Copy Functionality Toolkit

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Foreword

In 2003 Margaret Amatayakul, Mary Brandt, and Michelle Dougherty wrote an article titled “Cut, Copy, Paste: EHR Guidelines” for the *Journal of AHIMA*. In their article the authors stated that it was not an “uncommon scenario in healthcare today” for clinicians to use this functionality. They further went on to list risks and stress the importance of complete and accurate information within the health record.

As the healthcare industry continues to move toward an electronic health record (EHR) the amount of electronically created and stored information continues to increase. As clinical providers become more familiar with the capabilities and the technology surrounding documentation, questions about both the legality and integrity of the EHR and the technology that facilitates these providers in documentation practices also becomes more prevalent.

The traditional practice of handwriting documentation, single line strike through corrections or revisions in different colored ink will most likely be replaced with new technology. However the core principles of quality documentation will remain the same.

The Institute for Healthcare Improvement, along with other quality initiatives, outlines an overall industry focus on healthcare quality. This toolkit is designed to support and guide organizations, HIM professionals, and information technology (IT) professionals in the examination of the issues and circumstances wherein the healthcare industry needs to define, support, and execute best practices in dealing with copy technology in the EHR environment. This toolkit is intended to assist these individuals in developing their own policies and procedures surrounding this functionality.

For the purpose of this toolkit, the term *copy* means any one of the following synonyms: copy and paste, cloning, cut and paste, copy forward, re-use, carry forward, cut/copy and paste. This toolkit will not address the use of templates or macros within an EHR.

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Introduction

A health record is considered to be a legal business record for the healthcare organization that creates it. As such, it must be maintained in a manner that complies with legal standards. In order to thoughtfully and appropriately manage copy functionality, organizations must have sound documentation integrity policies within their organization. This is especially important given that EHR software implementation often changes operational processes and documentation and workflow practices within a healthcare setting.

The HIM professional can be an integral component of this organizational initiative. It is imperative for HIM professionals to inform information technology in order to ensure sound HIM principles. For this to occur, HIM professionals need to take a leadership role within their organizations, listening, conversing, and collaborating with other professionals.

History

The term "cut and paste" is derived from the traditional practice in manuscript-editing whereby people would literally cut paragraphs from a page with scissors and physically paste them onto another page. This practice remained standard as late as the 1960s and did not necessarily affect documentation within a healthcare record.

In 1974 Lawrence G. Tesler first transferred the manual "cut and paste" process into a computer-based text-editing process while working at the Xerox Corporation Palo Alto Research Center. The term *copy* refers to the simple method of reproducing text or other data from a source to a destination. This differs from the term *cut and paste* in which the original source text or data is deleted or removed from the documentation. As the healthcare industry continues to move forward with EHR implementation, HIM professionals can expect the popularity of this documentation method to increase.

Past Documentation Practices

Historically, some electronic documentation systems have allowed functionality that would not be considered acceptable today; for example, encounter cloning or copy content without attribution to the original source. More recently, EHRs have improved and have become more competitive. But users expect and will demand higher levels of functionality.

With these improved EHR designs, however, previously common but risky documentation practices are no longer acceptable. Every member of the healthcare team is responsible for ensuring documentation integrity within the healthcare record. Non-auditable copy functionalities that do not support transparency of authorship or origination present risks to documentation integrity.

Issues Today

Today, then, as a result, copy functionalities that do not meet the organization's data and documentation integrity policies should be considered unacceptable. According to a 2008 *Journal of AHIMA* article, "the innovation of the EHR, which allows for easier movement of information, has made it easier to reuse previous documentation with a single click."[1] The use of copy functionality without the ability to review, test, audit, and approve presents significant medico-legal risks. With appropriate checks and balances in place, cautious use of the functionality can be systematically evaluated so that documentation integrity is ensured.

HIM Professionals

The HIM professional has a responsibility to ensure quality, timely, and accurate documentation within the health record. Therefore, the HIM professional should be an active participant in the implementation process of functionalities that affect documentation practices within the EHR.

HIM professionals should have sufficient knowledge of the capabilities and, where applicable, gaps within the current electronic systems' abilities to provide accurate and timely documentation. Such matters should also be documented as known issues within the organization.

HIM professionals are not only responsible for overall documentation integrity, they are also directly affected by documentation practices. For example, inconsistent and ambiguous documentation directly affects the coding professional's effort to accurately assign diagnosis and procedure codes based on the source documentation.

