AHIMA Standards Task Force

HIM Practice Standards Project

Specification of Use Cases for

Information Management Practices in Healthcare:

Copy/Paste

Chicago, Illinois, USA

2017

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# Introduction

The AHIMA Copy/Paste Use Case was developed based on the *2011 AHIMA Copy Functionality Toolkit – A Practical Guide: Information Management and Governance of Copy Functions in Electronic Health Record Systems*[[1]](#footnote-1) As well as 2015 ECRI Institute’s Copy/Paste: Prevalence, Problems, and Best Practices report. [[2]](#footnote-2)

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/paste material easily identifiable

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

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

Recommendation D: Ensure that copy/paste practices are regularly monitored, measured, and assessed.[[3]](#footnote-3)

It also supports the *2017 Informational Report: Examining the Copy and Paste Function in the Use of Electronic Health Records* published by the National Institute of Standards and Technology (NIST), NISTIR 8166.[[4]](#footnote-4)

# Definitions

Used in the document: Copy/Paste, Copy and Paste, Copy&Paste, C/P.

RM: It would be nice to provide references to differentiate copy forward, copy/paste, carryforward, etc. Perhaps, ECRI toolkit would be helpful.

**Carryforward** –

**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.

**Copy forward** –

**Paste** – Creating a duplicate entry or reuse of information[[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. In the NISTIR the term “reuse” of information implies “paste” (p.21).

**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) Copying and pasting can be from one patient’s record to another and not limited to one patient.

Synonyms: copy/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**

**Chain of custody**

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

**“Note bloat”** –a way of representation of information in the HIT systems when key findings and actions are obscured by superfluous negative findings, irrelevant documentation, and different diagnosis, all of which make the record difficult and time-consuming to read[[8]](#footnote-8)

**Truncation of information**

**Validate**

**Verify**

## Scope

In 2017, this use case is limited to information captured in Admission, Discharge and Transfer (ADT) systems, EHR systems and Electronic Document Management Systems (EDMS). Patient’s Personal Health Record (PHS) systems are out of scope. In the future we will expand the use case to include ancillary information systems (laboratory, public health, pharmacy and others).

In addition, the 2017 scope is limited by the type of information listed in the Content section below.

## Actors

Table 1 presents the roles of business actors (humans) and technical actors (information systems) involved in the Copy/Paste Use Case. Business actors are grouped according to their roles under the following three scenarios:

1. Policy Setting, Data Verification and Risk Mitigation
2. Data Capture and
3. Education.

Table 1. Roles of Business and Technical Actors: Copy/Paste Use Case

|  |  |
| --- | --- |
| **Actors** | **Role Description: 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, completion of the medical records, report maintenance including review of reports for copy/paste use and provision of feedback to copy/paste users; education and awareness on the copy/paste use (see educator role below) |
| Risk Managers, Business Process Managers, Operation Excellence Officers | Staff participating in addressing any risks associated with copy & pasteNeed to list ALL risks and define specific activities by these 3 roles |
| **Data Capture Actors** |
| Registration staff | Staff responsible for registering patients when using copy/paste[[9]](#footnote-9) |
| Healthcare Providers (physician, nurse, pharmacist, care coordinator, diagnostic service technician, dietician, other)  | Those who involved in the provision of care and capturing patient information in the EHR and other health information systems |
| Scribes | Staff who is acting on behalf of the clinician to document patient information in the EHR and other health information systems |
| **Education Actors** |
| Educators | Staff, including HIM professionals, responsible for workforce training on the use of copy/paste. Training may be provided by consultants who provide training to healthcare organization’s personnel regarding the copy/paste; professional organizations and other |
| **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[[10]](#footnote-10) |
| 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.[[11]](#footnote-11) These include EMR, EPR, CPR systems (see Glossary section for the definitions).  |
| 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[[12]](#footnote-12) |

#

# Problems and Solutions

Table 2 presents problems (risks) to documentation integrity when inappropriately using copy/paste,[[13]](#footnote-13) solutions to mitigate these problems and the roles of business actors involved. These problems are grouped using ECRI’s four area (1-4 below) and an additional 5th area when poor use of copy/paste poses challenges to good clinical care by decreasing the quality of documentation via:

1. Facilitating introduction of new inaccuracies
2. Accelerating the propagation of inaccurate information
3. Promoting creation of internally inconsistent notes
4. Generating lengthy notes that may obscure important clinical information [[14]](#footnote-14)
5. Limited capacity of the information systems.

