Tip Sheet for Hospitalist Open Notes

Background:
The 21st Century Cures Act, a federal law from 2016, mandates that clinical notes should be accessible to patients, by Nov 2, 2020. This includes both inpatient and outpatient notes, as well as historical notes. Exceptions: psych notes before Oct 29th; HIV and cancer results until patient informed.

Target three areas to improve:

1. **Edit your note to tell a clear story**:
   Write more thoughtful notes and avoid blowing in pages of mindless data. Please see page 2, excerpts from "Restoring the Story and Creating a Valuable Clinical Note," from Annals of Internal Medicine, Sept 2020.

   - **Summarize information**: reduce the note bloat; do not blow in lengthy radiology reports and lab tests
   - **Restore the story**: edit out unnecessary details; don't simply repeat prior notes
   - **Update** note each day; make today's plan very clear
   - **Simplify the AVS**: explanation and instructions are written in simple terms

2. **Use socially acceptable terms**:
   Avoid unflattering terms; be descriptive without being judgmental. Possible substitutions for challenging terms:

   - difficult family → extremely involved family
   - unrealistic expectations → different goals
   - drug-seeking behavior → possible dependence issue
   - psychosomatic → possible somatiform disorder and anxiety
   - dying → appropriate hospice candidate
   - refused → declined

   Of course, race should ***not*** be mentioned, other than to describe primary language.

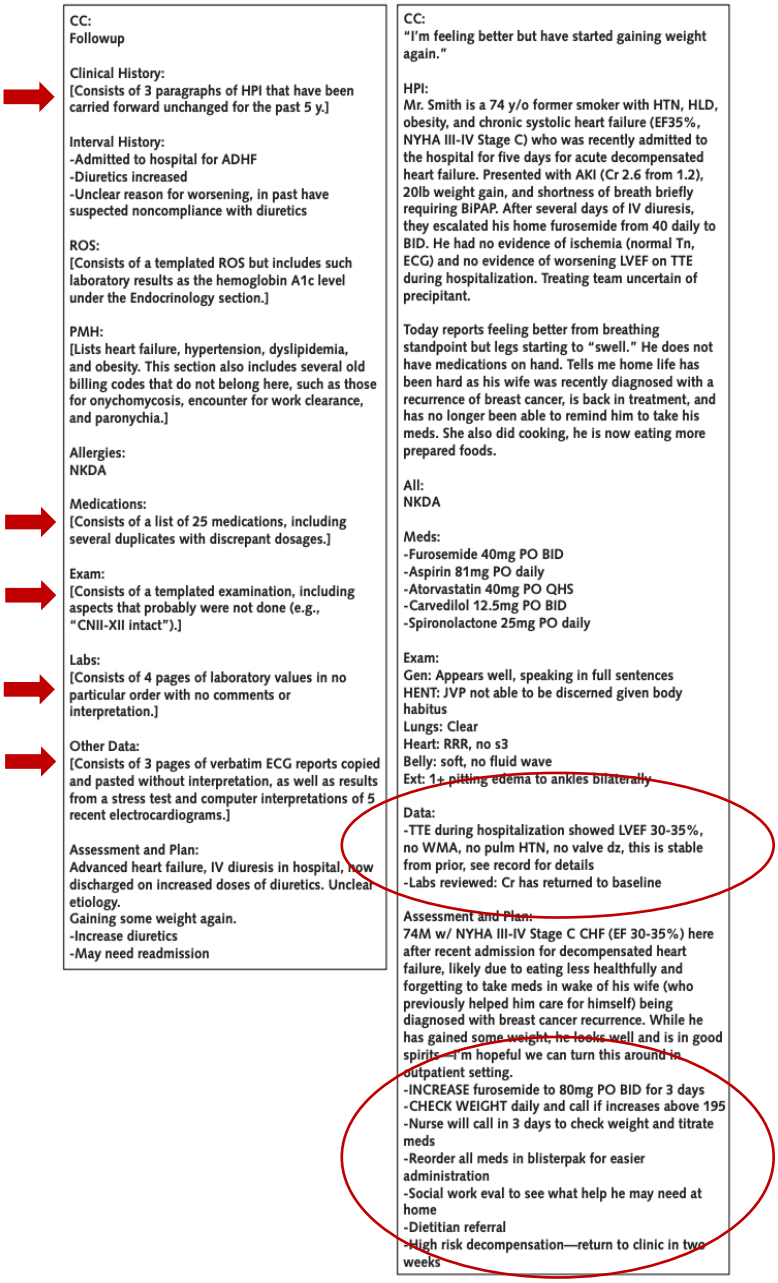
3. **Consider using auto-correct, to expand abbreviations and terms**:
   Write for the average person (middle school reading level), which means avoiding medical terminology, jargon and abbreviations. However, your note must still provide adequate detail for coding and billing. In order to accomplish both goals, use **auto-correct** in Epic:

   - From the Epic button, select "tools" "spell-checker" → "user dictionaries"
   - Then select the tab "auto-correct"
   - Type out your terms. Ex: LLE → left leg
   - Go to your note. Type "LLE" and press the space bar. Epic will auto-correct the term to "left lower leg"

Revised 10/3/20

Writing a better note, taken from "Restoring the Story and Creating a Valuable Clinical Note," by Gatzner HE et al, from Annals of Internal Medicine, Sept 2020

Figure. Improving on today's clinical notes.



