶ However, you may not independently access your mother's EHR with or without her written approval through your role as a scribe.
- ▶ **This is also true of your own medical record:** Each facility has a procedure in place for requesting a copy of your medical record. You are not permitted to access your own record without going through these appropriate channels.

Administrative Requirements^{170,171}

The HIPAA Privacy Rule applies to Covered Entities and Business Associates of all sizes, specialties, and facilities. Therefore, the rule enables each Covered Entity to analyze their own needs and resources when implementing their own HIPAA compliance solutions. The following are administrative requirements that Covered Entities are required to implement according to their size and resources in compliance with the HIPAA Privacy Rule^{170,171}

- **Patient Privacy Policies and Procedures:** Each entity must establish policies and procedures that it will adhere to in order to ensure HIPAA compliance. Each patient must be provided with a copy of the provider's privacy practices.
- **Privacy Personnel:** Each entity must designate an individual responsible for developing and implementing its privacy policies. This individual must also be available for contact in the event of a suspected violation.
- **Workforce Training & Management:** All employees, contractors, volunteers, or other persons who will encounter patient information for the purposes of their job must be trained on the Privacy Rule and the entity's privacy policies and procedures.
- **Data Safeguards:** Entities must maintain reasonable and appropriate administrative, technical, and physical safeguards to prevent intentional or unintentional use/disclosure of PHI. Examples of these safeguards may include:
 - ▶ A system for shredding physical documents
 - ▶ Securing medical records with a lock and key or pass code
 - ▶ Limiting physical access to medical information through key cards or pass codes

- **Complaints:** Each entity must have a procedure for individuals to make formal complaints regarding suspected HIPAA non-compliance or violations.

Penalties for Non-Compliance

Failure to adhere to your facility's HIPAA Privacy Policies can jeopardize a patient's rights to privacy and confidentiality, and may result in any of the following penalties^{170,171}

- Disciplinary action, up to – and including – termination
- Civil monetary penalties. These may range from \$100 violation fees to \$25,000 per year
- Criminal penalties, including imprisonment
- Civil lawsuit for violating state privacy laws

SuperScribe Applications

Here are a few recent cases involving HIPAA violators, along with the case outcomes:

- In 2009, two nurses were fired from a facility in Lake Geneva, WI for posting a picture of a patient's x-ray onto Facebook¹⁷².
- In 2010, a UCLA Health System employee was sentenced to 4 months in prison for viewing patient files with no work-related reason to do so¹⁷³.
- In 2013, six individuals were fired from Cedars-Sinai Medical Center in Los Angeles, CA for utilizing other employee logins and inappropriately viewing patient records^{174,175}.
- In 2013, four desktop computers were stolen from Advocate Medical Group (AMG)'s administrative buildings in IL, leading to a data breaches that impacted 4,029,530 patients. AMG was charged with multiple HIPAA violations and a settlement fee of \$5.55 million¹⁷⁶.
- In 2015, a health insurance employee responded to a malicious phishing e-mail that was part of a cyberattack on the company. The attack exposed the PHI of 79 million individuals and in 2018 the company paid \$16 million dollars for multiple HIPAA violations¹⁷⁷.

These cases provide examples of the thousands of potential HIPAA breaches investigated by the Office of Civil Rights (OCR) each year. As technology and social media make it easier than ever to share sensitive patient information, HIPAA enforcement will continue to rise.

HIPAA SECURITY RULE^{25,31,156,161,162}

Like the HIPAA Privacy Rule, the HIPAA Security Rule was the first of its kind. Whereas the HIPAA Privacy Rule deals with protected health information (PHI) generally, the **HIPAA Security Rule deals with *electronic* PHI (ePHI)** specifically. The Security Rule established the first set of national standards for protecting PHI that is stored or transmitted in an electronic form. With the widespread adoption of Electronic Health Record (EHR) systems, computerized provider order entry (CPOE), and cloud-based data storage solutions, these standards have proven to be vital to protecting patients' rights^{25,31,156,161,162}.



