AHIMA Standards Task Force

HIM Practice Standards Project

Specification of Use Cases for

Information Management Practices in Healthcare:

Copy and Paste

Chicago, Illinois, USA

2017

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# Copy & Paste Use Case Overview

The AHIMA Copy & Paste Use Case was developed based on the *AHIMA Copy Functionality Toolkit – A Practical Guide: Information Management and Governance of Copy Functions in Electronic Health Record Systems.*[[1]](#footnote-1)

It supports the recommendations from the ECRI Institute’s Partnership for Health IT Patient Safety that were developed with the AHIMA participation as follows:

Recommendation A: Provide a mechanism to make copy and paste material easily identifiable

Recommendation B: Ensure that the provenance of copy and paste material is readily available

Recommendation C: Ensure adequate staff training and education regarding the appropriate and safe use of copy and paste

Recommendation D: Ensure that copy and paste practices are regularly monitored, measured, and assessed[[2]](#footnote-2)

It also supports the 2017 Report: Examining the Copy and Paste Function in the Use of Electronic Health Records published by the National Institute of Standards and Technology (NIST).[[3]](#footnote-3)

Please provide additional sources as needed to the full TF

VA work – get information – Mick Talley – sharing data between civilian and military community, OSHA, eHealth Exchange (former NwHIN)?

Provide summary of WHY – use references above, etc. See section on Problems below.

Darice: <http://www.physiciandocumentation.org/>

Sharon: Cornel University guidelines

## Business Requirements

Review 2016 AHIMA bus req to select applicable reqs by principle

Review IHE profiles as applicable – move to Stds section for selected standards

|  |
| --- |
| **Health Information Availability: Business Requirements** |
| To be discussed – IHE Retrieve Form for Data Capture (RFD)?, IHE Retrieve Information for Display (RID)? |
| 1. Ability to capture and maintain information in a manner that ensures timely, accurate (complete and correct), and efficient access and retrieval. – *See Integrity Requirement #1 and #5; Protection #9; Accountability #7; Transparency #5* |
| 5. Ability to present/provide information that originates from disparate electronic systems, both internal and external to the organization in a meaningful way, and for a specific purpose via usable user interface. *– See Integrity #5 and #16* |

|  |
| --- |
| **Health Information Accountability: Business Requirements** |
| Add as needed |

|  |
| --- |
| **Health Information Protection: Business Requirements** |
| To be discussed – IHE ATNA  |

| Health Information Integrity (I): Business Requirements |
| --- |
| I-16. Ability to establish policies for “copy and paste” in the organization. |
| I-16. Ability to establish parameters for “enable / disable” capabilities for “copy and paste” in HIT product including disabling capability for certain areas of the Health IT system and not the entire system.[[4]](#footnote-4) |
| I-17. Ability to track “copy and paste” usage (e.g., via color coding, flags, notes, and/or using other visual identifiers), so information from a previous entry is identifiable and viewable in a subsequent entry, as well as presented in a complete chronological sequence within a single episode of care. This will include maintaining metadata on “copy and paste” usage in a data audit of the use of “copy and paste” function including the source, date, time, author of performing copy and paste.User interface must display the provenance (“chain of custody”) of the information associated with the use of ‘copy and paste’ (information origin, source, actor (person and information system) completed the copy& paste, the date and time of completion, original date/time when the information was created). However, this information should not be displayed by default, and only be shown on user demand to avoid the possibility of overwhelming clinical users and contribute to errors of commission (taking an incorrect action).  |

|  |
| --- |
| **Health Information Compliance (C): Business Requirements** |
| C-8. Ability to develop internal controls to monitor adherence to rules, regulations, and program requirements, thus assessing and ensuring compliance |

|  |
| --- |
| **Health Information Disposition (D): Business Requirements** |
| Add as needed |

## Definitions

Look for ECRI Toolkit or literature review document for definitions/harmonize

Copy -- act of copying text in an electronic health records (EHR) and/or copying of text from an outside document with the intent to move this text from one part of the record to another or into another record or document within the EHR system.

Paste -- Creating a duplicate entry or reuse of informaiton[[5]](#footnote-5) by transferring text, data, files or objects from an original source to a specific destination while the original text is not removed from the record.