CC:
Followup

Clinical History:
[Consists of 3 paragraphs of HPI that have been carried forward unchanged for the past 5 y.]

Interval History:
-Admitted to hospital for ADHF
-Diuretics increased
-Unclear reason for worsening, in past have suspected noncompliance with diuretics

ROS:
[Consists of a templated ROS but includes such laboratory results as the hemoglobin A1c level under the Endocrinology section.]

PMH:
[Lists heart failure, hypertension, dyslipidemia, and obesity. This section also includes several old billing codes that do not belong here, such as those for onychomycosis, encounter for work clearance, and paronychia.]

Allergies:
NKDA

Medications:
[Consists of a list of 25 medications, including several duplicates with discrepant dosages.]

Exam:
[Consists of a templated examination, including aspects that probably were not done (e.g., "CNII-XII intact").]

Labs:
[Consists of 4 pages of laboratory values in no particular order with no comments or interpretation.]

Other Data:
[Consists of 3 pages of verbatim ECG reports copied and pasted without interpretation, as well as results from a stress test and computer interpretations of 5 recent electrocardiograms.]

Assessment and Plan:
Advanced heart failure, IV diuresis in hospital, now discharged on increased doses of diuretics. Unclear etiology.
Gaining some weight again.
-Increase diuretics
-May need readmission

CC:
"I'm feeling better but have started gaining weight again."

HPI:
Mr. Smith is a 74 y/o former smoker with HTN, HLD, obesity, and chronic systolic heart failure (EF35%, NYHA III-IV Stage C) who was recently admitted to the hospital for five days for acute decompensated heart failure. Presented with AKI (Cr 2.6 from 1.2), 20lb weight gain, and shortness of breath briefly requiring BiPAP. After several days of IV diuresis, they escalated his home furosemide from 40 daily to BID. He had no evidence of ischemia (normal Tn, ECG) and no evidence of worsening LVEF on TTE during hospitalization. Treating team uncertain of precipitant.

Today reports feeling better from breathing standpoint but legs starting to "swell." He does not have medications on hand. Tells me home life has been hard as his wife was recently diagnosed with a recurrence of breast cancer, is back in treatment, and has no longer been able to remind him to take his meds. She also did cooking, he is now eating more prepared foods.

All:
NKDA

Meds:
-Furosemide 40mg PO BID
-Aspirin 81mg PO daily
-Atorvastatin 40mg PO QHS
-Carvedilol 12.5mg PO BID
-Spironolactone 25mg PO daily

Exam:
Gen: Appears well, speaking in full sentences
HENT: JVP not able to be discerned given body habitus
Lungs: Clear
Heart: RRR, no s3
Belly: soft, no fluid wave
Ext: 1+ pitting edema to ankles bilaterally

Data:
-TTE during hospitalization showed LVEF 30-35%, no WMA, no pulm HTN, no valve dz, this is stable from prior, see record for details
-Labs reviewed: Cr has returned to baseline

Assessment and Plan:
74M w/ NYHA III-IV Stage C CHF (EF 30-35%) here after recent admission for decompensated heart failure, likely due to eating less healthfully and forgetting to take meds in wake of his wife (who previously helped him care for himself) being diagnosed with breast cancer recurrence. While he has gained some weight, he looks well and is in good spirits - I'm hopeful we can turn this around in outpatient setting.
-INCREASE furosemide to 80mg PO BID for 3 days
-CHECK WEIGHT daily and call if increases above 195
-Nurse will call in 3 days to check weight and titrate meds
-Reorder all meds in blisterpak for easier administration
-Social work eval to see what help he may need at home
-Dietitian referral
-High risk decompensation—return to clinic in two weeks

Left. Typical outpatient follow-up note. This note shows such shortcomings as imported text, inaccuracies, and lack of detail about therapeutic plans. The clinician also misses the patient's story that explains the reason for the hospitalization. Automatically generated text that has been truncated is indicated by brackets; without this truncation, this note stretched to 8 pages. **Right.** Follow-up note that restores the story. By contrast, this note (1 page in its entirety) avoids importing data, synthesizes information, includes accurate information, and documents only the relevant components of the examination that was done. The patient's story about his wife's cancer diagnosis also shines through, providing context to both understand the reason for his decompensation and develop a therapeutic plan. Furthermore, this plan is specifically spelled out. ADHF = acute decompensated heart failure; AKI = acute kidney injury; BID = twice daily; BiPAP = bilevel positive airway pressure; CC = chief complaint; CHF = congestive heart failure; CN = cranial nerves; Cr = creatinine; dz = disease; ECG = echocardiography; EF = ejection fraction; eval = evaluation; ext = extremities; gen = general; HENT = head, ears, nose, and throat; HLD = hypersensitivity lung disease; HPI = history of the present illness; IV = intravenous; JVP = jugular venous pressure; labs = laboratory values; LVEF = left ventricular ejection fraction; M = man; NKDA = no known drug allergies; NYHA = New York Heart Association; PMH = past medical history; PO = by mouth; pulm HTN = pulmonary hypertension; QHS = every bedtime; ROS = review of systems; RRR = regular rate and rhythm; Tn = intraocular pressure; TTE = transthoracic echocardiography; WMA = wall motion abnormality; y/o = years old.