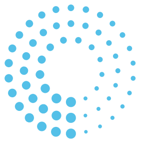 **HIMSS**

Cutting Through Note Bloat: Crafting Clear, Actionable Documentation in the HER

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When was the last time you skimmed a colleague's progress note without wincing at its sheer length? Documentation has evolved from a clinical necessity to an unwieldy chore, cluttered with extraneous data that often obscures the story rather than clarifying it. Note bloat is rampant, burdening physicians both in writing and, importantly, in consuming progress notes. It's time we rethink what—and why—we're documenting.

The electronic health record (EHR) has revolutionized healthcare, offering unprecedented access to data. Yet, with this power comes a tendency to overuse it. With just a few clicks, the EHR makes it easy to "pull in" data, from lab results to full problem lists. This convenience can quickly turn a straightforward visit note into a massive wall of text, complete with irrelevant lab results and redundant findings. Patient care suffers when documentation becomes more like a novel than a reference card. Instead of a quick cue card, we're left sifting through virtual tomes.

Rethink your audience: notes as communication, not chart dumps

Before diving into the "what" of documentation, let's reconsider the "why." Progress notes serve several core functions: they jog our future selves' memories, provide a clear clinical story for colleagues, and facilitate care coordination across teams. Notes should primarily communicate our reasoning, clinical assessment, and next steps. They are not intended to replace a thorough chart review for the next provider—EHRs already facilitate that.

Consider this: what's more meaningful to a clinician trying to understand a patient's recent course? Five years' worth of CBC results, pasted in raw form, or a concise sentence noting, "Hemoglobin has dropped from 14 to 11; iron studies and colonoscopy have been ordered"? The latter communicates the information clearly, allows for quick processing, and improves clinical decision-making.

Ditch the templates: customize to communicate

EHR templates can be both a blessing and a curse. They save time, but all too often, they generate notes littered with irrelevant sections, broken links, and the dreaded "no data found" messages. If a pre-filled section doesn't contribute to the patient's story, delete it. The extra scrolling and cognitive load only distract from the critical aspects of care. Our notes should be dynamic and focused, tailored to each patient encounter, not carbon copies of the last.

And please, resist the urge to "copy forward" entire sections without careful editing. Redundant information clouds critical updates. Instead, use EHR tools to quickly summarize key elements, focusing on the interval history and decision-making that guides your clinical plan.

Updating for compliance: new rules, new freedom

A significant part of note bloat can be traced back to outdated compliance practices. Historically, we documented exhaustive reviews of systems (ROS) and physical exams to meet billing criteria, often listing findings unrelated to the patient's primary issues. However, as of 2021,

CMS and AMA updated documentation guidelines to relieve these burdens. Under the current guidelines, neither an ROS nor a detailed physical exam (or even any PE) is required for E/M coding. Many physicians continue to include these out of habit or a sense of caution. Still, the change offers a new freedom: the ability to focus on meaningful clinical content, rather than box ticking.

The AMA's "Taming the EHR" playbook is an excellent resource for streamlining notes while meeting regulatory standards. It provides specific strategies and examples to help you rethink and simplify your documentation approach.

A simple example: high-quality notes, low overhead

To illustrate, consider a simple, yet complete, progress note for a Level 4 E/M encounter:

AMBULATORY NOTE – DERMATOLOGY

SUBJECTIVE:

The patient is a 49-year-old white female, established patient to Dermatology, last seen in the office on 08/10/2004. She comes in today for reevaluation of her acne plus she has had what she calls a rash for the past two months now on her chest, stomach, neck, and back. On examination, this is a flaring of her acne with small folliculitis lesions. The patient has been taking amoxicillin 500 mg b.i.d. and using Tazorac cream 0.1, and her face is doing well, but she has been out of her medicine now for three days also. She has also been getting photofacials at Healing Waters and was wondering about what we could offer as far as cosmetic procedures and skin care products, etc. The patient is married. She is a secretary.

FAMILY, SOCIAL AND ALLERGY HISTORY:

She has hay fever, eczema, sinus, and hives. She has no melanoma or skin cancers or psoriasis. Her mother had oral cancer. The patient is a nonsmoker. No blood tests. Had some sunburn in the past. She is on benzoyl peroxide and Daypro.

CURRENT MEDICATIONS:

Lexapro, Effexor, Ditropan, aspirin, vitamins.

PHYSICAL EXAMINATION:

The patient is well developed, appears stated age. Overall health is good. She has a couple of acne lesions, one on her face and neck but there are a lot of small folliculitis-like lesions on her abdomen, chest, and back.

IMPRESSION:

Acne with folliculitis.

TREATMENT:

1. Discussed condition and treatment with the patient.
2. Continue the amoxicillin 500 mg two at bedtime.
3. Add Septra DS every morning with extra water.
4. Continue the Tazorac cream 0.1; it is okay to use on back and chest also.
5. Referred to ABC clinic for an aesthetic consult. Return in two months for follow up evaluation of her acne.

EXPLANAION:

Diagnosis
Acne L70.9
Folliculitis L73.9
Antibiotic use Z79.2

E/M 99214 Established
Problem-Moderate, Chronic with exacerbation
Data-Straightforward
Risk- Moderate, Drug Management

Less is more: documentation as a clinical tool

Refining our approach to documentation is about more than cutting down on words. It's about creating a tool that enables safe, efficient patient care while reducing burnout for clinicians who rely on clear, actionable notes. A well-constructed note captures the essence of the visit without unnecessary details. What truly matters is the patient's story, your medical decision-making, and the next steps. That's all.

To access all of the note examples and other resources created by the HIMSS Clinician Burden Reduction Task Force, click here to access the Burden Reduction Task Force Toolkit.