Boost Charting Efficiency: A Sure-Fire Path to Better Job Satisfaction

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Whether we like it or not, electronic medical records are here to stay. And their takeover has been swift. Over recent decades, the EMR has gone from an obscure, bare-bones, often clunky digital notepad to a ubiquitous and powerful tool which tracks enormous amounts of patient data. To continue to practice medicine, we've had no choice but to go along for the ride. It's noteworthy that, during the course of this transformation, the amount of engagement the EMR has asked of us has increased consistently; not coincidentally, at the same time we've also seen proportional increases in provider burnout.[1,2] Perhaps nowhere is this issue more palpable than urgent care.

In our busy UC clinics, our primary duty is evaluating and managing a seemingly ever-growing volume of patients. Since the beginning of the pandemic, these pressures have only increased with staffing shortages and increasing gaps and delays in primary and specialist care. This creates a daily challenge of using our limited resources to safely, yet efficiently, provide excellent care for our patients.

In other words, we are tasked with not missing serious diagnoses while ensuring excellence in patient experience, all while not falling behind.

But when things get busy, as they inevitably do, the most universal part of our practice to suffer is staying caught up with our documentation. It's like sleep. When life gets busy and we are task-saturated, compromising on how much we sleep is most often how we try to "make time" to try to get more done in a day. And like forsaking sleep, postponing charting until the end of a shift (or worse, another day) catches up to us quickly and the results are painful. The knowledge of a mounting pile of unfinished charts weighs on the mind through the day and the feeling of demoralization only grows when that pile is staring us in the face at the end of an already busy shift. That's why working towards more efficient documentation is a powerful strategy to improve overall job satisfaction and mitigate burnout.

Synchronous chart completion has also been identified as a best practice. The Centers for Medicare & Medicaid Services specifically advises clinicians that "the service should be documented during, or as soon as practicable after it is provided, in order to maintain an accurate medical record."[3]

While this may not always be immediately practical, or even possible, it's worth noting that timely medical documentation has been so specifically identified as a quality-defining metric because it has obvious implications for patient safety.

Making this practice a habit is important for the protection of our patients for several reasons.

First, the speed and accuracy with which we are able to notate the patient's history and exam is greatest during or immediately after our evaluation, while the details are still fresh in our working memories. We can recall details like recent changes in the patient's blood pressure medications or when they last were treated for a UTI more accurately and include them in the chart, which may prove to be important data points in their care and follow-up.

Secondly, putting our thought processes in writing forces us to reflect further on the patient's presentation. Who among us hasn't had this experience? A patient comes in with a headache. The clinic is busy so you see them quickly, don't note any red flags, and discharge them promptly so you can move onto the next patient. "I'll get to their note later when things slow down," you think to yourself. But *later* rarely comes before the end of the shift. Then, with some struggle, you try to piece together the details of their headache story from memory and realize that you forgot to ask about recent trauma and anticoagulation use.

If you'd done most or all of the charting before the patient had left the clinic, these omissions in history would've been revealed and corrected by just asking a few more

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questions. Not only is concurrent charting more efficient, therefore, but also protective against gaps in thought processes which might negatively influence outcomes.

Finally, many patients will go on to receive subsequent care in the days following a UC visit for an acute issue. When our charting is incomplete, it leaves subsequent clinicians taking care of the patient in the dark as to your medical decision-making and plan. In fact, it's best to think of a patient's visit as incomplete until the chart has been created and signed. This has the added benefit of unburdening your cognitive bandwidth so you're able to move on and focus fully on the next patients.

Hopefully, the concept of concurrent charting isn't novel. We suspect many of you aspire to this with every shift. But if you're falling short, you're certainly not alone and there is hope for improvement with relatively few modifications in your practice.

The 80/20 rule (also known as the Pareto principle) states, roughly, that 80% of results come from the most important 20% of techniques.[4] Thankfully, this holds true for improving documentation efficiency.

We have found the six principles and tactics described below to yield remarkable and rapid boosts in documentation efficiency and provider productivity—and, consequently, their level of job satisfaction. As you'll see, these are practices that can be easily learned.

1. Maximize the use of "smart tools." All EMRs have similar efficiency tools, and it's worth investing the effort to customize them for anything you document frequently.

- If you're writing anything repetitively, create a *dot phrase* or macro (eg, pertinent negatives for patients with chest pain or a normal hand exam).
- Customize your user dictionary to convert common abbreviations to plain English (eg, f/u = follow-up or SOB = short of breath). In the age of the 21st Century Cures Act, this can also spare you the conflicts that may arise when patients read these acronyms.
- Include the exclusion criteria for clinical decision rules you use commonly (eg, PERC score or NEXUS C-spine rule) within your note with a dot phrase/macro rather than going to an outside resource to calculate them.

