

# Getting Your Notes Done on Time

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## These seven tips can help you spend less time on charting.

In the age of paper charts, physicians' notes were as quick to produce as their scribbled handwriting, and just as legible. Now that we have electronic health records (EHRs) and documentation guidelines, many physicians struggle to complete their notes in a timely manner.

Here are some charting tips (for those of us without scribes or dictation systems) that I've gleaned from years of practicing medicine and coaching residents and fellows.

**1. Leverage the skills of your team members.** You don't have to document everything yourself. For example, the medical assistant or nurse on your team can document the patient's concerns, review medications, and verify or document allergies. You can then quickly review the information for accuracy and sign off on the note.

**2. Get done what you can in the room.** When talking with a patient about his or her history or treatment plan, make notes as you go, summarizing aloud to engage the patient and ensure understanding. You can even complete electronic prescriptions in the exam room so the patient knows they have been sent and you don't have that work waiting for later.

**3. Know the E/M documentation guidelines.** A 99213 level of service does not require a comprehensive review of systems or a comprehensive exam. Document what's medically necessary and complete for today's visit, and no more. (For more information, see the *FPM* Documentation Guidelines topic collection at <http://www.aafp.org/fpm/medicare>.)


**4. Use your basic EHR functions.** Templates and the copy and paste functions are helpful for routine visits where clinical queries are standard, but use them judiciously. "Today's note" should accurately reflect the patient's condition today and your impression today, so

make sure to modify any templates or copied material to reflect this. In complex or changing situations, it may be faster and more accurate to avoid such features. But if it's flu season and you don't have a functioning influenza vaccine template, take 90 seconds to create one, and save yourself time down the road. In addition, use the relevant "data bucket" when appropriate. For example, if you have just obtained an element of social history that you want to use for future visits, place that in the "social history" area of the chart so that it can be carried forward and reviewed on future visits, thus saving you documentation time later. Once you've mastered these basic EHR features, continue to learn about your EHR functions. Most systems can do many more automated tasks than any one person knows, so talk to others and share tips.

**5. Let go of perfection.** The EHR can be a minefield for perfectionists and compulsive "box-checkers." Again, remember the documentation guidelines. Not all boxes need checking, and not all categories need filling on every visit. Know which ones do, and leave the rest alone.

**6. Forget the "opus."** The clinical note serves as neither biography nor ethnography. Be brief and focused. In the plan section of the note, be clear and concise enough that the next person looking at your note will be able to understand your clinical reasoning and follow the plan.

**7. Time yourself.** Using your smartphone or watch, see how long it takes you to complete a note. Then set a goal to decrease this. With residents, I suggest a goal of 5 minutes or less per note. However, this is far too long for most practicing clinicians because we would spend an hour documenting for every 12 patients seen. Set your own goals, and work to achieve them.

Of course, speed should not be our only goal. With new or complex patients, spending more time on documentation may be time well spent. These tips are designed to help you get through the majority of your routine documentation more efficiently, freeing you to work on other tasks – or go home earlier. 

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