The HIM professional is obliged to know, understand, and then manage copy functionality to support EHR documentation quality. The HIM professional must also work closely with the organization's IT department and technical system vendors. Availability and manageability are in turn based on the individual EHR system's functionality and may be further determined by the unique way that a given organization has implemented that system.

As such, the HIM professional can help to ensure that appropriate organizational-wide policies and procedures are in place to manage the functionality. (For sample organizational copy and sanctions policies policy see appendixes A and B.) HIM professionals should lead their organizations in developing copy policies and procedures that address:

- Operational processes
- Utilization of copy functionality
- Documentation guidelines
- Responsibility
- Auditing and reporting

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1. Dimick, Chris. "Documentation Bad Habits: Shortcuts in Electronic Records Pose Risk." *Journal of AHIMA* 79, no. 6 (June 2008): 40–43.

Risks

Certain risks are inherent in the use of copy functionality. These tools, if used inappropriately, may undermine the clinical decision making process. For example, copying information into the wrong patient health record could adversely impact patient care. And overuse of disk space, from redundant copied information, can affect overall system response time. Specific risks to documentation integrity of using copy functionality include:

- Inaccurate or outdated information that may adversely impact patient care
- Inability to identify the author or what they thought
- Inability to identify when the documentation was created
- Inability to accurately support or defend E/M codes for professional or technical billing notes
- Propagation of false information
- Internally inconsistent progress notes
- Unnecessarily lengthy progress notes

Appropriate Use

If provider documentation functionality such as copy is used appropriately, the functionality can assist providers in working efficiently while maintaining optimal care and compliant documentation. Stephen Levinson, MD, warns that "speed is not the same as efficiency, which requires tools that help physicians work quickly while maintaining optimal care and compliant documentation."[2] In that regard, copy functionalities may be appropriate when copied information is:

- Based on external and independently verifiable sources, such as basic demographic information that is stable over time
- Clearly and easily distinguished from original information, such as automatic summaries that populate data fields that are clearly identified as nonoriginal and cannot be mistaken for original information
- Not actually rendered as part of the record until after a re-authentication process and is auditable for identifying actual origination

Levinson notes that there are appropriate uses of copy forward functionality. "While copy forward is inappropriate for addressing a patient's medical history and physical examination findings, it can offer a benefit in bringing forward a patient's problem or medication list," he believes. "However, such functionality should require a second click for error proofing."[3]

It is recommended that the HIM professional work proactively to ensure that guidelines for appropriate use are in place. This should be done first and foremost for the execution of quality and timely patient care.

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2. Ibid.
3. Heubusch, Kevin. "An Appropriate Use of Copy Forward, with a Caveat." *Journal of AHIMA,* June 2008. Available at http://journal.ahima.org/2008/06/04.

Fraud and Abuse

Billing Concerns

Although there has been no official directive or comment from the Centers for Medicare and Medicaid Services (CMS), much has been written about copy notes from the local (state) Medicare carriers. Cigna Government Services Medicare of Idaho has written, "Cloning of documentation will be considered misrepresentation of the medical necessity requirement for coverage of services. Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made."[4]

Guidelines on cloning from First Coast Service Options include:

- "Documentation is considered cloned when each entry in the medical record for a beneficiary is worded exactly like or similar to the previous entries."
- "Cloning also occurs when medical documentation is exactly the same from beneficiary to beneficiary."
- "It would not be expected to see that every patient had the exact same problem, symptoms, and required the same treatment."
- The cloning policy "is not specific to EHRs, but applies to medical documentation in any format."[5]

Providers should understand that documentation of medical necessity is proof that the diagnostic tests, services rendered, treatments provided, or procedures conducted were ordered appropriately based on the patient's illness, injury, prevention of diseases, or other patient specific needs. Documentation of medical necessity of a service is the criterion for payment in addition to the individual requirements in selecting the appropriate level of code assignment. Providers should appreciate that the volume of documentation must not be the primary reason upon which a level of service is selected and reported. Rather documentation should support the level of services rendered. Documenting a comprehensive history and physical for a minor problem would not justify reporting a higher level of service if that service was not warranted by the patient's condition.

