To Scribe or Not to Scribe? That is the question. While Shakespeare's fictional character may have been contemplating something a bit more drastic than the decision to help providers with Electronic Health Records (EHR) by assigning clerical staff, it is worth noting that this particular issue may take more discussion than Hamlet's seven soliloquies to resolve. It is clear that there are a number of variables contributing to success or failure in the use of scribes, and the setting seemingly most predictive of success is a large practice delegating significant responsibility to other staff.

When modeling, it seems evident that the use of scribes can improve productivity and provider professional satisfaction. However, there is little research to suggest that this actually happens in practice or, even if it does, whether it is cost-efficient. In addition, many arguments suggest that the use of scribes is simply an expensive "work-around" that reduces the pressure on vendors to improve the usability and functionality of their software systems, and that this practice will move the cost burden of inefficient programs from software vendors to health care providers. Further, the limited availability of truly effective scribes may limit health centers' ability to implement programs.

Note: Is you're HER /EMR to time consuming? Do you want more personalization with you patients?

The focus on the problems with EHR is not to suggest that scribes will solve the problems – all the use of scribes will do is transfer the problems with the systems to someone else, fundamentally doing nothing to improve the situation, and merely adding costs to the end-users. This situation is no different from any other "work-around" – it is something a user does to bypass a problem with a product. If users are able to return to pre-implementation productivity through the use of scribes, they may be less likely to shop around for more effective products, putting less pressure on the software industry.

The Elephant in the Room – The Cost

The cost of providing scribe services to providers is a direct addition to the cost of EHR; while arguably the cost of scribes may be balanced by an increase in productivity and revenue capture, this appears likely to occur only in the ideal setting. Effectively this means, to potentially achieve the desired results, health centers would have to hire the most skilled and likely most costly, scribes available.

Scribe services vary dramatically in price, as would be expected given the wide range of possible qualifications. Outsource services appear to charge between $14 and $23/hour, presumably the price in larger metropolitan areas where such a service is practical. There are also "virtual scribe" service providers (yes, based in India), who may cost less, and might feasibly be used if the EHR is "cloud-based."

While competitive published data on scribe compensation is limited, the hourly rates currently reported for medical transcriptionists are between $15 and $20/hour.[xxiv] The scribe training programs suggest to potential students that they will earn at least $25/hour, which seems untenable for a position requiring only a high school education and a week or two of training. While of limited value, some of the online pay sites (e.g., glassdoor, payscale) report more realistic rates of $8 to $12/hour.

Various studies focus on the cost-benefit analysis of scribes in emergency departments, many of which indicate a clear cost benefit to the use of scribes, and some of these are cited by scribe services. Most cost-benefit analyses in a clinic setting are not the results of actual studies, but are simply created based on assumptions of the costs of scribes and the results of using them. Generally these predict a "break even" at somewhere between one additional patient per hour, and one additional patient every

three hours. The variance is due to assumptions concerning the cost of scribes (as well as whether they are subcontracted or hired directly) and the amount of time saved. Critical to believing these assumptions, however, is the fact that, at least ***as of late 2013, there h***

Medical Transcription Services

In today's healthcare environment, medical transcription services should offer a solution, not problems. You choose outsource professionals to improve your workflow and efficiency. You need immediate results, not additional barriers and delays for your clinician professionals. That is why MedScripts Inc is the right choice.

MedScripts Inc understands your workflow demands and need for efficiency and communication. As a result, we deliver transcription services the right way – with the focus on meeting your needs and exceeding your expectations. Unlike a lot of large medical transcription services, MedScripts has no desire to be the largest MTSO — we simply want to be the best.

Our motto: Exceptional Quality, Without Exception!

While outsourcing medical transcription is not a new concept, it might be new to you. And when done correctly, it's a pain-free process that gives you the freedom to focus on more important things, like patient care.

Here are the Top 10 Reasons why outsourcing your medical transcription might be right for you:

- Eliminate Capital Investment.
- Reduce Management Expenses.
- Reduce Direct Labor Costs.
- Handle increased volume without adding staff.
- Address existing staff shortage.
- Improve Report Accessibility/Distribution.
- Reduce IT Responsibility.
- Eliminate Transcription Staff Recruitment.
- Improve Report Accuracy.
- Improve Turnaround Time\Shorten Account Receivable Cycle.