SuperScribe Tip:

Whereas the HIPAA Privacy Rule deals with protected health information (PHI) generally, the **HIPAA Security Rule deals with *electronic* PHI (ePHI)** specifically.

The HIPAA Security Rule mandates that each facility develop and implement “the necessary safeguards” to protect ePHI in accordance with the HIPAA Privacy Rule. The Security Rule requires the enforcement of Administrative, Physical, and Technical safeguards that protect patient confidentiality and regulate ePHI access. These safeguards will be addressed below.

Administrative Safeguards^{31,178}

Administrative Safeguards: Administrative safeguards refer to actions, policies, and procedures developed to manage selection, development, implementation, and maintenance of security measures^{31,156,178}. These safeguards exist to protect ePHI and to manage the conduct of the covered entity's workforce in relation to the protection of that information.

Administrative safeguards may include:

- **Access Authorization:** Policies and procedures for granting access to ePHI such as through workstation- and EHR access.
- **Security Awareness and Training:** Programs designed to educate users on the health care organization's security policies (SANS.org).
- **Protection from Malicious Software:** Procedures for guarding against, detecting, and reporting malicious software.

- **Log-In Monitoring and Password Management:** Procedures for monitoring log-in attempts, reporting discrepancies, creating, changing, and safeguarding passwords.

Physical Safeguards^{25,31,156,162,179}

Physical Safeguards: Physical measures, policies, and procedures to protect a Covered Entity's electronic information systems and related buildings and equipment from natural and environmental hazards and unauthorized intrusion^{25,31,156,179}.

- **Facility Access:** All facilities should be secure. Your facility will provide you with a security badge you may use to enter and exit your facility. This should not be shared with anyone.
- **Workstation Use and Security:** Workstation use and ePHI access should be restricted to authorized users only.
- **Device and Media Controls:** The receipt and removal of hardware and electronic media that contain ePHI into and out of a facility or the movement of these items within a facility is strictly regulated and prohibited without proper authorization.
- **Disposal:** The final disposal of ePHI (and PHI in general) will be regulated by your facility, as will the use of any electronic media or hardware on which ePHI is stored.

Additional Physical Safeguard Tips:

- Do not bring any of your work home with you in any way, shape, or form.
- Do not transfer any portion of a medical record or any PHI to another media device:
 - ▶ Do not e-mail any portion of a medical record to yourself to access for personal use.
 - ▶ Do not transfer any portion of a medical record onto any electronic device.
 - ▶ Do not take pictures of any portion of a medical record– including imaging findings or images – with your cell phone or any other device.
 - ▶ Do not transfer any information from a medical record onto paper for personal use.
- Do not use, access, or download any software, devices, or suspicious websites on a facility workstation that could cause corruption.

CELL PHONES AND SIMILAR DEVICES ARE NOT ALLOWED ON THE FLOOR DURING A SHIFT.

Technical Safeguards^{25,31,156,161,162,180}

Technical Safeguards: Technological Safeguards are policies and procedures related to use of technology within the health care environment^{25,31,156,161,162,180}. These safeguards protect ePHI and control access to it. This occurs primarily through specified log-in username and password verification with specific access privileges developed in accordance with the HIPAA Privacy Act.

- Individual user logins, system audits, and data encryption are all examples of technical safeguards

In your role as a Clinical Scribe, you may only use YOUR unique scribe username and password to access and use any workstation, EHR, or ePHI at your facility while performing your scribe duties.

Technical Safeguards for Clinical Scribes

- You may not use another staff member's login information.
- You may not share your login information with anyone.
- You may not allow anyone else to use a workstation you are logged into, unless you log off first.
- You may not allow anyone else to access ePHI through your facility's electronic health record system (EHR) under your login information.
- You MUST log out of a workstation before leaving it unattended.
- **If you have login information that was assigned to you for a specific role other than that of a Clinical Scribe (such as a nurse or MA), you may not use that login information during your role as a Clinical Scribe.**

SuperScribe Applications

- You are excited to work with Dr. Jones as a scribe. However, you have not yet received your scribe username and password. Can you work for Dr. Jones under his login information?
 - **No.** You may not work as a scribe until you have received your own individually identifiable login information from your facility. Your login information must be unique to you AND to your specific scribe role. You may not work under anyone else's login information.