Copy/Paste Functionality – act of copying text in an electronic health records (EHR), copying of text from an outside document and pasting it into the EHR or pasting it to a new location within the record, in which the original text is not removed from the record.[[6]](#footnote-6)

Synonyms: copy and paste, cloning, copy forward, re-use, carry forward, pull forward (happen automatically), save note as a template. Represent any intent to move documentation from one part of the record to another.[[7]](#footnote-7)

Pre-populate is …

Chain of custody – define

Enable / disable - define, describe Microsoft OP challenges and how they can be overcome. Can be run by audits.

“Note bloat” – define

## Scope

This use case is limited to the information captured in HIT systems. Patients and PHR systems are out of scope.

Discuss the scope and limit as needed further. Scope may be limited by the type of information (see Content section below).

## Actors

The following are the business and technical actors involved in the Copy & Paste Use Case:

|  |  |
| --- | --- |
| **Actors** | **Description of the Role in the Copy & Paste Use Case** |
| **Business Actors** |
| **Policy Setting, Data Verification and Risk Mitigation Actors** |
| Compliance Staff/HIT Staff | Staff responsible for setting and monitoring organizational policies on copy & paste.  |
| HIM Staff | Staff responsible for data verification, report maintenance, completion of the medical records |
| Risk Managers | Staff participating in addressing any risks associated with copy & paste |
| Business process managers or operation excellence officers | Define their role |
| **Data Capture Actors** |
| Registration staff | Staff responsible for registering patients when they use copy & paste function[[8]](#footnote-8) |
| Billing staff | Staff responsible for generating a bill for healthcare services performed when they use copy & paste function during the billing function. This includes Insurance Verifier Registrar, who verifies patient insurance information and communicates with the payor  |
| Payor | Entities involved in paying for medical care when they use copy & paste function |
| Healthcare Providers (physician, nurse, pharmacist, care coordinator, diagnostic service technician, dietician, other)  | Those who involved in the provision of care. Those who capture patient information in the EHR record and other health information systems |
| Scribes | Acting on behalf of the clinician in documenting patient information in the EHR. |
| **Education Actors** |
| Educators | Staff, including HIM professionals, responsible for workforce training on the use of copy and paste. This may include other entities, e.g., vendors who provide training to healthcare organization’s personnel regarding the copy & paste |
| **Technical Actors** |
| Registration–Admission, Discharge, and Transfer (R-ADT) System | An administrative information system that stores demographic information and performs functions related to registration, admission, discharge, and transfer of patients within the organization[[9]](#footnote-9) |
| Electronic Health Record (EHR) System  | An information system that ensures the longitudinal collection of electronic health information for and about persons; enables immediate electronic access to person- and population-level information by authorized users; provides knowledge and decision support that enhances the quality, safety, and efficiency of patient care; and supports efficient processes for healthcare deliver.[[10]](#footnote-10) These include EMR, EPR, CPR systems (see Glossary section for the definitions).  |
| Health Information System (HIS) | Information system that supports healthcare delivery within a healthcare organization. It includes R-ADT, EHR, laboratory, radiology, pharmacy, financial, administrative and other information systems.  |
| Electronic Document Management System (EDMS) | Software consisting of many component technologies that enable healthcare businesses to use documents to achieve significant improvements in work processes[[11]](#footnote-11) |
| Financial System | Information system used by a healthcare organization to perform administrative and financial transactions associated with healthcare delivery |
| Payor System | Information system used by health plans to manage administrative and financial functions associated with the coverage and financing of healthcare for individuals enrolled in the health plan (health plan members). These functions manage information regarding the individual’s enrollment, eligibility, coverage and benefits, authorizations, claims, care coordination and other information related to the member  |
| Health Information Exchange (HIE) | An infrastructure to support information exchange between information exchange participants |
| Mobile Health (mHealth) Application | mHealth application (apps), i.e. portable device including but not limited to mobile phones, Personal Digital Assistants (PDAs) and other, that enables access to patient information across various information systems |

## Problems

Problems (risks) to documentation integrity of using “copy and paste” capability[[12]](#footnote-12) include:

