EHR Operations-Copy Functionality

Content Provided by the CSA Excellence Presentation Series
Objectives

• Examine the impact of copy functionality on the Legal Health Record

• Determine current organizational status for use of the copy/paste functionality

• Identify leadership tactics

• Discuss best practices
Background

- HITECH, MU and Health Information Exchange Impact

- Legal Health Record (LHR) = Legal Business Record
What is Your Role?

• The HIM Professional’s Role
  – Policy and procedures
  – Training
  – Auditing processes
Benefits of Copy/Paste

• Saves time to transfer information that does not readily change
• Efficient way to capture complex information
• Provides simple way to transfer important information to other providers (improving continuity of care)
• Reduces transcription errors
Challenges and Risks with use of Copy/Paste

- Inaccurate or outdated information
- Redundant information, which makes it difficult to identify the current information
- Inability to identify the author or intent of documentation
Challenges and Risks with use of Copy/Paste

- Inability to identify when the documentation was first created
- Propagation of false information
- Internally inconsistent progress notes
- Unnecessarily lengthy progress notes
Rules and Regs

- CMS
  - Medicare Claims Processing Manual
- OIG
  - Work Plans and audits
- HHS-OIG
  - CMS has adopted few program integrity practices to address vulnerabilities in EHRs
How Can HIM Lead?

- Develop policies/procedures addressing the proper use of the copy/paste feature to assure compliance with governmental, regulatory, and industry standards.
- Address the use of features such as copy/paste in their information governance processes.
How Can HIM Lead?

• Provide comprehensive training and education on proper use of copy/paste to all EHR system users.
• Ensure compliance via auditing
• Enforce policies and procedures
• Address significant issues through HIM Committee or PI processes
Statement of AHIMA Position

• The use of copy/paste functionality in EHRs should be permitted only in the presence of strong technical and administrative controls which include organizational policies and procedures, requirements for participation in user training and education, and ongoing monitoring. Users of the copy/paste functionality should weigh the efficiency and time savings benefits it provides against the potential for creating inaccurate, fraudulent, or unwieldy documentation.
Reported Errors Make Headlines

- EHRs Linked to Errors, Harm
- AMA Report on Patient Safety
- How copy and paste in electronic medical records affects patient care
Copy and Paste Still an Issue

• OIG to CMS: Make EHR fraud prevention efforts a priority (April 2015)¹
• Clinical Documentation in the 21st Century: Executive Summary of a Policy Position Paper From the American College of Physicians (February 2015)²

The Joint Commission QuickSafety advisory: Preventing copy-and-paste errors in EHRs

**RISKS:**
- Copying and pasting inaccurate or outdated information
- Redundant information in the EHR, which makes it difficult to identify the current information
- Inability to identify the author or intent of the documentation
- Inability to identify when the documentation was first created
- Propagation of false information
- Internally inconsistent progress notes
- Unnecessarily lengthy progress notes

**RECOMMENDATIONS:**
- Develop policies and procedures addressing the proper use of the CPF to assure compliance with governmental, regulatory and industry standards.
- Address the use of features such as copy-and-paste in the organization’s information governance processes.
- Provide comprehensive training and education on proper use of copy-and-paste to all EHR system users.
- Monitor compliance and enforce policies and procedures regarding use of copy-and-paste, and institute corrective action as needed.

http://www.jointcommission.org/issues/article.aspx?Article=bj%2b%2f2w37MuZrouWveszI1weWZ7ufX%2fP4tLrLl85oCi0%3d
ECRI Institute Toolkit for the Safe Use of Copy and Paste (Release date February 2016)

- Presents four safe practice recommendations, along with actionable resources to facilitate the implementation of these recommended safe practices
  - Provide a mechanism to make copy and paste material easily identifiable
  - Ensure that the provenance of copy and paste material is readily available
  - Ensure adequate staff training and education regarding the appropriate and safe use of copy and paste
  - Ensure that copy and paste practices are regularly monitored, measured, and assessed

https://www.ecri.org/resource-center/Pages/HITPartnership.aspx
Impact to the Legal Health Record