To specified solutions to the problems identified, we used those identified in the AHIMA 2012Toolkit and ECRI recommendations as follows:

AHIMA Recommendations:

* Define and implement organization’s acceptable uses of copy and paste

Define and implement documentation guidelines for the medical staff bylaws/rules and regulations developed by the organization, regulatory and accrediting agencies

* Define and implement operational processes, checklists and expected outcomes including
	+ Copy/paste responsibilities by business and technical actors
	+ Lists of do’s and don’ts for copy/paste
* Auditing and reporting including reporting entities, reports templates, scoring metrics and periodicity
* Regular monitoring, review and update of copy/paste practices
* Mitigation efforts and sanctions.

ECRI Recommendations

A: Provide a mechanism to make copy/paste material easily identifiable – see below AHIMA Checklist on Data Capture; AHIMA Checklist on Data Verification

B: Ensure that the provenance of copy/paste material is readily available – see below AHIMA Checklist on Audit

C: Ensure adequate staff training and education regarding the appropriate and safe use of copy/paste – see below AHIMA Checklist on Education[[15]](#footnote-15)

D: Ensure that copy/paste practices are regularly monitored, measured, and assessed – see below AHIMA Checklist on Compliance.

Table 2: Copy/Paste Problems, Solutions and Responsible Staff

|  |  |  |
| --- | --- | --- |
| **Problem** | **Solution** | **Responsible Staff** |
| **1) facilitating introduction of new inaccuracies** |
| 1. Inaccurate or outdated information on the patient that may adversely impact patient care
 | C/P policies; data/record verification; improved user interface to show identifiable c/p information; c/p audit*ECRI A-Provide a mechanism to make copy/paste material easily identifiable* *ECRI B-Ensure that the provenance of copy/paste material is readily available**ECRI C-Ensure adequate staff training and education regarding the appropriate and safe use of copy/paste ECRI D-Ensure that copy/paste practices are regularly monitored, measured, and assessed* | Providers, HIM staff reviewer |
| 1. Information on the wrong patient that may adversely impact patient care
 | C/P policies; data/record verification; improved user interface to show identifiable c/p information; c/p audit *“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.” [[16]](#footnote-16)* *ECRI C-Ensure adequate staff training and education regarding the appropriate and safe use of copy/paste ECRI D-Ensure that copy/paste practices are regularly monitored, measured, and assessed* | Providers, HIM staff reviewer |
| 1. WHY-Inability to accurately support or defend evaluation and management (E/M) coding for professional or technical billing notes
 | *?* |  |
| 1. Sloppy and paste – get references
 | C/P policies; data/record verification; improved user interface to show identifiable c/p information; c/p audit*ECRI A-Provide a mechanism to make copy/paste material easily identifiable* |  |
| **2) accelerating the propagation of inaccurate information**  |
| 1. Redundant information, which causes the inability to determine current information
 | C/P policies; data/record verification; improved user interface to show duplicate information *ECRI A- Provide a mechanism to make copy/paste material easily identifiable* |  |
| 1. Truncation of information[[17]](#footnote-17) when information is cut off at the certain point
 | Data/record verification; improved user interface to show *identifiable* c/p information *“EHR systems must be designed to enhance the visibility of the information being selected for copy and paste to prevent users from inadvertently copying only part of the information that was intended to be pasted which could minimize the possibility of incomplete reuse of information that could lead to morbid/mortal errors.”[[18]](#footnote-18)* *ECRI A- Provide a mechanism to make copy/paste material easily identifiable* |  |
| 1. Propagation of false information
 | Data/record verification; improved user interface to show *identifiable* c/p information: improved user interface to…*ECRI A- Provide a mechanism to make copy/paste material easily identifiable ECRI C-Ensure adequate staff training and education regarding the appropriate and safe use of copy/paste**ECRI D-Ensure that copy/paste practices are regularly monitored, measured, and assessed* |  |
