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Name of Your Organization

ELECTRONIC HEALTH RECORD (EHR)

COPY AND PASTE FUNCTIONALITY

POLICY AND PROCEDURE

1. Definitions: “Copy and Paste”. The process of copying existing text in the electronic health record, and posting it to a new destination. Synonyms include: “cut and paste”; “copy forward”; “carry forward”; “re-use”; or “cloning”. “Copy and Paste” does not include the use of tables, such as “templates” or “macros”.
2. Background: Some healthcare organizations have elected not to use (or shut off) “copy and paste” functionality. Our EHR and clinical teams have weighed the risks versus benefits of this functionality. Conclusion: The vast majority of our clinical EHR users will benefit from this efficient tool, and will use it responsibly to document their critical thinking and tell the patient’s story.
3. Appropriate Use:

* Exercising accountability to analyze and update copied forward content to assure that it is consistent with the patient’s current status;
* Authenticating, signing dating, and timing the updated clinical content; or,
* If the copied forward material is brought forward verbatim as a file note, the clinician will document the original source, author, date, and time of the content. For example: “As stated in Dr. \_\_\_\_\_’s note of date/time”. Or utilize a “hyperlink” back to the cited documentation.

1. Inappropriate Use:

* Over-utilization resulting in profound redundancy or “note-bloat”. This can lead to continuity of care concerns, including the inability of other providers to efficiently access critically needed clinical information;
* Creating coding and billing confusion, including uncertainty of who provided the care, when, and the patient’s current clinical status; and/or,
* Violation of federal, state, and/or other legal requirements including denial of reimbursement, fraud and abuse, etc. Only reasonable and necessary services provided at the time of the patient encounter will be considered by payers in determining the level of service.

1. Education and Training:

Objectives: To provide guidance to clinicians and provide tools to aid clinicians in utilizing copy and paste effectively and appropriately:

* How to analyze copied clinical content for accuracy, and edit & update it to reflect the patient’s current status;
* How to attribute the copied content to the original author, source, date, and time;
* How to analyze “lessons learned” from copy forward teaching examples that may result in significant patient care or reimbursement concerns;
* How to address potential medico-legal concerns, and enhance the credibility of the Legal Medical Record (LMR).

1. EHR Chart Review and Audits. Health Information Management, EHR IT, and Peer Review chart reviews and trending reports will be utilized to monitor the appropriate use and effectiveness of EHR copy functionality. Objectives:

* Are patient care data elements inappropriately repetitive?
* Is the copied forward material attributed to the original source, date & time? Can that be confirmed by audit trail?
* Are there patterns or flags of chronic inappropriate utilization of copy functionality by clinicians? Or,
* Are there HIPAA or confidentiality concerns?

1. Review and Possible Sanctions: Potential patient safety concerns or chronic misuse of copy functionalities will be reviewed by:

* The Peer Review or Credentialing Committee pursuant to their authority in the Medical Staff Bylaws and Rules and Regulations;
* Human Resource performance review of employed providers; and/or,
* The Compliance Officer.

Privilege restrictions, employment actions. or other sanctions may be imposed if inappropriate conduct is substantiated. Privilege restrictions or suspensions may be reportable to the National Practitioner Data Bank (NPDB), or state medical licensing bodies, as required by law.

Approved this \_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 2015

Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title/Position