- Information Integrity
  - Inaccurate data
  - Redundant information
  - Inability to identify original source of data
  - Propagation of inaccurate data
Clinical Trustworthiness

- Distrust of information
- Patient care
ED PROVIDER NOTE
12/26/2015

CHIEF COMPLAINT
Chief Complaint
Patient presents with

• Ear Pain
   ENT

HPI
 Hulls Harold is a 43yr male who presents with complaints of right ear irritation. You might be a redneck if... Your blood alcohol content has ever exceeded your I.Q. You might be a redneck if you have a home that’s mobile and three cars that aren’t! You might be a redneck if your wife’s hairdo gets chopped off by ceiling fans. You might be a redneck if you mow the lawn and find a ’56 Chevy. You might be a redneck if Thanksgiving was ruined because you ran out of ketchup. You might be a redneck if our boat has not left the driveway in 15 years. You might be a redneck if your front porch collapses and kills more than three dogs. You might be a redneck if you look at a family reunion as an opportunity to meet ‘Ms. Right’. You might be a redneck if our grandmother has ever been asked to leave a bingo game because of her language. You might be a redneck if... Your blood alcohol content has ever exceeded your I.Q. You might be a redneck if you have a home that’s mobile and three cars that aren’t! You might be a redneck if your wife’s hairdo gets chopped off by ceiling fans. You might be a redneck if you mow the lawn and find a ’56 Chevy. You might be a redneck if Thanksgiving was ruined because you ran out of ketchup. You might be a redneck if our boat has not left the driveway in 15 years. You might be a redneck if your front porch collapses and kills more than three dogs. You might be a redneck if you look at a family reunion as an opportunity to meet ‘Ms. Right’. You might be a redneck if our grandmother has ever been asked to leave a bingo game because of her language.
Medicare defines duplicate documentation:
- multiple entries in an individual’s health record that are worded exactly alike or similar to other entries
- duplicate documentation in health records that appear the same from patient to patient

Reporting of inaccurate codes
- May be misconstrued as fraud

Pattern of inaccurate reporting
- May be considered abuse
Coding Example – Using CAC

• Use of computer assisted coding application – autosuggests J96.21 Acute & chronic respiratory failure with hypoxia.
• Coder checks for evidence and CAC points to progress note with dx
• Coder reviews entire chart, realizes that physician has copy/pasted dx along with several other dx from a previous admission
• Could have resulted in change of DRG from 191 (COPD w/CC - $8,900) to 190 (COPD w/MCC - $10,450) – potential upcoding erroneously
Other Copy/Paste Issues

- Coding:
  - Is information “current” from this visit OR is it from an earlier visit?
  - Copy/paste of Problem List
  - Potential conflicting information - 1 physician can copy/paste from another one
  - Can increase time spent coding due to volume of progress notes
  - Ex. Chart appeared to be showing treatment for acute respiratory failure then suddenly it becomes pancreatitis
Other Copy/Paste Issues

- Release of information
  - Print outs can become extremely long
  - Could include erroneous information

- Patient care
  - Pt placed on antibiotics because of a UTI – found that the UTI was copied from previous visit
Understand EHR Functions and Features

- Is information copied forward distinctive?
- Audit trails included in EHR system
- Blocks of content should be individually authenticated
- Identify re-authenticated information
Current Organizational Status

Discovery Phase

• Policies and Procedures
• Current Practices
  – Risk and Mitigating Factors
• Ongoing oversight
  – Education programs
  – Training programs
  – Auditing programs
Discovery Phase Activities

• Identify definitions used for Copy Functionality:
  – Cloning
  – Copy and paste
  – Re-use
  – Cut and paste
  – Copy forward
  – Carry forward
  – Note saved as a template
Terms

- **Copy functionality**
  - Reproducing text or other data from a source to a destination (AHIMA)

- **Cloning**
  - Duplication of a note (Weiss & Levy)
  - When each entry in the medical record for a patient is worded exactly like the previous entries
  - When medical documentation is the same from one patient to another patient
  - Every pt has the same exact problem, symptoms, and requires same treatment – documentation is not unique for each visit