| 1. Pulling information out of context
 | Data/record verification; improved user interface to show *identifiable* c/p information; improved user interface to…*ECRI C-Ensure adequate staff training and education regarding the appropriate and safe use of copy/paste* |  |
| **3) promoting creation of internally inconsistent notes -** define inconsistent; provide examples |
| 1. Inability to identify the author or intent of documentation
 | Audit, provenance; improved user interface to display information chain of custody on demand*“User interface shall 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).”[[19]](#footnote-19)* *ECRI B-Ensure that the provenance of copy/paste material is readily available* |  |
| 1. Inability to identify when the documentation was first created
 | Audit, provenance; improved user interface to display when information was created on demand*ECRI A- Provide a mechanism to make copy/paste material easily identifiable**ECRI B-Ensure that the provenance of copy/paste material is readily available* |  |
| 1. Internally inconsistent progress notes
 | Data/record verification; improved user interface to show inconsistencies (how?)*ECRI A- Provide a mechanism to make copy/paste material easily identifiable* |  |
| **4) generating lengthy notes that may obscure important clinical information** |
| 1. Redundant information which can restrict efficient access to critically needed clinical information and data (field of noise)[[20]](#footnote-20)
 | Data/record verification; improved user interface to show duplicate information*ECRI A- Provide a mechanism to make copy/paste material easily identifiable* *ECRI C-Ensure adequate staff training and education regarding the appropriate and safe use of copy/paste**ECRI D-Ensure that copy/paste practices are regularly monitored, measured, and assessed* |  |
| 1. Formatting of information[[21]](#footnote-21)when there is a lack of computer algorithms to make information to be presented in a particular format or context
 | Improved user interface; improved user interface for information presentation to providers (how?) |  |
| 1. Unnecessarily lengthy progress notes (note bloat)
 | Improved user interface; improved user interface to show duplicate information*ECRI A- Provide a mechanism to make copy/paste material easily identifiable*  |  |
| 5) limited capacity of the information systems |
| 1. Need for the system to operate in a high volume environment – Explain?
 |  |  |
| 1. Limited capacity of the field in where information have to be pasted/truncated
 | Improved user interface by generating error message when system/field capacity is not available*“EHR systems must be designed to enhance the visibility of the information being selected for copy and paste to prevent users from inadvertently copying only part of the information that was intended to be pasted which could minimize the possibility of incomplete reuse of information that could lead to morbid/mortal errors.”[[22]](#footnote-22)* *ECRI A- Provide a mechanism to make copy/paste material easily identifiable* |  |
| 1. Error message needs to be presented to the users
 | Data/record verification; improved user interface to show error information*ECRI A- Provide a mechanism to make copy/paste material easily identifiable* |  |
| 1. Systems Performance - lack of performance criteria/ set of metrics for performance/for information and systems availability conformance
 | Audit, provenance*ECRI A- Provide a mechanism to make copy/paste material easily identifiable* *ECRI B-Ensure that the provenance of copy/paste material is readily available ECRI C-Ensure adequate staff training and education regarding the appropriate and safe use of copy/paste**ECRI D-Ensure that copy/paste practices are regularly monitored, measured, and assessed* |  |

# Content

Patient Information. Healthcare content requirements for copy/paste are presented in Table 3. They are organized by content that “can be” and “cannot be” copied/pasted within various records of the same patient. In addition, Table 3 also presents the content that “can be” and “cannot be” copied/pasted from the records of multiple patients into a specific report. The latter is important for big data, public health and population health surveillance. Content examples from the AHIMA 2012 Toolkit are shown by the asterisk\*, from the NISTIR – by double asterisk \*\*.