Inconsistent and ambiguous documentation can directly affect coding and reporting. For example, it may result in an inaccurate diagnosis code or present on admission assignment. It also may interfere with the coding process, slowing the process through an increase in physician queries seeking clarification, for example. Reporting of inaccurate codes may be misconstrued as fraud. A pattern of in accurate reporting, even without intent to defraud, may be considered abuse.

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4. Cigna Government Services."Medical Record Cloning Documentation Reminder." *Medicare Bulletin, Part B.* March/April 1999.
5. First Coast Service Options. "Requirements for the Payment of Medicare Claims—A Selection of Some Important Criteria." *Medicare B Update!* 4, no. 3 (third quarter 2006). Available at www.floridamedicare.com/Part_B/Medicare_B_Update/Archive/106399.pdf.

Clinical Trustworthiness

Fundamentally, in the context of this toolkit, the underlying concern of copy functionality is that it can damage the trustworthiness and integrity of the record for medico-legal purposes. A compelling reason for cautionary use of the copy functionality is patient care. From a clinical point of view, to copy information into records that is not current, accurate or applicable to the particular patient visit has may have a direct impact on patient care. If indiscriminate use of copy functionality results in the copy forward of medical conditions that were resolved, physical findings and symptoms may be inconsistent within the healthcare record. Other providers and organizational staff may become confused by the inconsistent documentation.

Misuse of copy functionalities can also create unanticipated risks. In one instance, an oncologist falsified patient encounters to create the appearance that he was meeting quality care guidelines. These fictitious encounters were only discovered when the organization began to investigate the physician's complaint under the equal opportunity laws that he had been passed over for promotion.[6] If not for this investigation, the records would have stood as valid in the system. False records of this sort most certainly undermine the clinical trustworthiness of the record.

Education and Training

Once an organization chooses to purchase a system with copy functionality, it must develop a detailed education and training plan. Organizations must define, prior to implementation of the functionality, all required education and training. Training should include appropriate hospital staff, providers, and HIM staff that may use the functionality. Each training session should be tailored to meet the needs of the end user. In addition, the training should include a review of organizational policies and procedures regarding appropriate use of the tool. (For a sample organizational education policy, see appendix C.)

Provider Training

Organizations must strive to eliminate the careless use of copy functionality with a thorough provider educational training program and organizational sanction policies, where appropriate. Provider training and education should be designed to promote:

- the importance of documentation integrity within each visit;
- notification in the event of incorrect documentation;
- trust by other clinicians who will rely on the documentation generated; and
- the ability for documentation to stand up to scrutiny by auditors, attorneys, and appropriate state and federal rules.

6. *Hussain v. Principi*, 344 F.Supp.2d 86 (D.D.C., 2004) October 28, 2004

Providers should attend system training in order to receive a user identification number to access the organization's system. At that same time and annually thereafter (or at the time of reappointment), providers should undergo extensive training regarding system functionality and specifically copy functionalities. Nurses and nursing-specific documentation systems must not be overlooked in training and education as well.

Ancillary staff such as physical therapy, case management, and social workers also document within the health record. As a result, these staff members must also be required to attend organization training and education in order to use the copy functionality. Training should be defined by the end user access and control parameters and should address all appropriate state and federal rules.

Risk Managers and Legal Counsel

As the health record remains the business record that organizations produce in litigation, the accuracy and integrity of that record must be credible and sustainable over time. Risk managers and legal counsel should understand the implications of inappropriate use of copy functionalities as well as a failure to meet defined organizational policies and procedures. Risk managers and legal counsel must be in a position to understand and support the appropriate use of copy functionality within the EHR.

In the event an adverse outcome occurs, end users need to understand how documentation is entered into the health record as well as the importance of sound documentation within the health record. Adverse outcomes represent a good opportunity to introduce the risks of poor documentation habits.

HIM Staff

HIM staff is uniquely positioned to understand, train, and defend the appropriate use of copy functionalities within their EHR system. HIM professionals must understand how the copy functionality works in order to implement organizational training on its use.

As stated earlier, ensuring documentation integrity within the health record is the responsibility of the HIM department. This includes ensuring integrity of any information entered within the record, whether handwritten or created electronically. Therefore, HIM staff must have extensive education in copy functionality and test its functionality prior to implementation. In addition, some organizations may choose for the HIM staff to be responsible for training organizational staff or providers on this functionality.

Auditing for Compliance

The organization has a duty to ensure that copy documentation follows all appropriate organizational, state, and federal requirements. Keys to accomplishing this include system tracking (audit trails), observation of organizational use, and testing of system capabilities.