- You also work as a Medical Assistant (MA) in the same clinic. May you log in with your MA username and password to work as a scribe for Dr. Jones?
 - ▶ **No.** You may not use your own login information for any role other than the role for which it was created and assigned. Different roles may have different ePHI access. **In this scenario, you would not be permitted to use your MA login for scribing purposes.**
- A patient asks to use your workstation to look up GoogleMaps directions. Is this allowed?
 - ▶ No. Only authorized users may use your workstation as it contains access to the EHR system. You may print off directions for the patient, but the patient may not use your workstation.
- Another scribe's workstation crashes; the scribe asks if s/he can use your workstation to enter some information into a patient chart before the patient is discharged. Is this allowed?
 - ▶ The other scribe may use your workstation **ONLY** if you logoff of the workstation and the other scribe logs into the workstation using his or her login information. Remember- you may not share a login for any purpose whatsoever.
- You have a zip-drive with you and want to save a picture of one of your patient's X-rays. Can you save this on the zip drive?
 - ▶ No. Information may not be removed from the facility or used for personal purposes.
- You are excited to begin working with your provider as a scribe. You do not have your scribe login information yet; however, you also perform *secretarial and clerical work* for your provider. Can you use *that* login information to work as a scribe until you receive your scribe login information?
 - ▶ No. You are only permitted to use login information for the role to which it is assigned.
- Another scribe at your facility is working on a provider note for a recent patient when his workstation crashes. He asks you to enter the remainder of the patient's radiology findings into the patient's medical record before he forgets. Can you do this?

- ▶ You are not directly involved in the patient's care so you may not access the patient's PHI unless asked to do so by a provider. Your access must then include a qualifying statement such as: "[your name] serving as temporary scribe for [provider name]."
- After you tell the scribe you cannot enter any information into his patient's chart he asks if you can open the patient's chart so he can see what information was lost; can you do this?
 - ▶ You are not involved in direct care of that patient and cannot access that patient's PHI.
- Your provider wants to order some Aspirin for a patient with signs of Heart Failure; however, the provider's login information unexpectedly stops working. He asks to borrow your workstation to enter the medication under your login information; is this allowed?
 - ▶ No. A provider cannot use your login information. Additionally, you are not able to enter or sign medication orders as a scribe.
- You are training another staff member to work as a scribe in your facility. The new scribe does not have her own login information; can she use yours?
 - ▶ No. Only you may use your login information.

Like the HIPAA privacy rule, Covered Entities and/or Business Associates must adhere to the HIPAA Security Rule or face penalties for non-compliance.

HITECH: Health Information Technology for Economic and Clinical Health

The **Health Information Technology for Economic and Clinical Health (HITECH) Act** was enacted in 2009 as part of the 2009 **American Recovery and Reinvestment Act (ARRA)**. The ARRA was a very large stimulus package signed into law by President Obama, which contained numerous laws regarding health care, education, renewable energy, transportation, and federal tax incentives, all of which were designed to stimulate the economy at

the time¹⁸¹⁻¹⁸³. **The HITECH Act was a major part of the ARRA and its main purpose was to promote the adoption and meaningful use of health information technology^{25,163-165,184-187}.**



SuperScribe Tip: “Meaningful Use”

refers to an EHR incentive program covered in Module III.

In addition to the federal EHR incentive program, the HITECH Act also included several key amendments to the HIPAA Privacy and Security Rules, including:

- The creation of four categories of HIPAA violations, based on culpability
- Four corresponding tiers of penalties, based on the type of violation
- New HIPAA breach notification requirements
- Setting a maximum penalty of \$1.5 million for all violations of an identical provision
- Applying direct penalties against Business Associates for violating HIPAA.