* Inaccurate or outdated information on the patient that may adversely impact patient care
* Information on the wrong patient that may adversely impact patient care[[13]](#footnote-13)
* Redundant information, which causes the inability to determine current information
* Redundant information which can restrict efficient access to critically need clinical information and data (field of noise)[[14]](#footnote-14)
* Truncation of information[[15]](#footnote-15) when information is cut off at the certain point
* Formatting of information[[16]](#footnote-16)when there is a lack of computer algorithms to make information to be presented in a particular format or context
* Inability to identify the author or intent of documentation
* Inability to identify when the documentation was first created
* Inability to accurately support or defend evaluation and management (E/M) coding for professional or technical billing notes
* Propagation of false information
* Internally inconsistent progress notes
* Unnecessarily lengthy progress notes (note bloat)
* Pulling information out of context
* CAPACITY –
	+ need for the system to operate in a high volume environment;
	+ capacity of the field in where information have to be pasted/truncated
* Error message needs to be presented to the users
* Systems Performance - lack of performance criteria/ set of metrics for performance/for information and systems availability conformance
* Sloppy and paste – get references

## Solutions

Recommendation A: Provide a mechanism to make copy and paste material easily identifiable - AHIMA Checklist on Data Capture; AHIMA Checklist on Data Verification

Recommendation B: Ensure that the provenance of copy and paste material is readily available - AHIMA Checklist on Audit

Recommendation C: Ensure adequate staff training and education regarding the appropriate and safe use of copy and paste - AHIMA Checklist on Education[[17]](#footnote-17)

Recommendation D: Ensure that copy and paste practices are regularly monitored, measured, and assessed[[18]](#footnote-18) - AHIMA Checklist on Compliance

Utilization of “copy and paste” capability in health information systems is based on:

* Organizational acceptable uses
* Operational processes and checklists including lists of do’s and don’ts for copy and paste

Documentation guidelines – what are they?

* Responsibility – Which One?
* Review and monitoring
* Auditing and reporting
* Sanctions[[19]](#footnote-19)

Monitoring reports and scoring tools

Error messages when system/field capacity is not available

STOPPED REVIEW HERE ON 3-6-17

### *Content*

“The following are examples of content that may be copied if the information has been verified and has remained the same over a specified time period:

* Demographics
* Medications
* Allergies
* Problems
* Labs and treatment or therapies” [[20]](#footnote-20)
* Elements of a History and Physical examination that have remained the same from the most recent previous visit.

Harmonize with NIST recommendation for the content

The following content should never be copied and pasted:

* Vital signs
* Assessment
* Care Plan
* WHAT ELSE?

The following content should be captured in a copy and paste audit report: - SEE Audit section below

information origin (source)

actor (person and information system) completed the copy& paste action,

the date and time of completion,

original date/time when the information was created

other?

 Slivochka: Should we make suggestions on what would be helpful for a vendor to have in a copy and paste report when generated?  Author of the note, who it was copied by, the department of who copied the information, type of note, identifiers?

### *Functional Requirements*

The following are the scenarios for the Copy and Paste Use Case:

1. Data Capture
2. Data Verification
3. Audit
4. Education/training
5. Compliance

Data Capture

Copy forward, pre-populate

Data Verification

?????

Audit

“Organizations should recognize the existence of copy functionality within their EHRs. Developing a work list to introduce the audit concept will help with the due diligence process.

*“User interface must display the “chain of custody” of the information associated with the use of ‘copy and paste’. However, this information should not be displayed by default, and only be shown on user demand to avoid the possibility of overwhelming clinical users and contribute to errors of commission (taking an incorrect action).”[[21]](#footnote-21)*

Basic questions to address are:

* Can a copy event be identified retrospectively?
	+ Different color font used
	+ Original author identified
	+ Original date and time noted
* Is an appropriately detailed audit log generated when a copy event occurs in the course of documentation? Basic information to include is:
	+ Name of user performing the copy function
	+ Identification of what information was copied
	+ Identification of where copied information originated
* Name of document/data field
* Date of original data
* Time of original data”