If an observed behavior is not permitted by organizational policy but is supported in the electronic system, the organization must decide how this will be monitored and measured for compliance. In addition, if unacceptable behavior is not tracked by the system and is therefore not detected, compliance must be handled differently than if the system can show retrospectively who, how, and when a risky functionality was employed. (For a sample copy audit policy, see appendix D.)

Develop an Audit Plan

Organizations can develop an audit plan by first determining how providers plan to use the copy functionality. If the intention is to allow the copy of documents from one system to another (e.g., from transcription import system to the EHR, from one progress note to another, from one assessment to another, across encounters, within encounters, template to template) the auditing capabilities may be complex.

Testing of each of the proposed uses should be done. Testing may require thorough investigation to systematically identify what can be audited and what cannot be audited. An interdisciplinary approach, including HIM professionals, IT staff, and perhaps system vendors, is recommended. Prohibiting the use of copy functionality by policy may not be sufficient. If the system does not allow the functionality to be turned off, auditing will still be necessary.

Build in State and Federal Requirements

HIM professionals are a key participant in the development of copy audits. The HIM professional has extensive knowledge of essential state, federal, organization-specific, and Joint Commission documentation requirements. To that end, the HIM professional can ensure that all of these standards are identified, reviewed, and met in conjunction with the proper implementation of the copy functionality. Failure to consider these key documentation requirements can result in inaccurate or erroneous information within the health record, even potentially a deficiency from an accreditation body.

Timely reporting is also a key part of the process to ensure that the audit results are reported to the appropriate organizational committee, and it should be a part of the ongoing review process. Violations of the copy policy should be identified, validated, and rectified through factual documentation. Such action should take place in an appropriate time frame.

Create a Work List

Organizations should develop and recognize the existence of copy functionality within their EHRs. Developing a simple initial work list to introduce the concept will help with the due diligence process. Basic questions to address are:

- Can a copy event be retrospectively identified?
- Is an appropriately detailed audit log generated when a copy event occurs in the course of documentation?

A compliance-oriented electronic record system will have rules that feed an auditing work list. For example, many systems can provide the HIM department with a list of

incomplete notes. Similarly, the system may be able to generate a list of encounters where providers have used the copy function. The work list could also capture what is deleted, copied, retracted, or recorded as an addendum within the health record itself and provide auditors with a starting point for compliance audits. Understanding exactly what the system does and what the options are for retrospective analysis is valuable knowledge in supporting appropriate practices and eliminating improper ones.

Organizations can consider the following reports or work lists:

- If utilization of copy functionality is available as an auditable event, review a sample of its use over a prior interval by one or more individual users.
- A listing of patients re-admitted within a certain amount of time (e.g., within 30 days, 3 months, 6 months). This report can be used to randomly audit documentation (e.g., review readmissions history and physicals or assessments within a certain period of time).
- A report that compares discrete data elements in the electronic record (e.g., pain score and the comment area of the pain assessment for the entire patient length of stay).
- Consider using coders or clinical documentation specialists to identify copy practices when reviewing for completeness of physician medical record documentation to support coding and billing.
- Review patients on a “teaching service” to verify original documentation by residents and medical students.
- Where copy use is not auditable there is commercially available software to analyze documents and identify duplicate phrases.

As the implementation of EHRs increases, organizations may consider changing the focus of their audit strategies to real-time audits to promote accurate and complete medical record documentation. Performing ongoing chart audits as the encounter occurs allows organizations to determine if documentation is complete and appropriate. (For sample testing activities, see appendix E.)

Organizational Policies to Consider

Because copy functionalities are a high-risk area, organizations will be best served by developing policies and procedures that include:

- Notification when an incorrect copy note has occurred.
- How and when audits will be conducted for auditable events.
- Who will perform the ongoing concurrent audits.
- The frequency for performing the audit.
- The time period covered by the audit.
- The description of the review population, the group, the service, the location, etc.
- How sample size is determined.
- A description of the outcome indicators (e.g., patient safety indicators).
- A description of planned analysis techniques.
- A corrective action plan based on findings. In the EHR environment, the action plan will also include identification of system functionalities that require mitigation,

correction, or elimination and reporting to the appropriate compliance officers, with periodic follow up until both functional and operational corrections are complete.

