AAFP Backgrounder: Chart Review Burden

Chart review burden has grown dramatically, driven by the explosion of electronic health records. The fee-for-service model demands that family physicians see 20 to 30 patients a day for 15 minutes each. The resulting time pressure sends clinicians rushing from one patient to the next, while their EHRs require them to navigate and open documents to review the chart for each patient. Physicians say they feel trapped on hamster wheels or that they're suffering "death by a thousand clicks." Meanwhile, new quality and value-based programs continue to expand the scope of clinical review. Today that review entails documenting answers to several open-ended queries, including:

- What is new in this patient's history?
- What is pertinent to today's visit?
- Am I missing a diagnosis or other clinical elements?
- Am I identifying all care gaps, quality metrics, and RAF gaps?

To meet this demand, family physicians spend more than 1.5 hours per clinic day (13% of their work) conducting chart reviews in support of visits and care. This time is often inadequate, particularly for the complex patients who are most at risk. Physicians squeeze chart review in right before seeing the patient as well as between visits, before clinics, and even the night or weekend before.

A broad time-and-motion EHR study of 100 million patient encounters with about 155,000 physicians from 417 health systems indicated 16 minutes of EHR use per visit, then broke down physicians' chart burden minute by minute.

- Chart review: ~5 minutes per visit (33%).
- Documentation: ~4 minutes per visit (24%).

Even if the care team helps prep the chart, the physician still must review all of the information. EHRs and document-management systems require time and many clicks to search, navigate, open, and read documents.

When physicians feel rushed and worry they may miss something, their professional satisfaction diminishes — and the quality of care suffers.

Sources of Burden

The information technology revolution has greatly increased chart review burden. Why?

EHR Document Explosion: Note Bloat

EHRs and payment requirements have expanded the scope of documentation to include large portions devoted to non-clinical purposes, including administrative, legal, research, and education. The use of structured data imports, templates, and copy-paste have bloated notes, turning review into a burden while making it more difficult to find the pertinent information and understand the medical decision making.

Extraneous Information

Notes and documents contain content not directly relevant to clinical care, including administration, billing, quality-improvement measures, avoiding malpractice, and documenting compliance.

Information Chaos

The health system now generates so much information that a physician user of technology must navigate overloaded matrix, one in which important data may be scattered, conflict with other information, or contain errors.

Time and Churn
The physician must dedicate extra effort to search, sort, and sift through a chart and each of its documents to retrieve pertinent data on a patient and their care. When information is missing, conflicts with other data, or appears incorrect, valuable time is spent asking the patient more questions.

"Other Documents"
Documentation that comes into the EHR from outside systems or has been scanned in may not be adequately labelled or summarized, requiring a physician to first find some "other document," then open and read through it to find any pertinent information — if time allows.