- **Copy and paste**
  - Selecting data from an original or previous source to reproduce in another location (AAMC) (not necessarily on the same patient)
Terms (con’t)

- **Copy Forward**
  - Bringing forward a portion of a note or an entire old note (Weiss & Levy)

- ** Carry Forward**
  - Similar to Copy Forward

- ** Re-Use**
  - Similar to copy and paste definition
Terms (con’t)

- Notes saved as a template
  - note is created with information already populated and provider can pull template up and just sign it as is

- Cut and paste
  - Removing or deleting the original source text or data to place it in another location (AAMC)
  - Should never do this – it changes the source information
Discovery Phase Activities

• Connect and Collaborate with other departments
  – Corporate Compliance
  – Internal Audit, if applicable
  – Clinical Documentation Specialist Department
  – Coding Departments
  – Quality Management
    • Patient Safety
Discovery Phase Activities

• Identifying Processes
  – Address issues identified with provider documentation when copy functionality is used incorrectly or inefficiently
  – Collaborate between physicians
  – Utilize HIM staff to attend new physician orientation and provide training
  – Documentation audits of newly hired physicians by coding staff
  – Review revenue cycle clinical denials to determine if duplicate documentation was involved
Discovery Phase Activities

- Audits can be a process audit to determine what, if any, processes were in place to determine copy functionality and to address issues.
- Audit can be a chart audit to determine the following:
  - Outliers
  - Type of problems occurring with copy functionality
Discovery Phase Activities

• When the copy paste function may be efficient:
  – Assists the providers in telling the patient’s story, documenting assessments, treatment, and how the patient responded to the care provided
  – Provides a documentation process so the patient can be discharged or moved to another facility in an efficient manner
Copy and Paste Challenges

• Copying problems that are no longer active
• Copying medications that are not longer current
• Up-coding
• Not identifying author
• Others?
Copy and Paste Challenges

• Outdated histories
• Outdated labs
• Entire chart note
• Taking credit for interpretations
• Attributions not documented
• Spelling errors, formatting issues
Duplicative Documentation Challenges

• Erroneous Error – 2 charts open at one time
• Physician – copied and pasted the office visit into the next 10 visits
• 60 page chart note
• Chart note documentation not unique to visit
• Bill multiple times for one procedure
What to Do?
Organizational Questions

• Is there an alternative to copying data in the EHR?
• Who is responsible for ensuring that all copy policies and procedures are enforced?
• Who will perform ongoing audits of provider documentation for appropriate use of copy?
• How are errors identified and corrected?
• What audit trails are available?
More Questions

• Does the organization know how their system’s copy functions can be used within the EHR?
• Has the organization identified how copy will be utilized within the EHR?
• Has the medical staff approved copy policy and procedures?
• Does the organization have a process for identifying and mitigating unacceptable functions or uses?
Alternatives

- Dictation or transcription
- Voice recognition
- Medical Scribes
- Templates
  - Drop down menus
  - Check boxes
- Macros/smart phrases
  - Phrases that are used routinely and can be populated automatically
Auditing for Compliance

- Lawsuits
- Risk Management
  - Organizational level
  - Vendor level
- Procedures
## Sample Auditing Checklist

<table>
<thead>
<tr>
<th>Audit</th>
<th>Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>• How will audits be conducted?</td>
<td>• Template to document the findings from the chart audits</td>
</tr>
<tr>
<td>• Who will conduct the audits?</td>
<td>• Report that will provide the data needed to identify how copy</td>
</tr>
<tr>
<td>• How often will the audits be conducted?</td>
<td>functionality</td>
</tr>
<tr>
<td>• What time period will be covered?</td>
<td></td>
</tr>
<tr>
<td>• How will sample size be identified?</td>
<td></td>
</tr>
<tr>
<td>• Audit Report</td>
<td></td>
</tr>
<tr>
<td>• Description of analysis technique</td>
<td></td>
</tr>
<tr>
<td>• How will the audits be selected?</td>
<td></td>
</tr>
<tr>
<td>– Population</td>
<td></td>
</tr>
<tr>
<td>– Group</td>
<td></td>
</tr>
<tr>
<td>– Service</td>
<td></td>
</tr>
<tr>
<td>– Location</td>
<td></td>
</tr>
</tbody>
</table>
Notify HIM

