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EDITORIAL

No Longer Beholden – Moving On from Elaborate Chart Notes

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"Physician, heal thyself." Luke 4:23

Clinical chart notes in the US are, on average, four times longer than those in other countries [1]. In 2021, new Medicare guidelines for outpatient billing provided a much needed administrative reprieve for clinicians. Coding level is no longer determined by the number of history, review of systems, physical exam and data review elements documented in our chart notes. The new, simplified visit coding is now based on time spent or complexity of medical decision making [2]. Knowing that excessive EHR documentation burden is cited as a major source of physician burnout [1], one might expect a) these new rules to be received with celebration and b) most notes to be pared down to the essentials. Not so. The elaborate masterpiece note is still prevalent. Why is this the case, and how might we accelerate meaningful change?

I gained helpful insight into this question while coaching a newer primary care physician in our organization to help her improve workflow efficiency, manage patient visits, chart, and address in-basket tasks. She used a detailed template for her progress notes and admitted that she never finished a note during a visit. As a result, she had limited time to address messages and a growing mountain of incomplete charts. When we spoke about her excessively detailed chart notes, she told me that she modeled her notes on those of other providers. These primary care notes often contained copious detail, along with copy and pasted lab and diagnostic test reports. She also remarked about her training, when the most thorough notes received great praise. To date, no mentor had provided specific instruction on revising her progress notes beyond the standard, high level overview from our department of billing compliance. Reinforcement of elaborate chart notes may be traceable to the growth of audit culture in medicine [3]. Note content is a convenient, measurable surrogate for quality. It is much easier to grade notes (especially with the disappearance of illegible handwritten ones) than the actual interplay which occurred during a clinical encounter. Similar numeric scales are used to evaluate clinician performance in domains such as patient satisfaction and value-based payment metrics. Scribes and voice dictation have helped ease the burden of charting metrics for those who have access to them, yet we are still left with long, complex documentation that adds to our workload on the back end. With the growth of chart transparency, we should consider patients as stakeholders who will benefit from simpler notes. The recent change in Medicare's billing documentation guidelines is a rare step ahead and away from audit informed assessment. We can take advantage of these new guidelines. What stands in the way?

Changing unhealthy behaviors is often challenging, as with improving eating habits or sticking with a new exercise routine. In these examples, there is some comfort in the status quo; junk food is delicious and the sofa can be more alluring than the Peloton. The connection to charting may not be apparent on the surface, but we document excessively out of convention, inertia, worry, and lack of will or energy to fight for a better way. We have come to accept a clinical documentation process that creates more computer distraction in the exam room and adds extra charting hours to the end of the day. Both are strong drivers of professional dissatisfaction.

Role modeling is what steered my young physician colleague toward her current excessive documentation habits and taught her to connect charting comprehensiveness to clinical excellence. This often takes place within the so called "hidden curriculum" in medical education. Herein students and residents adapt the frameworks they learn during the pre-clinical coursework to the behaviors they see demonstrated and reinforced in the context of real clinical practice. The hidden curriculum is rife with positive influence, such as helping trainees develop good habits of self-reflection and apply patient centered communication. It also has negative effects such as revealing biases, unexplained short-cuts and poor work-life balance [4].

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While medical culture's shared values and rituals provide comfort, solidarity and purpose, they may also be challenging to revise when circumstances evolve over time. The result can be the persistence of behaviors such as elaborate chart notes, which undermine clinician well-being and do little to improve patient care [5].

Leading physicians toward more efficient documentation may not necessitate a major professional culture change. Rather, the current culture can be leveraged to a positive, transformative end. We can, in essence, use one time honored aspect of culture (demonstration by senior clinicians) to help dispel another (elaborate notes) that is no longer useful. Demonstration may help physicians reform notes from the current state of excess to one that is more streamlined and efficient.

Our organization has a strong EHR education and support team that provides shoulder-to-shoulder tutoring on underutilized EHR utilities and shortcuts (smart phrases, etc.) Most of the support team of highly trained and knowledgeable staff are non-physicians whose roles are external to the physicians' workplace social sphere, limiting their cultural influence. Physician coaches could supplement these efforts, with doctors leading by example, sharing and explaining their own chart notes as models to follow.

During my session with the aforementioned struggling physician, I made a point to empower her to compose a markedly pared down progress note. We reviewed examples of notes deemed sufficient to justify various billing codes and withstand any medico-legal inquiry, then compared them to her typical bulky chart notes. The contrast was striking. I went on to stress the point that documentation volume does not equate to clinical thoroughness or thoughtfulness. It is time to replace elaborate note writing with more meaningful engagement with patients, along with redistributing precious saved time to self-care. Medicare has presented us with a gift horse; let's not look it in the mouth.

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