HEALTHTRUST
Workforce Solutions

DIVISION SCOPE OF SERVICE

Division: ALL HCA DIVISIONS-NOT INCLUDING SAN ANTONIO
Classification: TELESCRIBE – REMOTE
Applicant Name:

TeleScribe-Remote:
The TeleScribe-Remote must have equivalent qualifications and competence as employed individuals performing the same or similar services at the facility.

Definition of Care or Service:
The TeleScribe-Remote assists physicians with use of the facility specific medical record. TeleScribe will never need access to a HCA Healthcare facility.
Scope of Service may include:

- Enters data into the facility specific medical record (electronic medical record-EMR or electronic health record-EHR)
- Assists the physician or licensed independent practitioner in navigating the facility specific medical record for the location of patient information
- Maintains and secures patient data and records
- Follows up on orders and provides lab/imaging study results back to the healthcare team
- Demonstrates Clinical and Service excellence behaviors to include code of HCA Healthcare conduct core fundamentals in daily interactions with patients, families, co-workers and physicians.

Setting(s):

- Healthcare facilities including but not limited to hospitals, outpatient treatment facilities, imaging centers, and physician practices

Supervision:

- Facility responsibility for absence of logging in the VPro/DHP Kiosk:
  - A remote worker does not access the hospital to login the Verified Professional/DHP Kiosk. Therefore, it is the hospital's responsibility to ensure each time the VPro/DHP is scheduled to work that the VPro/DHP is compliant. Verification is made by viewing the online file in the appropriate HealthTrust credentialing system.
- Direct supervision by physician or other licensed independent practitioner
  - The physician/LIP shall review all documentation completed by the scribe, make any necessary amendments, and sign the medical record / patient chart at the conclusion of the patient encounter
  - The physician/LIP is ultimately responsible for the documentation associated with the care of the patient.
- Indirect supervision department director, site manager or designee

Evaluator:

- Department director or designee in conjunction with supervising physician or Licensed Independent Practitioner
  - The facility direct supervisor must evaluate competency by a review of applicable patient records, if the Scribe does not have 1 year work experience in a comparable role.

Tier Level: 2

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eSAF Access Required: YES

Qualifications:

- High School Diploma or GED (confirmed on background check)
- Completion of medical terminology course and documentation of completion of employer scribe training – see competencies below (should be included on Skills Checklist)
- Health requirements are waived due to the nature of the remote worker
    - **TeleScribe will never need access to a HCA Healthcare facility**

NOTE: Where education may not be defined in qualifications area of the Scope, HCA Healthcare requires the highest level of education completed (not training or courses) confirmed on your background check.

State Requirements:

- N/A

Experience:

- N/A for Central and West TX, and Continental
- All other Divisions require one year experience as a Scribe.
    - If one year of experience is not provided then proof of training must be shown on Skills checklist (see competencies below), along with reassessment date within 90 days of Credentialing File Submission.

Competencies:

The TeleScribe-Remote will demonstrate:

- Accurate patient information review and evaluation
    - Uses at least two ways to identify that the patient record being accessed is for the correct patient, and this is done before initiating documentation in that patient record
    - When acting as a scribe during a procedure, the scribe participates in the pre-procedure process to verify that the documentation in the patient record correctly reflects the verbal verifications of the correct procedure, for the correct patient, at the correct site and if there is a discrepancy, the scribe alerts the procedure team before the procedure commences
    - Accesses the patient medical record appropriately
    - Maintains confidentiality and privacy in accordance with HIPAA regulations
- Documentation in the medical record
    - Documents in the medical record according to:
        - Facility standard / policy
        - Local, state and federal regulatory guidelines for documentation
    - Demonstrates the knowledge and skills necessary to document patient care in the medical record as dictated by a physician or licensed independent practitioner
        - Documentation is legible and clear
    - Organizes, maintains and coordinates clinical documentation related to patient care
        - Demonstrates proficiency in clinical documentation through use of electronic devices
        - Demonstrates proficiency in using multiple clinical documentation forms in the medical record
    - Evidence of scribe including name and title of scribe will be contained in the final medical record, e.g., Record scribed by S. Stone, Scribe
- Training
    - Must possess a basic knowledge of computer skills and facility specific computer programs
- Other
    - Must have the ability to multi-task and stay focused in a stressful environment.

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o Must have legible penmanship
References: FAQ from The Joint Commission regarding: Use of Unlicensed Persons Acting as Scribes, 5/18/11 Retrieved from: http://www.jointcommission.org/standards_information/jcfaqdetails.aspx?StandardsFaqId=345&ProgramId=1
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Your signature confirms you will be able to comply with the Qualifications and Competencies listed within this Scope of Service and that you will confirm education via your background check.

Applicant Printed Name: _____

Signature: _____

Date: _____