A compliance-oriented EHR 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 report with a list of encounters where providers have used the copy function. 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 (for example, within 30 days, 3 months, 6 months). This report can be used to randomly audit documentation (for example, review re-admissions history and physicals or assessments within a certain period of time).
* A report that compares discrete data elements in the electronic record (for example, 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 health 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, consider commercially available software to analyze documents and identify duplicate phrases. [[22]](#footnote-22)

## Use Case Scenarios

### *Scenario 1: Data Capture*

1. Data Capture

### *Scenario 2: Data Verification*

1. Data Verification

### *Scenario 3: Audit*

1. Audit

### *Scenario 4: Education/Training*

1. Education/training

### *Scenario 5: Compliance*

1. Compliance

See examples of the scenario descriptions below:

**Business Requirements #I-16 and #C-8**

Checklist: Ability to Establish Parameters for “Enable /Disable Copy & Paste” Action

* Define organizational policy for copy & paste action by
	+ Specifying clinical documentation and content in which copy & paste action can be performed
	+ Specifying actors (business and technical) responsible for performing copy & paste action
	+ Specifying audit procedure and documentation for performed copy & paste action
	+ Specifying training procedure for the personnel involved in performing and auditing copy & paste action

**Business Requirements #I-17and #C-8**

Checklist: Ability to Perform and Track “Copy and Paste” Usage by HIT Users

* Perform copy & paste action by
	+ Coping necessary section(s) in the original document
	+ Pasting necessary section(s) into the new document
	+ Verifying copied/pasted section(s) between the original and new documents by providing electronic signature and date/time stamp of completed action
* Identify copy & paste action retrospectively by
	+ Viewing highlighted copied text in the original document
	+ Viewing highlighted pasted text in the new document
	+ Identifying/tracking the identification numbers of the original and new documents
	+ Identifying/tracking the actors (business and technical) of the original document
		- Business actor: name, role, signature
		- Technical actor: system name and ID
		- Date/time stamp when the original document was created
	+ Identifying/tracking the actors (business and technical) who performed copy& paste action (name, role, signature) and where the action was performed
		- Business actor: name, role, signature
		- Technical actor: system name and ID
	+ Identifying/tracking the date and time of the performed copy& paste action
		- date/time stamp
* Generate the audit log of copy & paste actions in real time by specifying
	+ The name of actor performing the copy function
		- Business actor: name, role
		- Technical actor: system name and ID
	+ What information was copied
	+ The original document information was copied from
	+ The new document where information was pasted to
	+ Date/time when the action was performed

# Appendix 1: Examples of Copy & Paste Use

The following case scenarios demonstrate the appropriate use of copy & paste. [[23]](#footnote-23)- harmonize with Actors above, Add preface to each scenario

**CASE SCENARIO 1**

*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 HER and orders the appropriate tests. On day one of the hospital stay, the physician completes a progress note. On subsequent days two and three, the physician completes progress notes updating the patient’s progress and documents the results of all tests. On day four, the patient is discharged home. The PCP copies forward the chief complaint and physical examination from the progress note on day one. 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.

**CASE SCENARIO 2**

*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 the physician should have noted the original source document and updated the note with the specific information from this encounter. System functionality would allow the user to confirm that the physician 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 3**

*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 forward 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’s. 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 in a manner consistent with organizational policies

# Appendix 2: Samples of Copy & Paste Policies

See examples of policies in the AHIMA Toolkit[[24]](#footnote-24). Decide which ones to use. Provide additional examples from the organizations as needed

## Appendix A: Sample Copy Policy

## Appendix B: Sample Sanction Policy

## Appendix C: Sample Copy Functionality Education Policy

## Appendix D: Sample Checklist of Organizational Questions

## Appendix E: Sample Checklist of Vendor Questions

## Appendix F: Sample Copy Functionality Audit Policy

## Appendix G: Sample Checklist for Auditing Copy Functionality

## Appendix H: Sample Copy Functionality Testing Policy

## Appendix I: Sample Checklist for Notification Procedures for Inappropriate Use of the Copy Functionality

1. AHIMA Copy Functionality Toolkit – A Practical Guide: Information Management and Governance of Copy Functions in Electronic Health Record Systems. 2012. URL: <http://bok.ahima.org/doc?oid=105646> [↑](#footnote-ref-1)
2. ECRI Institute. Copy/Paste: Prevalence, Problems, and Best Practices. 2015. URL: <https://www.ecri.org/Resources/HIT/HTAIS_Copy_Paste_Report.pdf>

