Scribe Workflow and Goals

Roles and Responsibilities

A scribe's core responsibility is to capture accurate and detailed documentation (handwritten, electronic, or otherwise) of the encounter in a timely manner. Scribes are not permitted to make independent decisions or translations while capturing or entering information into the health record or EHR beyond what is directed by the provider.

Scribe Goals:

- ❑ Save all notes for the provider you have worked with that day by the end of the day. This should be done in a timely manner and be done no later than 30 minutes- 1 hour post seeing your last patient of the day.
- ❑ ALL charges should be inputted prior to seeing the next patient.
- ❑ Provider efficiency and productivity can increase with the use of scribes as well. When implemented with a successful clinical workflow, providers may see more patients rather than spend valuable time documenting.

Documentation Duties for Medical Scribes

- Examples of information entered by a scribe may include, but are not limited to:
- History of the patient's present illness
- Review-of-systems (ROS) and physical examination
- Vital signs and lab values – in the note or if your provider takes vitals themselves you chart in the direct charting of the workflow. CMA will document the vital signs and labs will be in flow sheets or documentation if scanned in.
- Results of imaging studies
- Progress notes
- Continued care plan and medication lists

Workflow of a Scribe during a visit with provider's:

1. Review patient chart to review medical hx, family hx, procedure hx and why the patient is presenting to the clinic for an appointment.
2. After reviewing the patient chart you should be able to determine the diagnosis that should be placed for that visit for the note-- this should already be in the list of diagnosis for the patient. Do not diagnose patient with new diagnosis without verbal directions to do so from a provider.
3. You will then go into the exam room with the provider. During this time, your goal is to do the following:
    a. History of the patient's present illness – before leaving the room
    b. Review-of-systems – before leaving the room
    c. Physical exam – before leaving the room
    d. Continue care plan (A&P) – before leaving the room
    e. PCP f/u – Use this template when inputting the follow up time and reason:
        i. Requested date/time-- this will be the date the task shows up for the front desk as "due" which means they will be checking if patient scheduled the f/u visit. The date needs to be 1 week prior to the date the PCP wanted to see them. Example: Provider wants to see patient February 28 for mood check-- this date would read february 21-- this is so the front desk is proactive and scheduling patients for f/u on time.
        ii. Reason for visit-- This will look like this format, RTC (for the reason) on (Exact date provider wants them to follow up). Example: RTC for mood check on February 28.
        iii. RTC date is the exact date the patient needs to be seen and the date the reach solution for texting the patient goes off of-- Example: 02/28/2018
        iv. No other section needs to be filled out-- if the patient is returning for physical in 1 year time, please make the requested time/date 1 month out from appointment. Example: Reason for visit: RTC for physical in April 2020, Requested time/date: March 2020-- exact dates are not pertinent information for this far out appointments.
    f. During or after the visit with the provider and patient you may need to input labs or orders – please do this in a timely manner when verbally asked to do so. This is to make sure orders are not forgotten. Please ask the provider for help if you are not sure which labs to order or not sure which diagnosis to associate the lab order with. This is important to communicate with your provider. Double check where labs need to be ordered from (Tuality being request, Marietta being Quest and out of office, CMA blood draw being Quest and in office, and etc)
    g. After the visit and before moving forward to the next visit with a new patient you should have ALL charges entered. This is important.
    h. Save the note no later than 30 minutes post visit. This is important and if saved any later you will forget important pertinent information. Please do not spend too much time editing your note-- the provider will have to do this anyway so get what you can down in each section and 'save and close' the note. The note title should be saved as the diagnosis you use and if new medication was started or d/c medication-- this can be edited by the provider so do not spend a lot of time deciding the title (should take 10 seconds to title note).
4. Move forward and follow steps 1-3 again with the next patient.