Of note: At the time of this toolkit development (June 2008), the Certification Commission for Healthcare Information Technology does not require copy functionalities of any type to be auditable events. HIM professionals should not assume that because their organization has purchased a CCHIT-approved system that the audit functionality is available in their system.

Case Scenarios

The following case scenarios—representing both potentially appropriate and inappropriate use—can help organizations understand how copy functionality may work in their settings. The scenarios can also serve as a teaching tool.

Case Scenario 1

Jane Doe presents to a hospital emergency room for a laceration. While washing dishes this 35-year-old female cut her hand on a knife in the dishwater. She presents to the ED, is triaged, and moved to examination room 1. Following evaluation from the physician, the patient receives 10 sutures with instructions to follow up in 10 days for suture removal. The physician documents his emergency room encounter for this visit, including a complete history and physical and system evaluation. In 10 days the patient returns with no complaints and her sutures are removed. The physician examines the patient and finds no signs of infection and instructs the nurse to remove the stitches. The physician then pulls up his prior ED note, highlights the history and physical and system evaluation sections, and copies that information into the new visit history. The ED coder reviews the documentation and bills for a Level 5 ED visit.

Result: The first visit was reported consistent with facility E/M guidelines. However, the second encounter was inappropriately reported at the same level as the first visit because the physician pulled forward documentation of services that were not actually performed on the second encounter. The ED coder could not determine that the documentation within the record was from a previous encounter.

What should have happened? If the physician utilized the copy functionality he/she should have noted the original source document and update the note with the specific information from this encounter. System functionality would allow the user to confirm that he/she copied an entry. The ED coder would recognize the information that was pulled forward, and could then establish the ED level for the second encounter based appropriately on the services performed during that encounter only.

Case Scenario 2

A 55-year-old male is admitted through the emergency department of a large academic medical center following a motor vehicle accident. The patient is admitted to the intensive care unit for a left temporal bone fracture, left femur fracture, grade-2 spleen laceration, and multiple cuts and bruises. In the course of his hospital stay, the patient is

followed by the trauma service, neurosurgery service, and orthopedic service, all of which have attending physicians, residents, and physician assistants in addition to medical students.

The patient remains in ICU for five days before he is transferred out to the surgery unit to be followed by the trauma service. During his stay in ICU, the trauma medical student initiated daily progress notes for the trauma service, which were expanded upon by the trauma resident and physician assistant within the electronic record. Each progress note was then co-signed by the attending physician.

The orthopedic medical student copied forwarded diagnostic information from the previous day's documentation, added new documentation and then forwarded it to the orthopedic attending for co-signature. Both wrote new progress notes each day, which were signed by the attending physicians.

The neurosurgery medical student used the copy functionality to copy the neurosurgery progress note from the previous day and add his follow up. The neurosurgery resident simply added his information below the medical student. The attending co-signed each note without noticing that the student had used copy functionality and selected a level of service based on the entire note.

Result: The trauma service was writing new notes each day that were then co-signed by the attending service. No documentation issues were identified. The orthopedic service used copy functionality to bring forward diagnostic information only. In addition to this diagnostic information, the medical student and resident wrote different clinical information and updates. The orthopedic attending co-signed each note; therefore no documentation issues were identified. The neurosurgery service, however, used copy to pull forward information from the initial progress note, thus implying that the neurosurgery service was providing the same level of detail in the examination on subsequent visits as on the initial visit. If that is not in fact occurring, the neurosurgery service may be at risk for fraud related to the level of service.

What should have happened? The neurosurgery service should have indicated which information was pulled forward from previous notes and which information was new information. The attending physician is ultimately responsible for the progress notes within the patient record and should ensure that any resident utilizing copy functionalities has been adequately trained consistent with organizational policies.

Case Scenario 3

A 65-year-old woman is a direct admission from her primary care physician (PCP) for pneumonia. She is admitted to the hospital under the care of her PCP to a general medicine floor. The PCP documents an extensive history and physical examination in the EHR and orders the appropriate tests. On day 1 of the hospital stay the physician completes a progress note. On subsequent days 2 and 3 the physician completes progress notes updating the patient's progress and documents the results of all tests. On day 4 the patient is discharged home. The PCP copies forward the chief complaint and physical

examination from the progress note on day 1. The PCP indicates that the information is copied by inserting quotation marks around the documentation and noting "copied from day 1 note." He notes on the final progress which phrases have been copied forward and then adds new content underneath.

