STATE OF THE NOTE SUMMIT 2021

MEDICAL SPECIALTY DO'S AND DONT'S

ACP American College of Physicians | EHRA HIMSS ELECTRONIC HEALTH RECORD ASSOCIATION

STOP WRITING THIS

THINGS TO FOCUS ON

History of Present Illness

A section of pertinent clinical details, relevant to the diagnoses being addressed in the visit is **essential, useful, and valuable** for many of the notes' recipients.

Assessment and Plan

Include **any details that affect the plan for the patient's conditions**, their challenges (both medical and social) and your medical decision making process. The age of narrative notes is now!

THINGS TO RECONSIDER

Chief Complaint

History of present illness will often repeat the chief complaint, or just state it in a clearer way. **Don't repeat it**, and if you keep it, don't use shorthand.

Relevant Physical Exam Data

There is no requirement to include the entire Physical Exam, including vitals. However, **pulling in the relevant items to the diagnoses** and current state of the patient is important to the clinical utility of the note.

Patient Instructions

Generally, your assessment and plan, and instructions have significant overlap, with one written for the patient and the other for yourself. **Consider combining** them and simply writing a more easily interpreted plan.

Abbreviations

Patients will see your notes, **be thoughtful about when abbreviations will be easily understood**, and when the full phrase is more understandable. Software should help with this!

Time Spent

Your time in the chart should be **tracked in the EHR**, and you are not required to list your complete time in your note. However, this is an issue that varies by organization and payer.

Discuss at your organization

THINGS TO DROP FROM YOUR NOTE

Complete Reviews, Prior Histories, Clinical Lists, & Procedure Notes

You are no longer required to document the work you did for review as part of medical decision making in the note. **Keep the items that are relevant** to your History of Present Illness, or Assessment and Plan, but let the rest be shown elsewhere.

Available in the health record.

WRITE THIS INSTEAD

History of Present Illness
Jack B Quick is a 60 y.o. year old male who returns for evaluation and treatment of left knee pain. The patient's symptoms began 3 years ago. The pain is rated as 6/10. Treatment to date has been Injection. Last injection performed last visit (11/18/2020), with good improvement for a couple of months then started wearing off. Since the last office visit the patient states that the symptoms have begun to increase. Patient tells me that he is getting 3 to 4 months of relief from his injections. Patient has no other concerns.

Objective
Vital Signs: Resp 16 | Ht 5' 11" (1.803 m) | Wt 132.5 kg (292 lb) | BMI 40.73 kg/m²

General Exam
Extremities: Examination left knee reveals tenderness diffuse over the medial joint line.Edema absent. Effusion absent. Positive crepitus. Ambulates without limp.

Imaging Studies
None obtained today.

Assessment and Plan
Left knee moderate osteoarthritis with medial meniscal pathology. Patient is doing well with conservative treatment would like to continue with this. He is getting good relief from cortisone injections and like for this be repeated today. He was given intra-articular steroid injection as requested. We will see him back in 3 months for reevaluation (around 6/29/2021).

FIVE RECOMMENDATIONS FOR EHRs

1. Automate writing in SOAP, and reviewing in APSO
2. Combine Patient Instructions and A&P
3. Expand abbreviations for patient-facing documents
4. Allow linking out to data that is elsewhere in the EMR
5. Allow for simple inclusion of discrete exam data

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