Re: The Use of Medical Scribes in Health Care Settings: A Systematic Review and Future Directions

To the Editor: We appreciate the review entitled "The Use of Medical Scribes in Health Care Settings: A Systematic Review and Future Directions," by Drs. Shultz and Holmstom.[1] We are in complete agreement with the key points raised: electronic health records have important benefits to patient care and health systems, but can be time consuming, disruptive during face-to-face encounters with patients, and a source of professional dissatisfaction.

Meaningful use of an electronic medical record requires effort and a thoughtful approach. Medical scribes are able to improve and personalize the documentation of clinical encounters. As noted in the review by Shultz and Holmstom,[1] medical scribes have been shown to improve clinician efficiency as well as various financial measures.

We recently implemented a process by which the medical scribes at our institution document chronic medical conditions using the Medicare-based risk adjustment model of hierarchical condition categories (HCCs). Risk adjustment further increases the documentation burden on providers to meet annual documentation requirements. If these requirements are not met, or if documentation is incomplete, reimbursement rates for the population cared for by the group or institution at large are negatively affected. Using medical scribes, we have seen modest improvements in the documentation of the HCC-related diagnoses among our primary care patient population.

Drs. Shultz and Holmstrom help shed light on the limited data available concerning the use of medical scribes in various clinical settings. In addition, they highlight the importance of more research to understand how scribes can be used in the patient care arena, suggesting small-scale studies first.

At the core of our practice is a passion to care for people, not computers. We firmly believe that medical scribes augment the patient–provider relationship. To our knowledge, ours is the first application assessing the utility of medical scribes in the documentation of HCCs and risk adjustment. Our program may represent an additional method by which scribes can add to the financial vitality of a practice and help refocus providers' attention on the patient rather than the electronic health record.

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The above letter was referred to the author of the article in question, who offers the following reply.

Response: Re: The Use of Medical Scribes in Health Care Settings: A Systematic Review and Future Directions

To the Editor: We thank Dr. Martel and Mr. Imdieke for their comments.[1] We agree that 1 potential benefit of medical scribes is improved documentation of a patient's medical complexity. The stakes for improved documentation are growing notably higher as more patients are enrolled in health plans that factor medical complexity into their reimbursement models. Martel and Imdieke cite the hierarchical condition categories risk adjustment model used by the Centers for Medicare and Medicaid Services to adjust capitation payments for Medicare Advantage (Part C) enrollees. Such models are designed to mitigate the effect of adverse selection, whereby high-cost patients enroll disproportionately. In 2010 Part C enrollees accounted for just under a quarter of all Medicare beneficiaries; in 2015 the fraction had grown to nearly one-third.[2] Suffice it to say, risk adjustment models are here to stay, and the pressure on physicians to (accurately) report the requisite data are likely to become more intense.

Martel and Imdieke note that using medical scribes at their institution has led to modest improvements in documenting hierarchical condition category–related diagnoses within the primary care population. We applaud the effort they describe, and in the spirit of scholarly debate challenge them to measure and report their findings in the peer-reviewed literature. In this era of evidence-based decision making it is not enough to merely proclaim an improvement; one must make the case empirically using methods that hold up under scrutiny. As stated in our review, "Given the nascent state of the science, methodologically rigorous and sufficiently powered studies are greatly needed."[3] We sincerely hope Martel and Imdieke take their work to the next step by reporting their findings in the scientific literature, and we

look forward to learning more about their exciting outcomes.

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Re: The Diversity of Providers on the Family Medicine Team

The recent policy brief by Bazemore et al[1] points out the need for increased diversity among team members for an optimally functioning patient-centered medical home. The clinical pharmacist is an optimal member of this team based on their training, which complements that of physicians. Multiple studies have shown that pharmacists were able to improve blood pressure control in patients with previously uncontrolled hypertension, improve diabetes control in patients with uncontrolled diabetes, reduce polypharmacy, and improve medication safety.[2–6]

What is it about the family physician–pharmacist relationship that makes it work so well—seemingly better than other team combinations—in attaining patient-centered chronic disease goals? Perhaps it is the deep relationships that pharmacists and family physicians form and the ability of pharmacists, under collaborative agreements, not only to make recommendations to providers but also to order laboratory tests, initiate and adjust medications, and thoroughly educate patients about their medication therapies. Pharmacists enhance the ability of the primary care team to improve both medication outcomes and safety. As a medication expert without diagnostic skills, a pharmacist can fit tightly in step with the family physician as the diagnostic expert. No other health care professional brings this medication-centric knowledge and provides this ability to merge evidence with patient-specific parameters and patient-centered goals.

This relationship is most successful without an algorithm or step-by-step plan, but instead with a trusting relationship between provider, patient, and pharmacist that is built through the development of transparent goals by the entire team. It is precisely this complementary relationship that adds to the successful team dynamic. While payment models may be slow to catch up, and patients and physicians may be reluctant to add a pharmacist to the team because of cost, consider seeing patients as physician–pharmacist pair. Working together, pharmacists and physicians can use their specific training to form actionable items for the patient in front of them, ultimately providing better outcomes at a lower cost and with improved patient *and* provider satisfaction.

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The authors of the original article are in agreement with the authors and declined to comment.