Ms. Slivochka:

from one patient’s record to another and not limited to one patient. - Assess and describe risks with using copy/paste across patients

1. Should there be made mention of repetitive – DEFINE use of templates to represent information on a specific patient

should consideration be given to a tool to rate different areas of note types?  For example, assessment and plan should never be copied.

Split into New Information, PCP Data… - get the LIST from Lori Tolley

Validate content with different users (HIM, Providers, Risk Managers)? – PLEASE REVIEW THIS LIST WITH VARIOUS STAKEHOLDERS IN YOUR ORGANIZATIONS AFTER LORI’S FEEDBACK BELOW

Harmonize with NIST recommendation for the content

Table 3. Content Requirements: Copy/Paste (C/P)

|  |  |  |
| --- | --- | --- |
| Content | Conditions | Risks |
| **The Same Patient** |
| **Information that CAN BE copied/pasted --**The following are examples of content that may be copied if the information has been verified and validated and has remained the same over a specified time period |
| Demographics\*  | Verified at every visit |  |
| Medications\*  | Verified at every visit |  |
| Allergies\*  | Verified at every visit |  |
| Problems\*  | Verified at every visit |  |
| Laboratory report results and treatment or therapies\* | After a XX period of time[[23]](#footnote-23) |  |
| Elements of a History\* (what are they?) | If remained the same from the most recent previous visit**LW: Should be a timeframe on “most recent” as some patients only go to the doctor once every several years** |  |
| Elements of Physical Examination\* (what are they --weight, height, BP, ??)  | If remained the same from the most recent previous visit**LW: Should be a timeframe on “most recent” as some patients only go to the doctor once every several years** |  |
| Discharge Summary[[24]](#footnote-24)\*\* | ??? |  |
| WHAT ELSE?LW: **Progress Notes, Quick notes, Consults, Specialty notes such as Neurology, Cardiology, etc.** |  |  |
| **Information that SHALL NOT BE copied/pasted** –The following content should never be copied and pasted |
| Vital signs\* |  |  |
| Assessment\* |  |  |
| Care Plan\* |  |  |
| New test result\*\*  | Expected in a few days  |  |
| Authorizations\*\*  |  |  |
| Consent forms\*\*  |  |  |
| Anesthesia records\*\* |  |  |
| Any documentation not specific to the admission.  |  |  |
| WHAT ELSE?LW: **DNR wishes of the patient** |  |  |
| **Multiple PatientS – Do we need this?** |
| SPECIFY |  |  |
|  |  |  |

Discuss presentation in the Table (above) or the list (below).

From AHIMA Toolkit

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

* Demographics
* Medications
* Allergies
* Problems
* Laboratory report results and treatment or therapies after a XX period of time” [[25]](#footnote-25)
* Elements of a History and Physical examination that have remained the same from the most recent previous visit.

The following content should never be copied and pasted:

* Vital signs
* Assessment
* Care Plan
* New test result that is expected in a few days should never be populated with the old one from the earlier record

Authorizations

Consent forms

Anesthesia records

Any documentation not specific to the admission.

Audit/Provenance Information. Table 4 presents data elements for copy/paste provenance and audit trail. This content is included in a copy/paste audit report and is available on demand for HIM staff for compliance, data quality (e.g., accuracy) and information integrity assessments, information protection and reporting.

Discuss presentation in the Table or the list.

Original content in the original data source (both system and record)

Where - information origin (source)

Who - Name of author of the original documentation

When - original date/time when the information was created

* Frequency - How many times this information was copied

Copied/Paste content in the new data source (both system and record)

Where – information pasted to ( new information location)

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

When - the date and time of copy/paste completion

* Frequency - How many times this information was copied

 Ms. Slivochka:

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

Instead of audit concept, should we say monitoring plan?

