Copy and Paste by Any Other Name - Cloning, Carry-forward – is not a Rose!

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Introduction:
The copy and paste function in the electronic medical record (EMR) can turn into a thorn-in-the-side when ineffectively used by health care providers for documentation. Dimick identifies three words that start with "C" to mean the same thing - copy and paste – cloning – carrying forward.[1] Cloning can be defined in the following way; each note in a medical record is worded just like or similar to the previous entries for the same patient, or from one patient to another patient. This common practice can raise concerns about record credibility, plagiarism, and the risk of legal and monetary ramifications (i.e. malpractice, overbilling, and fraud). In addition, cloning can negatively impact on clinical decision making and make it difficult to find and prioritize current essential information about the patient. Based on both personal record and article reviews most providers do not intentionally use copy and paste to provide ineffective patient care or distort or falsify documentation; often though, the end result from use of this technique can be compromised patient care and the inability to meet an insurer's requirement for documentation of medical necessity. Some additional issues can include a(n):

- Increase in redundancy
- Increase in length of notes
- Increase in repetition of errors
- Increase in need to keep handwritten notes
- Decrease in record integrity
- Decrease in record effectiveness
- Loss of a meaningful orderly narrative
- Over-write of and by other providers

Background:
Hammond, et al at the American Medical Informatics Association (AMIA) Symposium Proceedings in 2003 indicated that cloning of patient documentation did not become a pervasive issue until the late 1990s with the introduction of the use of electronic medical records (EMR) and the copy and paste function from computer software.

In Thielke, Hammond, and Helbig's study of 1479 Veterans' Administration (VA) patients and 167,076 VA records using a specially designed software program to identify word sequences, they found greater than 90,000 instances of identical 40-word repetitions. They also found copying in three percent of all patient exams and 25% of all patient charts. They also created a risk categorization for this cloning that classified physical examinations, use of another authors notes, or duplication from more than six months previously to have the potential for the greatest risk. *Copying of physical exams were considered "highest risk" because this is a record of the writer's direct observations in a clinical encounter.*

Cloning Risk Classifications[3]

Code	Risk Description
1	Artifact, not misleading, no risk
2	Artifact, minimally misleading, minimal risk
3	Human, not misleading, no risk
4	Human, minimally misleading, minimal risk
5	Human, misleading, some risk
6	Human, clinically misleading, major risk

According to Hammond et al risks 5 and 6 are the most potentially dangerous for patient care. Risk 4 may have a significant impact on accurate coding and could result in either under coding or fraudulent over coding.[2]

There is also information from the study by Thielke et al that inpatient medical services demonstrated the greatest percentage of copying, in increasing frequency – from interns, followed by medical students, then residents, then attendings.[3] In addition, subspecialty medical services showed an exam copying rate between 5 and 10%; overall 1:4 electronic records had a physical exam copied and 1:7 electronic records had an exam copied from another author or from six months earlier or more.

In a self-administered survey by O'Donnell, Kaushal and Barron, attitudes by physicians indicated that 90% used copy and paste (cloning) and 70% used it most of the time. In evaluating these attitudes, 71% of respondents reported known inconsistencies and outdated information compared to notes not copied and pasted.[4] The majority of providers who both used and did not use CPF agreed that the documentation was more outdated, inconsistent, and it was more difficult to find essential information. They also reported disparity between identified benefits and liabilities of using cloning based on whether the employee was a health care provider or held billing or legal responsibility.