ScribeConnect and its scribes are considered Business Associates under the HIPAA Privacy and Security rules. In accordance with HITECH policy, any breach of HIPAA caused by a Business Associate can result in direct penalties to the Business Associate (not the Covered Entity). **Because the HITECH Act significantly impacts independent clinical scribes and actions, it is critical for independent clinical scribes to understand the scribe role and responsibilities with regard to HIPAA and patient confidentiality at all times.**

Scribe and Provider Signatures and Attestations

CMS' 2017 Evaluation and Management Guide instructs that medical documentation for each patient encounter include **date and legible identity of observers**, including provider statement of identity and signature^{142,188,189}. This aligns with HIPAA's Privacy and Security rules and with the Health Information Technology for Clinical Health (HITECH) act of 2009, which require individual login identification for all individuals who access any electronic medical records^{55,162}. This policy also aligns with those provided by the National Academy of Medicine (NAM), in which all certified electronic health record systems and technology (CEHRT) must log and track activity of all individuals who access the EMR¹⁶². Moreover, CEHRT system activity logs are subject to regulatory audits at any time¹⁶².

Currently, scribe attestations are not specifically required by CMS^{171,190} even though clinical scribes *are* direct observers of the patient encounter in most cases. Moreover, scribes *are* required to use individually identifiable login information when accessing and documenting a patient's medical record^{55,162}. Moreover, all scribe interaction with any certified electronic health record systems or technology (CEHRT) is logged and tracked by the CEHRT, and are subject to audit¹⁶².

Although CEHRT activity logs provide the date and identity of all observers of the patient's medical record, **Clinical Scribes are strongly encouraged to include an attestation on each medical record that specifies the date and scribe identity**⁵⁷. An example may include:

"I, [scribe name and credentials], personally scribed the services dictated to me by [name of practitioner and credentials] in this documentation on [date] for [patient's name]. [Include scribe's electronic signature and timestamp]"¹⁹¹.

It is also suggested that **providers working with scribes include the following attestation** either directly preceding or following the above suggested scribe attestation:

"I [provider name and credentials], personally performed the services described in this documentation on [date] for [patient's name] as scribed by [scribe name and credentials] in my presence. I have reviewed and verified that all the information is accurate and true"¹⁹¹.

CMS does provide the following **attestation statement suggestion for providers using scribes:**

"I [full name of the practitioner], hereby attest that the medical record entry for [date of service] accurately reflects signatures/notations that I made in my capacity as [insert provider credentials] when I treated/diagnosed the above listed Medicare beneficiary. I do hereby attest that this information is true, accurate, and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability¹⁹²."

Review & Assessment

Review

1. The **Health Insurance Portability and Accountability Act (HIPAA)**, passed in 1996, was the first set of national standards passed to protect the privacy and security of individually identifiable health information. HIPAA is comprised of two rules:
 - **The HIPAA Privacy Rule**, which addresses the use and disclosure of all **Protected Health Information (PHI)**
 - **The HIPAA Security Rule**, which protects PHI transmitted or stored electronically.
2. The **HIPAA Privacy Rule** provides national standards for protecting individually identifiable health information and applies to four entities: health plans, healthcare providers, healthcare clearinghouses, and business associates⁴⁴.
3. HIPAA applies to statutorily defined Covered Entities and Business Associates.
 - **Covered Entities** include health plans, health care providers, or health care clearinghouses
 - **Business Associates** entail persons or entities which process or access PHI on behalf of a covered entity.
4. ScribeConnect is a scribe service provider. We provide a service on behalf of health care providers, thus we are considered a **Business Associate** and we are subject to the HIPAA Privacy rule
5. PHI includes any information, including demographic data, that relates to:
 - Past, present, or future physical or mental health or condition of the individual
 - Provisions of health care to the individual
 - Past, present, or future payment for the provision of health care to the individual
6. In order to constitute Protected Health Information (PHI), patient information must have both of the following two elements:
 - Information relating to the condition/treatment/payment for treatment of the patient
 - A patient identifier (such as name, DOB, date of treatment, etc.).