- Identify patient record
- Identify the type of note
- Date/time
- Author
- Identify the information copied
- If possible identify the source data
Clearly Define Procedures

- How to report incorrect information?
- Who is responsible for reporting incorrect information?
- Who will be notified of incorrect information?
- Who has permission to correct information?
- Who investigates how the incorrect information was entered?
- What is the process for ensuring corrections are made in all systems and updated to all providers?
- How are providers notified when they have incorrectly entered information?
- When is a corrective discipline plan initiated?
- What is the process for education?
Following Your Copy and Paste Policy

• What steps are in place when non-compliance is reported?
  – Conduct an audit to include:
    • interviews were with key stakeholders and end users
    • Review source documentation or previous versions
    • Determine if action follows the policy or not
What to look for in an audit

- When copy functionality is used, attribution as to original source & date must be documented
- Chart notes are reviewed before authentication by all providers
- Templates should be standardized
- Are cloned visits causes for any denials you have received?
What to look for in an audit

• Look for notes copied forward from one visit to another or one day to another
• Do providers bring in “old lab” values into the visit?
• Are procedures copied forward into other visits so it looks like the procedure was performed again?
• Does the provider document a full assessment & final dx, after study that is clear and concise?
## Investigation Tool

<table>
<thead>
<tr>
<th>Statement of Issue</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Concerns</td>
<td></td>
</tr>
<tr>
<td>Information yielded from investigation</td>
<td></td>
</tr>
<tr>
<td>Root cause</td>
<td></td>
</tr>
<tr>
<td>Recommendations</td>
<td></td>
</tr>
</tbody>
</table>
## Example: Investigation

<table>
<thead>
<tr>
<th>Statement of Issue</th>
<th>One patient’s encounter copied into 20+ records belonging to different patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concerns</td>
<td>HIPAA, Patient Safety, Billing,</td>
</tr>
</tbody>
</table>
Information yielded from investigation

Multiple patient records involved. One patient’s encounter copied into 20+ records belonging to different patients.

Copy./Paste issue led to an erroneous documentation issue

Billing completed—some patients have incorrect diagnoses codes based on the erroneous copied information.

User not verifying in the correct patient’s record before “accepting” the documents.

Interfaces affected: Billing, Data Warehouse

Letters back to patients and referring physicians.
<table>
<thead>
<tr>
<th>Root cause</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continued use of department system vs. new EHR system.</td>
<td>Technical: Create a script to continuously clear the clipboard.</td>
</tr>
<tr>
<td>Training issue (how to copy/paste)</td>
<td>Training: User must take responsibility for verifying information is pasted to the right record.</td>
</tr>
<tr>
<td>Technical issue with clipboard</td>
<td>Training: Users trained to send message to HIM through in-box when they notice an error.</td>
</tr>
<tr>
<td></td>
<td>Auditing: HIM to randomly audit department’s documentation</td>
</tr>
</tbody>
</table>
Records Sent to Multiple Locations

Incorrect records sent out across the continuum:
• Records are interfaced to multiple locations
• Records faxed/mailed to multiple primary and referring physicians
• Records mailed to patients
• Records used for billing
Commitment

• Training
  – Who will train?
  – Who will attend?
  – Is it mandatory?
  – Is it provided annually?
What to Train

• How to Document
  – Good workflows
  – Clear understanding of what needs to be captured
  – What can be brought forward
  – Partner with medical staff leaders to address

• Teach providers that careless copying creates untrustworthy records
What to Mandate

• Mandate Training?
• Initial training prior to receiving access
• User/role specific
• Annual training
• Any providers who documents in the record
Policy and Procedure

- Guidelines
  - Organizational use
  - System specific use
  - System selection criteria
  - Sanctions – Rules and Regulations
  - Corrections
Sample Copy/Paste Policy

- **Title:** Utilization of Copy/Paste Functionality for Documentation within the Health Record