Harp's unique combination of technology, processes, and services:

- Accelerates turnaround time.
- Reduces costs.
- Minimizes capital outlay.
- Transforms dictation into meaningful clinical information to support optimal patient care.

Our transcription technology and services drive exceptional electronic documentation that better supports the data challenges your facility is facing today, such as ICD-10, Meaningful Use, and Core Measures.

Acting as an extension of your facility, MEDSCRIPTS INC uses an entirely U.S. based workforce of high-quality and experienced medical transcription editors who consistently produce documents with 98% accuracy or above. With 99.9% uptime, clinicians experience reliable dictation and document receipt.

We bring the following benefits to our client relationships:

- A seasoned management team. With over 100 years of combined industry experience our management team brings vision, clarity and integrity to our client relationships.
- A commitment to use only U.S. based healthcare documentation specialists Medscripts will provide experienced healthcare documentation specialists based here in the United States with the commitment that no work will be sent offshore.
- Available production capacity to adequately meet your fluctuating needs. The MedScripts Production Team includes a Transcription Operations Manager, our Healthcare Documentation Specialists, Supervisors, and Quality Assurance Team Members. We currently serve a variety of healthcare organizations across the country and are proud of our commitment to customer service.
- A proven Quality Assurance program. Harp's Quality Assurance (QA) program is designed to ensure our clients the highest quality transcription. Medscripts Inc Healthcare Documentation Specialists are required to maintain an accuracy score of 98.5%. Medical documents are legal documents. This makes the quality of the chart our number one priority.
- A commitment to pricing transparency. MEDSCRIPTS INC subscribes to the Billing Methods Principles published by the Medical Transcription Industry Alliance, a national organization for medical transcription service providers. These principles include the following items:
    - Verifiability: A medical transcription billing method should be subject to verification, with such verification being available to both parties to the transaction.
    - Definability: A medical transcription billing method should accurately define measures and be free from definitional ambiguity.
    - Measurability: A medical transcription billing method should allow for complete understanding of the formulas used in its calculation and result in a clear and concise invoice.
    - Consistency: A medical transcription billing method should be generally reliable and consistent in its application.
    - Integrity: A medical transcription billing method should be fair and honest, resulting in invoices that accurately reflect and charge for services rendered.
- Platform Independence: Unlike many medical transcription service organizations, MEDSCRIPTS is platform independent; meaning we do not mandate which dictation/transcription/speech recognition solution will best meet the needs of your facility. Instead we focus on providing the high quality, well-trained labor resources needed to best support the healthcare documentation creation process at your facility. Our platform independence allows us the flexibility to step in at a moment's notice and assist your facility's backlog, either on a PRN, overflow or total outsource basis. As a platform independent provider of outsourced transcription services we have supported clients on a variety of platforms including but not limited to:
    - 3M/ChartScript.net/ChartScript.com
    - Arrendale
    - Dolbey
    - Epic
    - GE
    - IDX
    - Infraware
    - Meditech
    - M*Modal/MedQuist
    - Nuance/eScription/Dictaphone
    - McKesson

Can the EHR documentation be achieved effectively and efficiently by alternative means?

Fortunately, there is a viable option: productivity focused transcription solutions by a company like Emdat. A transcription platform that is focused on productivity like Emdat allows the physician to dictate on-the-go via a mobile transcription and speech recognition app (works on booth Droid or Apple smart phones). The mobile app allows can automatically enter the dictated note/data into the patient record where it populates specific fields and is eminently retrievable. The problem of efficient documentation while maintaining effective and efficient patient care is solved without the additional expense of a scribe.

With a unique transcription and voice recognition platform like Emdat, productivity is not lost with the use of an EHR. Emdat helps you realize the ROI promised by your EHR vendor. The result is less distraction from patient care, less expense than using a scribe, increased productivity and a more all around effective, efficient, seamless EHR implementation.