7. Under the HIPAA privacy rule, PHI may only be used or accessed under 2 scenarios:
 - Under a defined permissible purpose under the HIPAA Privacy rule
 - If such use is expressly authorized by the patient.
8. Even when a Covered Entity or Business has permission to use/disclose PHI under the HIPAA Privacy Rule, such use or disclosure must be limited to the “**minimum necessary**” amount to fulfill his/her duties.
9. Penalties for breaching HIPAA include:
 - Disciplinary action, up to and including termination
 - Civil monetary penalties (anywhere between \$100 per violation and up to \$25,000 per year)
 - Criminal penalties, including imprisonment
 - Civil lawsuit for violating state privacy laws
10. The **HIPAA Security Rule** pertains to the security of **electronic PHI (ePHI)** and mandates Administrative, Technical, and Physical safeguards to protect PHI that is electronically transmitted or stored.
11. Use or access of patient information for pure personal gain (having no work-related reason) is a direct violation of HIPAA.
12. Most hospitals and EHR Systems create, document, and save audit trail reports that track each chart accessed by each individual user. This audit trail is used to ensure individual HIPAA Compliance.
13. The **Health Information Technology for Economic and Clinical Health (HITECH) Act** was enacted in 2009 as part of the American Recovery and Reinvestment Act (ARRA). The main HITECH Act included many health care technology provisions designed to promote the adoption and meaningful use of health information technology⁴⁵⁻⁵².
14. CMS' 2017 Evaluation and Management Guide instructs that medical documentation for each patient encounter include **date and legible identity of observers**, including provider statement of identity and signature⁵³⁻⁵⁵. Therefore, Clinical Scribes are strongly encouraged to include an attestation on each medical record that specifies the date and scribe identity³².

- a. An example may include: *“I, [scribe name and credentials], personally scribed the services dictated to me by [name of practitioner and credentials] in this documentation on [date] for [patient’s name]. [Include scribe’s electronic signature and timestamp]56.”*
15. Providers working with scribes are encouraged to include the following **attestation** either directly preceding or following the above suggested scribe attestation:
- a. *“I [provider name and credentials], personally performed the services described in this documentation on [date] for [patient’s name] as scribed by [scribe name and credentials] in my presence. I have reviewed and verified that all the information is accurate and true56.”*
16. CMS provides the following **attestation statement suggestion for providers using scribes:**
- a. *“I [full name of the practitioner], hereby attest that the medical record entry for [date of service] accurately reflects signatures/notations that I made in my capacity as [insert provider credentials] when I treated/diagnosed the above listed Medicare beneficiary. I do hereby attest that this information is true, accurate, and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability57.”*

Assessment

1. What are 4 examples of PHI that you will have access to as a scribe?
 - a. _____
 - b. _____
 - c. _____
 - d. _____
2. What are the top 5 things you plan to do (or not do) in order to ensure compliance with HIPAA?
 - a. _____
 - b. _____
 - c. _____
 - d. _____
 - e. _____
3. In the event that a provider or other staff member asks you to take an action that would violate HIPAA, how would you personally respond?
4. Explain what the “Minimum Necessary” Rule means:
5. What are the three types of safeguards required by the HIPAA Security Rule? Describe each type of safeguard in your own words, and provide an example of one way in which you may encounter each type of safeguard as a scribe:
6. Would it be permissible to update your Facebook status explaining the type of patient cases you saw that day? Why or why not?
7. During your shift, you see another scribe tossing a patient tracking sheet carelessly into a nearby trashcan. What should you do?
8. When accepting a new patient’s case on behalf of the provider, you recognize the patient’s name as a fellow classmate. How should you respond?
9. Explain why HIPAA was enacted and why it is so important to patients:

10. Provide examples of 5 different HIPAA violations you may encounter in your role as a scribe:

- a. _____
- b. _____
- c. _____
- d. _____
- e. _____

11. What are some ways you can ensure compliance with the HIPAA Security Rule?

12. **Think Critically:** One of your fellow scribes comes in as a patient and is unconscious. They are scheduled to work in 4 hours. Are you permitted to call your Site Manager to let him or her know? Why or why not?

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