Result: The physician appropriately used the copy functionality.

Questions to Ask

Organizational Questions

The organization has a duty to ensure the integrity of the health record in using any new functionality of an EHR. HIM professionals are well equipped and positioned to carry this out. Healthcare organizations are at risk if they do not identify and mitigate systems compliance gaps. Organizations should be asking the following questions:

1. Is there a better means than copy functionalities to accomplish the clinical objectives, such as through the use of forms or templates that are more readily standardized and auditable?
2. Can the organization ensure that EHR end users have been trained and understand the organization's expectations when it comes to accurate, timely, and thorough documentation for the care that was rendered to each patient?
3. Does the organization know how its systems' copy functions can be used within the EHR?
4. Does the organization know how copy functionalities should be used within the EHR?
5. Does the organization have a process for identifying and mitigating unacceptable functions or uses?
6. Has the organization identified how copy will be utilized within the EHR?
7. Has the medical staff approved copy policies and procedures?
8. Who is responsible for ensuring that all copy policies and procedures are enforced?
9. Who will audit the provider's documentation for appropriate use of copy?
10. Is the organization following its sanction-policy and following through on enforcement of disciplinary actions when appropriate?

Vendor Questions

When implementing an EHR system or a module within the system, the HIM professional should be prepared to ask a series of questions that will aid in appropriately implementing the functionality. For the most part, better auditing capabilities may address some of the concerns with copy technology that healthcare providers have. Defining accountability is a key requirement of the electronic system when inquiring about copy functionality. Sample questions to ask a vendor include:

1. Does the system allow for "soft" copy forward? (Or does it require re-validation of the copied information?)
2. How are chart corrections identified and corrected and by whom?
3. What audit trails are available that would indicate a report has been edited?

4. Is information that is copied forward brought forth in a distinct color or otherwise easily identified?
5. Are blocks of content individually authenticated, allowing for original and copied information within the same note?
6. How is re-authenticated information identified?
7. How are source documents identified?

Summary

Whether or not health information is generated electronically or handwritten, review and validation of the documentation process must still continue in order to ensure the integrity of the information and therefore the integrity of the health record. Failure to ensure health record integrity places the organization at risk for patient care concerns as well as fraud and abuse issues. HIM professionals should be aware of the technologies within their specific electronic systems and how they are employed.

According to Kenric Hammond, MD, the Veterans Affairs (VA) Puget Sound Health Care System expanded its clinical information system to include copy functionality. Although "concern arose over potential for propagation of erroneous information, lapsed professional ethics, billing irregularities, and potential liability exposure, disabling copy functionality was considered impractical."[7] The VA subsequently spent time studying the use of this functionality. Reportedly, a total of 2,645 orders were reviewed and only 2.35% of the orders were considered to have somewhat misleading or clinically misleading risky use of the functionality.[8]

Understanding, addressing, and validating the creation of health information is as important in the electronic record as it was in the paper record. This presents an important opportunity for HIM professionals to take the lead. HIM professionals hold the unique skills necessary to convene the stakeholders to conduct the appropriate investigation, set and enforce policies, and perform ongoing auditing.

Robert Pearlman, MD, chief of the Ethics Center's ethic consultation service stated that "… not *all* copying and pasting is bad, or raises ethical concerns. Copying and pasting can be a wonderfully efficient way to quickly enter complicated data and findings that might be relatively consistent over time and only need minor modification from day to day."[9] With appropriate checks and balances in place, cautious use of copy functionality can be a benefit.

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However, the use of copy functionality without the ability to review, test, audit, and approve presents significant medico-legal risks. For this functionality to be used properly, HIM professionals need to take leadership roles within their organization, listening, conversing, and collaborating with other stakeholders.

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Appendix A
Sample Copy Policy

Utilization of Copy Functionality for Documentation within the Health Record

PURPOSE: The purpose of the health record is to provide a basis for planning patient care and for the continuity of such care. Each record should provide documentary evidence of the patient's medical evaluation, treatment, and change in condition as appropriate. The purpose of this policy is to provide guidance on the use of copy functionality when documenting in the EHR. For the purpose of this policy copy shall be understood to include cut/paste, copy forward, cloning, and any other intent to move documentation from one part of the record to another.

POLICY: Providers documenting in the EHR must avoid indiscriminately copying and pasting another provider's progress note, discharge summary, electronic mail communication, and redundant information provided in other parts of the health record.

