Closing the Documentation Gaps in Your EHR

Documenting accurate health care data is important to both practitioners and patients, because as we've all heard, "if it isn't documented it isn't done". Reimbursement regulations require correlating notes to billed services, and patients expect accurate, compiled health records. With the adoption of EHRs, the resulting document can compile so much data that a one page SOAP note is now six pages, including a variety of demographic and historical information not necessarily reviewed by the provider generating the final document. The practitioner may not recognize items missing.

Checking for Documentation Gaps in your EHR

To maximize the potential of an EHR and for patient safety, it's important to ensure there are no documentation gaps, and that what is captured in the EHR is consistent with the document produced. To avoid being caught with vital, trapped data in the chart, we recommend performing a documentation gap analysis.

Start by selecting a variety of visit types including a sampling of procedures. Follow all EHR screens, taking a screen shot if possible. Generate the final document and compare it to the data entered. Are there gaps?

Documentation gaps may be intentional or unintentional. Some intentional examples include:

- Practitioner's personal use: This could serve as a personal reminder for subsequent visits, not intended for inclusion to a chart note.
- Alert: This may be used for a variety of reasons including non-compliance such as drug-seeking behavior. It could be a safety alert such as recognizing the patient is a fall risk.
- Not pertinent to current service: Some structured data may be eligible for compilation to a visit or procedure note, but the clinician deems it is not relevant to the current note, awaiting the appropriate reason for visit to incorporate that table or information to the note.

Unintentional examples can come from multiple areas within the EHR, which is why we suggest sampling a variety of visit types. Data unintentionally left out of the EHR-generated document may include the following:

- Marked boxes for findings
- Free-text boxes
- Pop-up template items
- User Error - For example, the EHR may have a check box to include a section to the final note. Missing the checkbox means it is not pulled to the document.

Closing the Gaps

Create a listing of the EHR documentation gaps, mapping to specific sections in the EHR and where the documentation should be placed within the visit note. Check with the EHR vendor if gaps found are "known issues," and what update or fixes are available. Representatives from the clinical team, such as the Medical Assistant, Nurse, and Practitioner should review the findings as a group, possibly with an EHR super-user. From the analysis, the clinical team can recognize and prioritize the gaps that need addressed, and conduct further testing if needed. Alert the entire clinical team to gaps discovered and the work around.

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