

## **ATTACHMENT II**

**TITLE:** **USE OF CLONED DOCUMENTATION IN THE ELECTRONIC HEALTH RECORD**

**PURPOSE:** The purpose of the health record is to provide a basis for planning patient care and for the continuity of such care. Each record should provide documented evidence of the patient's medical evaluation, treatment, and change in condition as appropriate. The purpose of this policy is to provide guidance related to the appropriate use of previously entered data within the electronic health record (EHR). This is a new policy. [Key words: cloning, template, copy and paste, data linking, copy forward, macro].

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### **POLICY STATEMENT:**

The Health System will ensure appropriate use of the electronic health record (EHR) for the purpose of maintaining timely, accurate, and clear documentation of a patient's medical evaluation, treatment, and change in clinical condition. All providers documenting in the EHR must avoid indiscriminately copying and pasting progress notes and duplicate/redundant information provided in other parts of the EHR.

### **POLICY ELABORATION:**

#### **I. DEFINITIONS**

- A. Medical Record Cloning** – copying and pasting the patient information in an EHR from one date of service to another for the same patient. Documentation is also considered “cloned” when the medical documentation is exactly the same for different patients as may be documented through the use of templates.
- B. Copy and Paste** – selecting data from an original or previous source to reproduce in another location. Examples:

1. Progress Note
2. Narrative reports from diagnostic studies such as imaging studies.

**C. Data Linking** – using shortcuts to insert data from another part of the patient record into a progress note. Examples:

1. Past Medical History, Family History, Social History.
2. Medication List
3. Problem List
4. Lab Data
5. Flowsheet data (e.g. responses to PHQ-9 depression screening questionnaire).

**D. Copy Forward** – a function that copies a significant section or entire prior note. Examples:

1. History of Present Illness portion of a previous note.
2. Review Of Systems
3. Physical Examination

**E. Template** – documentation tools that feature predefined text and text options used to document the patient visit within a note.

**F. Populating via Default** – data are entered into a note via an electronic feature that does not require positive action or selection by author. For example, when documenting the Review of Systems in a patient history, an EHR may have functionality that enters the phrase “all other systems negative” without requiring the author to select a checkbox, or otherwise indicate that the work was performed.

**G. Macro** – expanded text that is triggered by abbreviated words or keystrokes. Not generally considered copy/paste, but rather abbreviating required keystrokes.

## **II. GENERAL INFORMATION/REQUIREMENTS**

- A.** There can be value to copying information, but it must be done selectively and thoughtfully with the goal of producing a clear, useful, and accurate patient note.
- B.** Regardless of the tools used to create the note, the individual signing it acknowledges responsibility for the entire content, whether it is original, copied, pasted, imported or reused.
- C.** The note must accurately represent clinical work performed on the day of service, with clear attribution of the work of others.
- D.** Copied information must be reconfirmed and revised, as necessary, by the provider authoring the note to accurately reflect the specific date of service.

## **III. ACCEPTABLE USE OF PREVIOUSLY ENTERED DATA**

- A.** Copying and pasting or copying forward of HPI, ROS, PFSH, Physical Examination, and Plan of Care from a previous visit note, by the same author must meet these conditions:
  - 1. The information is reviewed with the patient and fully updated to reflect current reality.
  - 2. The information is medically necessary to support billing and coding for the current visit.
- B.** Copying and pasting or copying forward of HPI, ROS, and PFSH from a previous visit note, by a different author must meet these conditions:
  - 1. The original author, source, and date of the information are documented.
  - 2. The information is reviewed with the patient and fully updated to reflect current reality.
  - 3. The information is medically necessary to support billing and coding for the current visit.

- C.** Data linking to insert data from another part of the patient record into a progress note must meet these conditions:
1. The information is reviewed and updated prior to being pulled into the current note.
  2. The date the information was updated and the person who performed the update are documented.
  3. The information is medically necessary to support billing and coding for the current visit.

**IV. UNACCEPTABLE USE OF PREVIOUSLY ENTERED DATA**

- A.** Copying an entire previous note without appropriate edits.
- B.** Copying information from one patient record to the record of another patient.
- C.** Copying medical student notes (other than the Review of Systems and Past Medical History, Family History, and Social History).
- D.** Copying an attestation by the attending.
- E.** Copying the plan of care from a provider with another service.

**V. Plan for Auditing/Monitoring Documentation:**

- A.** The Medical Records Department will audit 10% of inpatient and 4% of outpatient medical records annually effective June 1, 2014. All inpatient and outpatient medical records identified with inappropriate use of previously entered data will be referred for corrective action and monitored for facility-wide trending. These audits will include both Faculty and House staff notes.

## **VI. REPORTING MECHANISM FOR CONTINUED FINDINGS OF INAPPROPRIATE USE OF CLONED DOCUMENTATION**

Each provider identified with an improper copied document will receive individual feedback from the auditor and allowed an opportunity to make necessary clarifications within a designated time frame. If an error is discovered in the EHR that requires correction, it must be corrected via an appropriate amendment in accordance with Health System policy if the note has been signed. At the end of each month in which the audit was conducted, each respective Department Attending and Program Director, if appropriate will receive updates on unacceptable cloned documentation audit findings. Cumulative audit findings of unacceptable cloned documentation use will be reported monthly to the Medical Record Committee.

### **REFERENCES/BIBLIOGRAPHY:**

AHIMA. Copy Functionality Toolkit.

AHIMA. Integrity of the Healthcare Record: Best Practices for EHR Documentation. Journal of AHIMA 84, no 8.

Department of Health and Human Services Office of Inspector General., December 2013

UT Medicine Health Science Center San Antonio. Clinical Operations Handbook of Operating Procedures.

**OFFICE OF PRIMARY RESPONSIBILITY:** Medical Information Services