

STRUCTURE AND SYNCHRONICITY FOR BETTER CHARTING

Two key characteristics will help you to ensure that your notes communicate not only what you did, but also what you were thinking.

How many times have you read a medical note that does not make the selection of the diagnosis or treatment clear? Have you ever read your own notes after receiving notice of a malpractice suit and winced at the inconsistencies?

Poorly constructed medical notes are a widespread problem. I've seen it while reviewing the charts of medical students and residents to ensure that they met the standard of care and avoided malpractice risk. While most physicians document history and physical data with the required number of CPT elements, few clearly convey a line of reasoning that reveals their clinical thought process. A note that documents a detailed history and moderately complex decision making does not necessarily illuminate why certain decisions were reached or why a particular treatment was justified.

I wanted to find out where in the educational process students learned key documentation concepts, so I did some research that included informally querying medical students from multiple medical schools who were rotating at our residency. None of them could describe learning a formal structure for completing assessments and plans, which is consistent with a study that found only 4 percent of standardized encounters were accurately charted by medical students.¹ I also discovered that the 2010 United

States Medical Licensing Examination clinical skills exam guide states that students are expected to present a list of differential diagnoses in order of likelihood along with desired evaluations, but no requirements existed for discussing the clinical rationale.²

As a result of these and other findings, I developed a formal framework, described in this article, to teach residents and students an appropriate way to construct their notes. The initial feedback has been highly positive.

Documenting a confirmed diagnosis

To begin, let's review what should be included when documenting a confirmed diagnosis. Generally, six elements are needed (see also "The structured note" summary on page 17).

1. New or established diagnosis. The first element overtly communicates to coders whether the diagnosis is new or established, since this helps to determine code selection.

2. Controlled or uncontrolled. The second element should communicate whether the status is controlled or uncontrolled, which also directly affects complexity and reimbursement.

3. Treatment goal. The treatment goal should be

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clearly stated. How can one justify the decision to refill, increase or decrease a medication if the desired benefit is undefined? For example, simply refilling albuterol for asthma may actually hurt the patient if he or she needed a controller medication after reporting daily rescue medicine use.

4. Evaluation or surveillance. Any evaluations or testing, whether for the intrinsic disorder or for comorbidities, must be included in the plan as the fourth element. For instance, ordering an A1C test is beneficial in monitoring diabetes, but the evaluation element also reminds physicians to screen for diabetic retinopathy or hyperlipidemia.

5. Management. Documentation of treatment or management should always be listed, even if only to write, “Continue carvedilol 12.5 mg bid.” Using action verbs such as “resume” or “increase” helps communicate the treatment instructions.

6. Disposition. The final element is disposition. This is likely to include instructions for the patient to return to the clinic after a certain period of time, criteria that should prompt him or her to call the office sooner than scheduled and any actions the patient should perform at home, such as keeping a food diary or blood pressure log.

Following this structure, a note for a confirmed diagnosis might look like this:

- Hypertension: Established, uncontrolled by home blood pressure (BP) log; systolic BP

in 150s. Treatment goal: systolic BP in 130s. Complete chemistry panel/lipids/urinalysis in one week. Increase lisinopril now to 20 mg every morning, 60 tabs, five refills. Consult nurse education for dietary approaches to stop hypertension (DASH diet). Return to clinic in one month with BP log.

- Asthma: Established, controlled. Treatment goal: albuterol needed less than three times weekly. Complete annual pulmonary function tests at next visit. Refill mometasone 220 mcg one puff daily. Continue albuterol two puffs four times daily as needed. Return to clinic in three months or sooner per asthma action plan.

Documenting an unconfirmed diagnosis

When documenting an unconfirmed or symptom-based diagnosis, two elements borrowed from the five-step “microskills” model can enhance the note and provide a glimpse into the physician’s thoughts.³ It is critically important for the physician to *commit* to a diagnosis and explain *why*, among the various differential options, this suspected diagnosis is most applicable to this particular patient. Testing to confirm or rule in the working diagnosis should be listed along with empiric or symptomatic treatment. Less likely diagnoses should be listed next, along with why they are not as probable and how to rule them out. Finally, parameters for reviewing the evaluation and treatment response should be defined. See also “The structured note” on page 17.