ECRI Institute. Partnership for Health IT Patient Safety. Heath IT Safe Practices: Toolkit for the Safe Use of Copy and Paste. 2016. URL: <https://www.ecri.org/Resources/HIT/CP_Toolkit/Toolkit_CopyPaste_final.pdf> [↑](#footnote-ref-2)
3. National Institute of Standards and Technology (NIST). Examining the Copy and Paste Function in the Use of Electronic Health Records. NISTIR 8166. 2017. URL: <http://nvlpubs.nist.gov/nistpubs/ir/2017/NIST.IR.8166.pdf> [↑](#footnote-ref-3)
4. *The hospitals should necessarily, be given the ability to turn­off the ‘copy and paste’ function in certain areas of the EHR.* <http://nvlpubs.nist.gov/nistpubs/ir/2017/NIST.IR.8166.pdf> Page 28 [↑](#footnote-ref-4)
5. We have used the term “reuse” of information to imply paste. Page 21 and to imply paste function throughout the document <http://nvlpubs.nist.gov/nistpubs/ir/2017/NIST.IR.8166.pdf>. [↑](#footnote-ref-5)
6. AHIMA Pocket Glossary. 2014, p.37 [↑](#footnote-ref-6)
7. AHIMA Copy Functionality Toolkit – A Practical Guide: Information Management and Governance of Copy Functions in Electronic Health Record Systems. 2012. URL: <http://bok.ahima.org/doc?oid=105646> [↑](#footnote-ref-7)
8. AHIMA, Pocket Glossary of Health Information Management and Technology. Chicago, IL. 2014, p. 127. [↑](#footnote-ref-8)
9. Ibid, p. 127. [↑](#footnote-ref-9)
10. Ibid, p. 53. [↑](#footnote-ref-10)
11. Grzybowski D. Strategies for electronic document and health record management. AHIMA. Chicago, IL. 2014. pp. 31,40,47,159. [↑](#footnote-ref-11)
12. AHIMA Copy Functionality Toolkit – A Practical Guide: Information Management and Governance of Copy Functions in Electronic Health Record Systems. 2012. URL: <http://bok.ahima.org/doc?oid=105646> [↑](#footnote-ref-12)
13. “*Enabling the user to easily transition from the current chart with unrestricted access to input information to another chart by a deliberate action (i.e., identification / activation of the patient chart), would help prevent errors of documentation in wrong patient chart.” NISTIR 8166.p 31.URL:* <http://nvlpubs.nist.gov/nistpubs/ir/2017/NIST.IR.8166.pdf> [↑](#footnote-ref-13)
14. American College of Physicians (ACP). (Informatics Section) statement about the “field of noise” reference here.   [↑](#footnote-ref-14)
15. Other problems during copy and paste that could be added are “truncation of information” and “formatting of information.”

<http://nvlpubs.nist.gov/nistpubs/ir/2017/NIST.IR.8166.pdf>

Page 1, 15, 22, 27

An example of how the text with the problems of copy of paste would look like is seen in the Executive Summary on Page 1 [↑](#footnote-ref-15)
16. Other problems during copy and paste that could be added are “truncation of information” and “formatting of information.”

<http://nvlpubs.nist.gov/nistpubs/ir/2017/NIST.IR.8166.pdf>

Page 1, 15, 22, 27

An example of how the text with the problems of copy of paste would look like is seen in the Executive Summary on Page 1 [↑](#footnote-ref-16)
17. We would like to reference you to the following publication if you find it useful::

<http://nvlpubs.nist.gov/nistpubs/Legacy/SP/nistspecialpublication800-84.pdf> [↑](#footnote-ref-17)
18. ECRI Institute. Partnership for Health IT Patient Safety. Copy and Paste Recommendations. 2016. URL: [↑](#footnote-ref-18)
19. AHIMA Copy Functionality Toolkit – A Practical Guide: Information Management and Governance of Copy Functions in Electronic Health Record Systems. 2012. URL: <http://bok.ahima.org/doc?oid=105646> [↑](#footnote-ref-19)
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