PROCEDURE:

1. Providers are responsible for the total content of their documentation, whether the content is original, copied, pasted, imported, or reused.
2. If any information is imported or reused from a prior note, the provider is responsible for its accuracy and medical necessity.
3. Providers are responsible for correcting any errors identified within documentation. (INSERT HOSPITAL CORRECTIONS POLICY)
4. Providers must notify (INSERT JOB TITLE; e.g.; HIM Director) immediately regarding any error(s) in the source note. All notes from the original source that contain errors must be corrected.
5. If the provider uses information from a prior note, he/she must reference the date of the previous note. (ORGANIZATION POLICY SHOULD DEFINE TIME LIMITS.)
6. Providers are responsible for citing and summarizing applicable lab data, pathology, and radiology reports rather than copy such reports in their entirety into the note.
7. Providers are responsible for clearly identifying who performed each service documented within the note. When entering patient data into the medical record that the provider did not personally take or test, the provider must attribute the information to the person who did.
8. If the provider references a form within the record (e.g., review of system form), he/she must reference the form with sufficient detail to uniquely identify the source. Example: "For review of systems see form dated 1/1/08."
9. Providers are required to document in compliance with all federal, state, and local laws and Medical Staff Rules and Regulations.
10. Once a note has been signed as final, additional information may only be added as an addendum.

11. Failure to comply with this procedure subjects the provider to corrective disciplinary action per (INSERT HOSPITAL SANCTION POLICY NUMBER/REFERENCE HERE).

(INSERT SPECIFIC DEPT/JOB TITLE, e.g., HIM Department):

1. Shall be required to monitor provider compliance with organization policy
2. Shall forward reports and trends to the appropriate Committee

See also
(LIST RELATED HOSPITAL POLICIES HERE)

Appendix B
Sample Sanction Policy

Copy Function Sanction Policy

PURPOSE: To provide guidance for action in the event of inappropriate use of copy functionality in the EHR. For purposes of this policy, *copy* shall be understood to include cutting and pasting.

POLICY: Providers documenting in the EHR must avoid indiscriminately copying and pasting another provider's documentation as well as the process of copying forward information from previous notes, without clear attribution in an effort to increase documentation in a current visit. Indiscriminate use of copying and pasting lengthens the note, may lead to fraudulent provider billing, adds redundant information that may be unnecessary, and may increase organizational liability.

PROCEDURE:

1. (INSERT APPROPRIATE PARTY, e.g., HIM Department) is responsible for referring cases of inappropriate copying and pasting to the (INSERT APPROPRIATE PERSONNEL) for corrective action, review, and facility-wide trending.
2. The (INSERT THE APPROPRIATE HOSPITAL COMMITTEE) is responsible for reviewing the corrective action and facility wide trending report. This committee shall make recommendations on disciplinary action in which continued inappropriate use of copy technology is identified.
3. Failure to comply with the organizational policy regarding copy functionality may be deemed a violation of hospital policy. (INSERT HOSPITAL POLICY NUMBER OR REFERENCE REGARDING PRIVACY VIOLATIONS/SANCTIONS)
4. Further disciplinary action may be taken by the (INSERT HOSPITAL PRIVACY/SECURITY COMMITTEE) if violations of this policy are substantiated. (INSERT MEDICAL STAFF RULES AND REGULATIONS OR HOSPITAL POLICY REFERENCE).

See also
(LIST RELATED HOSPITAL POLICIES HERE)

Appendix C
Sample Copy Education Policy

Education Policy for the Use of Copy Functionality

PURPOSE: To provide guidance on the required education that a provider must attend prior to the use of any copy functionality. For the purpose of this policy, *copy* shall be understood to include cut and paste, copy forward, cloning, and any other intent to move documentation from one part of the record to another.

POLICY: Providers documenting in the EHR must attend organizational education training on the copy functionality with the electronic health system.

PROCEDURE:

1. Any provider utilizing copy functionality within the EHR must attend training prior to his/her initial use of such technology.
2. Providers must demonstrate their understanding of all applicable state and federal rules regarding appropriate documentation.
3. Providers must demonstrate their ability to appropriately use the functionality, including but not limited to copy forward, copy, cutting, note identification, note authorization, and identifying source information.
4. Providers must attend annual training.