Table 4. Data Provenance: Copy/Paste

|  |
| --- |
| **Source Content (Information to be copied)** |
| WHERE – Name/ID of facility who maintains source EHR (content manager) |
| WHERE – Source document ID and record ID from which information to be copied |
| WHEN – *“Time stamp when documented <(*captured*)>in <*source*> EHR”[[26]](#footnote-26)* first time |
| WHEN –*“Time stamp when it is signed (locked*)”in source EHR |
| WHO – Name/ID of provider who locked information in source EHR (content author/creator) |
| HOW – How often this content was accessed/copied ---May access/retrieve/view but not copy – do we need to record this access/view of info? |
| WHOM –To whom (facility and provider names/IDs – content consumers) this content was supplied by copy /paste |
| **Target Content (Information to be pasted)** |
| WHERE – Name/ID of facility who maintains target EHR (content consumer) |
| WHERE –Target document ID and record ID to which information was pasted |
| WHO – Name/ID of provider who accessed information for coping (content consumer)--- May access/retrieve/view but not copy – do we need to record this access/view of info? |
| WHO –Name/ID of provider who pasted information (content consumer) --- May access/retrieve/view/paste– do we need to record this access/view of info? |
| WHEN – Time stamp when accessed/copied |
| WHEN – Time stamp when pasted (captured, documented) in target EHR document/record |
| WHEN – Time stamp when it is signed (locked) in target EHR document/record |
| WHO – Name/ID of provider who locked information in target EHR (new content author/creator) |

### *Functional Requirements*

The following are the scenarios for the Copy/paste Use Case:

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

GE: What exactly are you looking for?

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

Data Capture

Copy forward, pre-populate

RM: Just copy/paste or all related functions?

Data Verification

?????

RM: Is this to do with editing?

NISTIR 8166 recommendation:

*EHR systems should provide a concept for reconciling that the copied information was read consciously and edited by the clinical provider which would promote the attribution of the source of the information.*

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

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Audit

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

“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.

Slivochka: instead of audit concept, should we say monitoring plan?

*“User interface must display the “chain of custody” of the information associated with the use of ‘copy/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).”[[27]](#footnote-27)*

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

RM: NISTIR 8166 recommendation: *User interface must display the “chain of custody” of the information associated with the use of ‘copy/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).* <http://nvlpubs.nist.gov/nistpubs/ir/2017/NIST.IR.8166.pdf> Page 29

* + 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.

Ms. Slivochka: should we suggest a report and some manual review will ensue?

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:

* When utilization of copy functionality is available as an auditable event,[[28]](#footnote-28) 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. [[29]](#footnote-29)

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

Ms. Slivochka: Is there value in teaching proper ways to copy/paste.  This is a great article to consider the “do’s and don’ts.”  <http://www.amednews.com/article/20130204/profession/130209993/2/>

RM: 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>

### *Scenario 5: Compliance*

1. Compliance

Ms. Slivochka: In the course of advising to monitor copy/paste, reporting is very important and having a scoring tool and follow-up.

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

RM: Disable certain areas of the Health IT system and not the entire system. *NISTIR 8166: The hospitals should necessarily, be given the ability to turn­off the ‘copy/paste’ function in certain areas of the EHR.*

<http://nvlpubs.nist.gov/nistpubs/ir/2017/NIST.IR.8166.pdf> Page 28

* 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**

Ms. Slivochka: should consideration be given to a tool to rate different areas of note types?  For example, assessment and plan should never be copied.

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

RM: These features have to presented on demand to avoid complicating already dense interface. <http://nvlpubs.nist.gov/nistpubs/ir/2017/NIST.IR.8166.pdf> Page 29

* 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. [[30]](#footnote-30)- 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?**

Ms. Slivochka: under what should have happened, should we mention the system should be able to determine who was the author of the original note?

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[[31]](#footnote-31). 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

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18. Ibid, p.31 [↑](#footnote-ref-18)
19. Ibid. p. 31 [↑](#footnote-ref-19)
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22. Ibid, p.31 [↑](#footnote-ref-22)
23. \*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-23)
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