Appropriate Use of the Copy and Paste Functionality
in Electronic Health Records

Purpose: The purpose of this position statement is to address the use of "copy and paste" (there are other terms used such as cloning and carrying forward, identical documentation, or make me the author) functionality in electronic health record systems (EHRs). Use of the copy and paste (copy/paste) functionality in EHRs can result in redundant, erroneous, and/or incomprehensible health record documentation. Misuse of this functionality has the potential to result in or contribute to several overarching challenges, with implications for the quality and safety of patient care, medico-legal integrity of the health record, and fraud and abuse allegations.

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.

AHIMA stands ready to leverage its experience and expertise and to lead a multi-stakeholder effort to identify, develop, and promote best practices regarding the copy and paste functionality in EHRs in order to help ensure high quality clinical documentation and health information integrity.

Recommendations: To ensure appropriate use of the copy/paste feature in EHRs and reduce risks associated with improper design and use, AHIMA proposes that public and private sector organizations work together to implement these recommendations:

Industry Stakeholders

- Industry stakeholders should collaborate on the development and promulgation of "best practice" standards for monitoring compliance with governmental, regulatory, and industry standards and organizational policies/procedures related to clinical documentation.
- Industry stakeholders should share responsibility for ensuring that EHR systems support compliant clinical documentation and related billing and coding practices.

- Industry stakeholders must recognize and comply with sound principles and practices regarding clinical documentation.
- Industry stakeholders should collaborate on the development and promulgation of copy/paste "best practice" standards in order to minimize the risks associated with this functionality. These standards should include alternatives to copy/paste for increasing efficiency of documentation capture (such as linking to the original source rather than duplicating the information).
- The knowledge, skills, and expertise possessed by HIM professionals should be leveraged by policy makers, healthcare providers, and EHR system developers to provide practical solutions to information integrity, management, and governance challenges, including on EHR functionalities such as copy/paste.
- Further research on the potential and actual impact of copy/paste on quality of care, patient safety, fraud and abuse, and legal liability, as well as on effective strategies for preventing negative consequences from the use of this functionality, should be undertaken by both the private and public sectors.

EHR System Developers

- EHR system developers should be expected to employ EHR system design and usability standards and implementation specifications that promote accurate and compliant documentation.
- EHR systems should be designed such that healthcare provider organizations are able to configure the use of the copy/paste functionality, including recording copy/paste user actions, audit capabilities, and reporting.

Public Sector

- Agencies such as the Office of the National Coordinator for Health Information Technology (ONC) and the National Institute of Standards and Technology (NIST) should continue to address EHR usability issues, with an increased focus on documentation capture processes (such as copy/paste) that may present potential risks for quality of care, patient safety, and fraud.
- The ONC should include appropriate copy/paste functionality within EHR certification criteria.
- In order to maximize the opportunity for appropriate and successful use of EHR functionalities such as copy/paste, the Centers for Medicare and Medicaid Services (CMS) should confirm that the copy/paste functionality is allowed under the Medicare Conditions of Participations. CMS should augment their existing provider training and

educational materials to include examples of appropriate use of copy/paste functionalities.

Healthcare Provider Organizations

- Healthcare provider organizations should develop policies/procedures addressing the proper use of the copy/paste feature to assure compliance with governmental, regulatory, and industry standards.
- Healthcare provider organizations should address the use of features such as copy/paste in their information governance processes.
- Healthcare provider organizations should provide comprehensive training and education on proper use of copy/paste to all EHR system users.
- Healthcare provider organizations should monitor compliance and enforce policies/procedures regarding use of copy/paste and institute corrective action as necessary.

Background: Incentive programs have accelerated adoption of EHRs in recent years.[1] A desired outcome of EHR implementation is to increase the quantity and utility of data available to clinicians about each patient.[2] While increased availability of this information is useful for informed clinical decision-making, too much information can lead to difficulties in navigation and synthesis.[3]

Widespread implementation of EHRs has changed how clinical information is documented.[4] EHR systems have developed and employed various methods of supporting documentation for electronic records, including "copy and paste" (reproducing text or other data from a source to a destination).[5,6] While electronic documentation provides a number of benefits as compared to paper-based documentation, including improved legibility, real time accessibility, and decreased cost, it can be more cumbersome and time consuming for clinicians.[7,8]

The copy and paste function provides the ability to re-use all or parts of detailed narrative information and is seen by physicians and EHR system users as a valuable and time saving tool.[9] This duplication of notes can be conducted within a single patient's record or across multiple patients' records.[10] Copying and pasting of healthcare documentation from previous medical record entries is not a new phenomenon[11] and seems extremely common—indeed, prevalent—with at least one study finding that as many as 90 percent of physicians use this functionality in daily progress notes and that a majority of narrative notes contain copied text.[12,13,14]

Benefits of documentation assist features (i.e., EHR functionalities that assist with documentation, such as copy/paste) include improved efficiency of data capture, timeliness, legibility, consistency, and completeness.[15] Efficiency of documentation can be increased in a

time-constrained environment.[16] Judicious use of copy and paste enables the creation of a better clinical note to support communication among care providers.[17] Industry stakeholders such as third-party payers have an interest in assuring appropriate documentation for payment and may review claims along with medical record documentation to ensure proper payment. Other stakeholders may review and compare data and documentation for performance and outcomes measures.

However, a number of challenges and risks associated with the copy/paste function have been identified. These include:

- Inaccurate or outdated information
- Redundant information, which makes it difficult to identify the current information
- Inability to identify the author or intent of documentation
- Inability to identify when the documentation was first created
- Propagation of false information
- Internally inconsistent progress notes
- Unnecessarily lengthy progress notes[18]

Copied and pasted notes may lead to a number of unintended consequences. First, copy/paste might interfere with or compromise communication among the members of the care team.[19] Second, there are implications for the quality and safety of patient care such as medical errors resulting from inaccurate or outdated clinical information.[20] Third, the medico-legal integrity of the health record is potentially jeopardized because information overload can cause clinicians to miss important pieces of information and medical errors can occur as a result of inaccurate information.[21] Finally, the inappropriate use of copy/paste may actually facilitate or appear to facilitate attempts to inflate, duplicate, or create fraudulent healthcare claims.[22] Recent investigative news reports have suggested that EHR documentation practices have led to inflated Medicare claims.[23,24] The impact of EHRs on fraud and abuse has also caught the attention of the Department of Health and Human Services Office of Inspector General.[25,26,27,28]

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Notes

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