(INSERT APPROPRIATE PARTY; e.g., HIM Department):

1. Provides for annual provider training
2. Documents provider demonstration of understanding of functionality
3. Ensures providers understand how to appropriately identify, cite source document, copy from other media (e.g., e-mail), and identify original ancillary test (e.g. laboratory)
4. Ensures new providers are trained
5. Ensure that appropriate audit trails identify providers who may be using copy functionalities who have not attended training

See also
(LIST RELATED HOSPITAL POLICIES HERE)

Provider Education Training Form Checklist

Date:________________________
Provider:_____________________
User Identification:___________________

1.______ Provider demonstrated understanding of copy functionality.
2.______ Provider demonstrated understanding of applicable state/federal regulations.
3.______ Provider received copies of all related organizational policies and procedures.
4.______ Provider demonstrated understanding of how to site source document.
5.______ Provider demonstrated understanding of cut functionality.
6.______ Provider verbalizes understanding that he/she is responsible for the content of his/her documentation whether the content is original, copied, pasted, imported or reused.
7.______ Provider verbalizes understanding documentation must clearly identify who performed each service.
8.______ Provider attests to understanding that once a note has been signed as final, additional information may only be added as an addendum.
9.______ Provider verbalizes understanding of the requirement for annual training.

Trainer Name:_____________________________________

Trainer Signature:__________________________________

Original Form: Medical Staff Credentials File
Copy: (INSERT APPROPRIATE PARTY; e.g., HIM Department)

Appendix D
Sample Copy Audit Policy

Auditing for Copy Functionality

PURPOSE: The purpose of the health record is to provide a basis for planning patient care and for the continuity of such care. Each record should provide documentary evidence of the patient's medical evaluation, treatment, and change in condition as appropriate. The purpose of this policy is to provide guidance on the audits required in conjunction with the copy functionality within the EHR. For the purpose of this policy. *copy* shall be understood to include cut and paste, copy forward, cloning, and any other intent to move documentation from one part of the record to another.

POLICY: In order to protect the integrity of the health information record and to provide quality patient care, copy functionality within the EHR should be used in conjunction with all applicable state and federal regulations. Noncompliant use of copy functionalities is considered a sanction offense in accordance with the organizational policies.

PROCEDURE:
(INSERT RESPONSIBLE PARTY; e.g., HIM Department):

1. Determines how and when audits will be conducted
2. Determines who will perform these ongoing concurrent audits
3. Establishes frequency for performing the audit
4. Establishes time period covered by the audit
5. Identifies how the sample size is determined
6. Identifies a description of the outcome indicators
7. Determines how copy functionalities within the record are identified
8. Designs a corrective action plan based on findings
9. Provides a detailed list of copy functionalities as they exist within the electronic system
10. Provides testing of copy functionalities prior to implementation and prior to version updates
11. Identifies copy functionalities and categorizes by whether they are retained as auditable events or otherwise identifiable as copied (e.g., date and time stamps, showing that a large number of data elements or a large block of documentation was generated in the system concurrently and instantaneously)

See also
(LIST RELATED HOSPITAL POLICIES HERE)

Appendix E
Sample Copy Functionality Testing

As with any new technology, comprehensive testing of functionality should occur prior to implementation. This toolkit recommends three copy functionalities for testing. Ideally the system has a test environment or other means to make sure that testing does not have problematic impact on the actual patient information system.

While they are not comprehensive tests, the following three points provide a first set of screening questions to apply and to target areas for further investigations:

1. Copy functionalities that originate in software other than the EHR, such as copy in Microsoft Windows
   a. Can this be blocked or disabled for use in your EHR system?
   b. Is there a way to monitor or otherwise identify its use?
   c. If there is no way to automate use monitoring and the functionality cannot be disabled, what other alternatives are available to ensure proper documentation?
2. Copy functionalities that permit duplication of sections of a patient record for use in new documentation, such as medication or problem lists
   a. Is the original source (date, time, and author) of the information visible in the record?
   b. Is the original source of the information traceable in the audit functionalities?
   c. Does the system require sufficient review of the copied documentation to ensure it is reviewed and intended by the clinician?
3. Copy functionalities that duplicate an entire prior encounter record from a different date, and possibly from a different author or different patient, and represents it as today's documentation.
   a. Is the original source (date, time, and author) of the information visible in the record?
   b. Is the original source of the information traceable in audit functionalities?
   c. Does the system require sufficient review of the copied documentation to assure it is reviewed and intended by the clinician?