Following this structure, a note describing symptom-based diagnoses might read as follows:

- Abdominal pain: Suspect biliary dyskinesia due to epigastric location, relation to fatty meals, body habitus and negative right-upper-quadrant ultrasound for gallstones. Confirm with cholescintigraphy (HIDA). Treatment: fatty food avoidance. Doubt pancreatitis given nondrinker and negative ultrasound, but rule

Generally, six elements are needed to document a confirmed diagnosis.

The treatment goal should be clearly stated as it drives medication changes and other key clinical decisions.

The disposition element should include any follow-up instructions for the patient.

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Article Web Address: <http://www.aafp.org/fpm/2011/0700/p15.html>

out with amylase/lipase. Doubt gastroesophageal reflux disease (GERD) given proton-pump inhibitor use and contrast to usual GERD symptoms. Return to clinic after HIDA scan and consider surgery consult.

- Rash: Suspect allergic photodermatitis given location in sun-exposed areas and onset after use of new sunscreen lotion. Confirm by stopping lotion. Treatment: PABA-free sunscreen. Doubt lupus given no prior history and absence of other complaints. Doubt prescription medications due to no admitted use. Return to clinic if symptoms persist after lotion change.

Synchronicity

Finally, synchronicity should be evident in every note both globally and locally, that is, both within and across the major sections. For example, the past medical history should match the medication list. If it doesn't, a reviewing physician may wonder what other aspects of care were sloppy or incomplete. Here's an abbreviated example of poor *local* synchronization:

- Past medical history: hyperlipidemia, COPD.
- Meds: tiotropium, lisinopril, levothyroxine.

Synchronicity between the subjective/objective (S/O) and the assessment/plan (A/P) sections of the note is also important. For example, if the physician documents three abnormal items in the S/O section, but the A/P only lists two diagnoses, then a mismatch

exists between abnormal data collected and assessments made. Not only might this pattern result in underpayment, but it also puts physicians in indefensible positions if a malpractice case ensues. Most important, it may contribute to patient harm.

Here's an abbreviated example of poor *global* synchronization:

- Subjective/objective abnormal data: Epigastric burning pain at bedtime, non-scarring hair loss three months postpartum, loss of urine with coughing and laughing.
- Assessment: GERD, telogen effluvium.

Summing it up

Structure and synchronicity are part of disciplined note construction, which is critical to effective communication between physicians. Better documentation may also contribute to clearer medical decision making, which is needed for reimbursement and malpractice defense. Instruction in comprehensive note writing should be promoted in early predoctoral education and continued throughout postgraduate medical training. **FPM**

Send comments to fpmedit@aafp.org.

1. Szauter KM, Ainsworth MA, Holden MD, Mercado AC. Do students do what they write and write what they do? The match between the patient encounter and patient note. *Acad Med.* 2006;81(Suppl 10):S44-S47.
2. U.S. Medical Licensing Examination. *2010 Step 2 Clinical Skills: Content Description and General Information*. <http://download.usmle.org/2010/2010CSinformationmanual.pdf>. Accessed May 17, 2011.
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When documenting an unconfirmed diagnosis, the physician should commit to a diagnosis and explain why the diagnosis is the most likely.

Synchronicity should be evident in every note. For example, the rationale for each drug on the medication list should be implicit in the past medical history.

Better documentation contributes to clearer medical decision making, which is needed for reimbursement and defense against malpractice suits.

THE STRUCTURED NOTE

The table below shows the essential components of a detailed assessment and plan.

| Confirmed diagnosis | Symptom-based diagnosis | SYNCHRONIZE LOCALLY AND GLOBALLY |
|--|--|----------------------------------|
| New or established diagnosis Stable or uncontrolled Treatment goal Evaluation/surveillance (including related comorbidities) Management Disposition | Suspected diagnosis Rationale Evaluation (to confirm) Management Less likely diagnoses Rationale Evaluation (to rule out) Disposition | |