2. Take advantage of any *superpowers* available. Scribes and voice-recognition dictating give us something akin to a superpower. Getting used to using these tools may take time, but once you get over the hump, they're huge time savers. You can even try dictating with whatever software your organization uses on a computer in the patient's room. Skin exams can be complex and hard to template, as can medical decision-making for moderate to complex cases. Consider dictating this information right in front of the patient. In our experience, the response has been almost universally positive. Patients appreciate the enhanced transparency, and you save time by not having to repeat your reasoning as a soliloquy later.

3. Use templates judiciously. Templates can be extremely helpful timesavers. The top 10 complaints, including things like cough, sore throat, ear pain, and dysuria, make up the vast majority of UC patient visits.[5] These all require similar points in the history of present illness and evoke fairly limited differentials. Starting from a nearly completed template with relatively few blanks for the pertinent data saves an enormous number of clicks and keystrokes.

Over time, see where you're spending the most time in these templates and continue to make incremental adjustments to hone them. This format, compared with starting a blank note for each patient, can also prompt us to ask certain questions which we may otherwise forget (eg, date of last menses, recent antibiotic use, etc.).

4. Resist "note bloat." Long templates take more time to complete. For most UC complaints, a very limited history and physical is sufficient. While it may feel helpful to import the patient's entire past medical history, medications, and family history, this information can be found elsewhere in the EMR and could distract both you and future readers from the information relevant for the patient's current UC presentation. Other examples of problematic *note bloat* include copy-and-pasting long portions of prior visits rather than summarizing them and including irrelevant, overly detailed review of systems and physical exam comments. (Recall that since the 2021 CMS updates in E/M billing criteria, levels of service are now only determined by our MDM).[6]

5. Consider timing of discharge. Our UCCs use queuing software which adjusts open visits depending on the rate at which patients are seen. When using such systems, clicking the "discharge" button essentially indicates that the patient's care is complete. But if the note isn't finished, it's not accurate to say that care is complete. As we discussed earlier, only the patient-facing portion has been accomplished. Instead, consider completing the chart *before* discharging the patient. This also has the previously mentioned benefit of forcing us to review and stress-test our clinical reasoning while the patient is still in the clinic.

6. Recognize complicated cases and be prepared to spend more time on those charts. It's helpful to broadly lump patients into two categories: low-risk/straightforward or high-risk/complex.

- For low-risk patients, keep charting focused and short. Excessive history, exam, or MDM in these cases is a waste of your mental energy and a source of note bloat. Get charts for things like otitis media, cystitis, and sore throat done quickly and move on. You don't need long paragraphs of MDM explaining why you think someone just has a cold.
- For high-risk patients, slow down. Older patients, patients with multiple comorbidities, abnormal vital signs, and/or potentially dangerous chief complaints like chest pain or abdominal pain require a more time-intensive and thoughtful evaluation. While this is the vast minority of UC patients, thankfully, you probably will see at least a few of them each shift. Use the time that you've saved by avoiding overcharting on the simpler cases to focus more attention on the assessment and documentation for these more complex cases.

The Pareto principle reminds us that strategically making targeted changes in our practice habits can have a disproportionate impact on our overall efficiency. Charting, for most clinicians, is the least appealing part of the job. This can lead to a tendency to simply slog through our documentation, like the chore that it may often feel like. However, paradoxically, by consciously turning towards changing our habits and implementing strategies like those we've discussed, documentation can quickly become much less time-consuming and onerous. And, extending the Pareto principle, if we make the 20% of our job that's least pleasant even a little less painful, we can expect a disproportionate increase in the enjoyment we're able to rediscover in our work. ■

References

1. Asan O, Smith PD, Montague E. More screen time, less face time. *J Eval Clin Pract*. 2014;20(e1):896-901.
2. Babbott S, Manwell LB, Brown R, et al. Electronic medical records and physician stress in primary care: results from the MEMO Study. *J Am Med Inform Assoc*. 2014;21(e1):e100-e106.
3. Centers for Medicare & Medicaid Services. Chapter 12–Physicians/nonphysician practitioners. Medicare Claims Processing Manual. Available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf. Accessed May 3, 2023.
4. Pressman RS. *Software Engineering: A Practitioner's Approach*. 7th ed. Boston MA: McGraw-Hill; 2010.
5. Experity. An Analysis of ICD-19, CPT, and E/M Coding Trends Over 5 Years. Available at: https://www.experityhealth.com/research/icd-10-cpt-and-e-m-coding-trends/. Accessed May 3, 2023.
6. American Medical Association. CPT Evaluation and Management (E/M) Office or Other Outpatient (99202-99215) and Prolonged Services (99354, 99355, 99417) Code and Guideline Changes. Available at: https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf. Accessed May 3, 2023.