- **Policy:** Providers documenting in the EHR must avoid indiscriminately copying and pasting another provider’s progress notes, discharge summary, electronic mail communication, and redundant information provided in other parts of the health record.
Sample Procedure

- Providers are responsible for the content of their documentation, whether it is original, copied, pasted, imported or reused
- The provider is responsible for the accuracy and medical necessity of the note
- Providers are responsible for correcting any errors identified and alerting the HIM professional
- Copying prior documentation must be referenced
- Providers are required to follow all state, federal, and local laws, including the medical staff bylaws, rules and regulations
- Failure to comply will result in disciplinary action being taken
Policy at one hospital

• Basic Tenets

• The provider’s note should accurately reflect the work done by that provider on the day of service.
• The provider’s note should not contain data that was not directly obtained or reviewed/confirmed by the author.
• Objective data such as Demographic information or Past History may be copied or linked into a note.
• Subjective data such as the History of Present Illness, Physical Examination, or an Assessment is unique to the provider entering the note and should never be copied from another author.
• The provider is responsible for all data entered into a note once the note is accepted into the electronic record.
Sample Sanction Policy

- **Title**: Copy Function Sanction Policy
- **Purpose**: To provide guidance for action in the event of inappropriate use of copy functionality in the EHR
- **Policy**: Provider 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
Sample Sanction Procedure

• “Who” is responsible for referring cases of inappropriate copying and pasting to “whom” for corrective action, review, and facility wide trending.

• “Who” 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.

• Failure to comply with the organizational policy regarding copy functionality may be deemed violating hospital policy.

• Further disciplinary action may be taken.
Sample Education Policy

- **Purpose**: To provide guidance on the required education that a provider must attend prior to the use of any copy functionality
- **Policy**: Providers documenting in the EHR must attend organizational education training on the copy functionality with the electronic health record
- **Procedure**: Any provider utilizing copy functionality must attend training prior to initial use of such technology
- Providers must demonstrate their understanding of all applicable state and federal rules regarding copy and paste
- Providers must demonstrate their ability to appropriately use the functionality and know how to attribute
- Provider must attend annual training
Provider Education Training Form

Date: _________________  Provider: ___________________

1 ___ Provider demonstrated understanding of copy functionality.
2 ___ Provider demonstrated understanding of applicable state, federal regulations.
3 ___ Provider received copies of all related organization policies and procedures.
4 ___ Provider demonstrated understanding of how to site source document.
5 ___ Provider verbalizes understanding of their responsibility for the content of the documentation whether the content is original, copied, pasted, imported or reused.
6 ___ Provider verbalizes understanding of the requirement for annual training.

Form is signed by physician and trainer.
Audit Policy Example

• **Purpose:** The purpose of the health record is to provide documentary evidence of the patient’s medical evaluation, treatment, and change in condition. The purpose of this policy is to provide guidance on the audits required in conjunction with the copy functionality in the EHR.

• **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 functionality is considered a sanction offense in accordance with the organizational policies.
Audit Procedure Example

- Determine how and when audits will be conducted
- Determine who will perform these ongoing concurrent audits
- Establish frequency for performing the audit
- Establish time period covered by the audit
- Identify how the sample size is determined
- Identify a description of the outcome indicators
- Determine how copy functionalities within the record are identified
- Design a corrective action plan based on findings
Final Take Aways

• Learn and know your EHR system
• Partner and collaborate with medical staff
• Create and implement copy functionality policy
• Create and implement education policy and checklist
• Create and implement an audit policy
• Perform chart audits
• Emphasize accuracy and ownership (and trustworthiness)
Resource/Reference List

- **AHIMA Copy Functionality Toolkit** – A Practical Guide: Information Management and Governance of Copy Functions in Electronic Health Record Systems, AHIMA Updated 2012
- CMS Documentation Requirements
- Local Medicare and Medicaid Carriers
- AHIMA Position paper 2014 - **Appropriate Use of the Copy and Paste Functionality in Electronic Health Records**
- EHRs Linked to Errors, Harm, AMA Says
- Research in Ambulatory Patient Safety
- How copy and paste in electronic medical records affects patient care
- "Do Electronic Medical Records Decrease Liability Risk?"