Robert Hirschtick, in an editorial in the *Piece of My Mind* section in the Journal of the American Medical Association, states that, *as physicians have become more adept with the time-saving features of EMR, their notes have been rendered incapable of conveying usable information by their bloated and obfuscated nature* (i.e. – increased length, decreased effectiveness).[5]

There is a concern that copy and paste does not meet "the medical necessity requirements" for coverage of Medicare services and that it could be considered a misrepresentation since each entry must be specific to the patient at the time of encounter. As of yet there is no formal policy regarding copy and paste from the Centers from Medicare and Medicaid Services (CMS).

from the Centers from Medicare and Medicaid Services (CMS). The 2011 Health and Human Services (HHS) Office of the Inspector General's 2011 Work Plan targets evaluation of EMR documentation for improper payments.[6] As of September 24, 2012, in a letter sent to chief executive officers of hospitals and academic medical centers from Kathleen Sebelius, Secretary for the U.S. Department of Health and Human Services, and Eric Holder, Attorney General for the U.S. Department of Justice, cloning was identified as a red flag for possible overbilling and fraud.[7] This means that patient documentation by providers will be subject to greater scrutiny with an increased risk of denial of services, and recoupment of payment. Other insurers are not far behind in responding to these concerns.

Discussion:

There are some very real benefits to the use of effective EMRs and their corresponding features. These can include improved legibility, better time conservation, ability for more real time entry, increased time for patient interaction, more comprehensive documentation with the capacity for improved billing, increased ability to capture data, increased ease of entry, increased ability to stay within mandated trainee work hours, and as a result of these improved clinical efficiency. Despite these benefits, most institutions that have the copy and paste function within their EMR have not implemented any governance to ensure that those functions are used appropriately. As stated previously, most providers do not purposefully use cloning for improper reasons (i.e. overbilling, compromised patient care); it is often the result of work flow and the nature and functionality of the electronic record. The critical issues raised are whether the documentation meets the requirements for medical necessity and more importantly meets the standards for quality patient care.

Some institutions such as Vanderbilt Medical Center in Nashville, Tennessee, and various Medicare Administrative Contractors (MACs) are developing methods to better govern the use of cloning.[6] This includes the development of policies and procedures for the use of copy and paste such as periodic random audits, policies of "if you sign it, you own it", and "do not document what you do not do", and an automatic pop-up when a physician uses copy and paste that attests to the accuracy of the documentation. As we move forward, some ideas to consider to help ensure that the standards for quality medical care and medical necessity are met include:

1. Require source attribution
2. Automate attending monitoring of trainee notes
3. Educate on appropriate versus inappropriate use of copy and paste – (i.e. appropriate use includes such things as demographics, medications, allergies, problems, correct author identification; inappropriate use includes such things as medical history and physical examination findings)
4. Conduct audits
5. Re-engineer functions in EMR for greater efficiency and better work flow
6. Create auto highlighting/italicizing of copied and pasted text
7. Collaborate with informatics designers to identify and create better methods to document
8. Use voice recognition documentation methods
9. Develop EHR tools that provide audit trails, alerts, protected access to entries by other providers
10. Promote use and accuracy of current problem lists
11. Minimize inserting data available in other places in the record
12. Realign incentives for appropriate documentation
13. Use structured notes with assigned responsibility for various components based on role on health care team
14. Develop institutional/departmental policies and procedures and a system of governance on appropriate use of electronic documentation and copy and paste function

For access to more information on copy and paste guidelines and CE certification please go to the following resource, The Legal Health Record: Copy and Paste Guidelines, Webinar, Nov 17, 2009, American Health Information Management Association.[8]

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What 's new in Nutrition?

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Nutrition is an integral part of the healing process. The role of nutrition in healing is often underappreciated and the service of dietician/ nutrition specialists underutilized. This brief review provides information about useful resources, intended to guide clinical evaluation and treatment of malnutrition. Even though the calorie and protein requirements, during illness are increased, appetite and dietary intake is often decreased. Malnutrition has been defined by American Society of Parenteral and Enteral Nutrition (ASPEN) and the Academy of Nutrition and Dietetics (AND)to aid early recognition and intervention in malnourished subjects.

Etiology based categorization of malnutrition is widely accepted. Such categorization aids evaluation of severity and allows appropriate intervention. It is now understood that timely interventions in hospitalized patients to improve nutritional status, or to prevent malnutrition, can improve outcomes and decrease healthcare costs.

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