21st Century Cures Act
Charting Etiquette Tips and Scenarios

Audience: All Providers

Starting Friday, Dec. 31, HM will auto-release USCDI V1 Clinical Note types to patients' **MyChart** accounts — ***unless the provider deems auto-releasing may cause patient harm or the patient requests***. Remember, patients and parents/guardians have always had legal access to their medical records, including clinical notes, but now they'll have secure and easy access to this information, electronically.

To prepare, use these tips and common scenarios to help improve your note-writing skills.

Note Writing Tips

Engage Patients

- When writing or dictating clinical notes, involve patients in the process.
- Show your patient what you're typing and read it aloud or dictate your note in front of the patient.
- This will give them a chance to ask questions.

Use Simple, Easy-to-Understand Wording

- Keep wording as simple and as nontechnical as possible.
- It's okay to use medical terms but if possible, use simpler terms.
- Abbreviations and acronyms are often misunderstood. To convert these into full words, use **SmartPhrases** or autocorrect dictionary tools.

Check Accuracy

- Efficiency tools can sometimes cause inaccurate documentation.
- If you use tools like NoteWriter Macros and SmartPhrases to quickly document basic history or exam information, if you didn't do the full history or exam, be sure to modify your note.
- Don't copy/paste or copy forward information that's no longer accurate.
- Thoroughly review your note, so you can update anything that's changed or remove information that's no longer applicable.
- Only attest to the amount of time spent and make sure your note explains what you're attesting.
- **Inpatient and ED**: Be sure your note explains that the attestation may include time not spent at bedside.
- **Outpatient**: Since you can now bill for all time spent on the date of service and not only face-to-face time, modify your attestation in your note.
- Document video visit time in the **Visit Navigator** attestation and not in your note.

Reduce Note Bloat

- Don't leave out anything important but think about what information really needs to be in your note.
- Consider eliminating data that can easily be found somewhere else in the chart.
- Be mindful when copying information from another note.
- Ensure the previous note was shared.
- Don't copy previously unshared notes or results unless they're deemed appropriate.

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Sensitive Topics

- When addressing sensitive topics, like obesity, mental health or suspicions of a life-threatening illness, don't withhold information.
- State the information directly and objectively.
- Be sure to include descriptions, explanations and plans.
- Patients want and deserve to know this information.
- Examples
    - **Obesity**:
        - State the patient's body mass index and the definition for overweight, obese or morbidly obese.
        - Discuss weight loss strategies and focus on positive changes the patient has made.
    - **Cancer possibility**: Note specific concerning symptoms and the plan for further evaluation and/or treatment.
    - **Substance use and mental health**:
        - Don't label the patient.
        - Describe findings and your recommendations.

Be Objective, Don't Label or Make Negative Comments

- If you disagree with your patient or another provider, state the facts but don't make negative comments.
- Don't make assumptions.
- Describe behaviors, but don't subjectively label.

Scenarios

Most patients want to see their documentation as it's written, including specific medical language, since they often share this information with other providers. However, for some situations, consider alternate wording.

Instead of Using This	Use This Alternative
Possible pejorative wording	
"GI refuses to scope the patient."	"GI service doesn't recommend endoscopy; we'll continue to discuss options."
"He is a drug abuser" or "He is a drug addict."	"He uses injection drugs."
"Mr. Z is an addict." "Mr. Z abuses substances." *Neutral term is user and not addict or abuser.*	"Mr. Z uses heroin and reports taking five pills a day." "Mr. Z has a positive toxicology screen for…"
"She is non-compliant with her medications."	"She is not taking her medications because…" or "She has trouble remembering to take her medications."
Behavioral health wording	
"She is paranoid and delusional."	"She states 'There is a transmitter in my tooth. It talks to me.'"
"He is aggressive, inappropriate and malicious."	"He yelled obscenities and punched two staff members."
"Mrs. S has been aggressive all day."	"Mrs. S attempted to punch and bite staff members when ADL care was given."

Wording possibly misunderstood	
"Mr. Z is morbidly obese." *Balance dx wording for both coding and patient reading.*	"BMI > 40." "Morbid Obesity relating to worse knee pain." "Obesity: patient working hard on weight loss."
"Patient was SOD. F/U next appt." *Use EHR auto-correct dictionary tools to auto-expand commonly misunderstood or impenetrable acronyms or use speech recognition tools.*	"Patient was short of breath. Follow up at next appointment."
• "Family has unrealistic goals." • "Family is in denial." • "Family dynamic is challenging and difficult." • "Patient is unreasonably insisting on…"	• "We have met with the patient's surrogate decision makers to discuss prognosis and options for care." • "We discussed *x* therapy, recommended *y* and explained *z*…." • "After hearing this information, family requested *b*, *c*…"