Columbia St. Mary's
A Passion for Patient Care

Hospital EHR – Medical Staff Newsletter

July 2017 (2nd edition), Volume 4, Issue 6

For questions, comments, or suggestions regarding the EHR or this newsletter, please contact me directly.
Suzanne Wilkerson, MD_ Medial Director Hospital Clinical Informatics
Suzanne.wilkerson@ascension.org, 414-326-2519 (office), 414-557-6860 (Pager)

Topics this edition

'Copy and Paste' in EHR – use caution
Nuance eScription Update
PowerNote Correct Functionality Enhancement, 7.31.17
"History and Physical Update" - New PowerNote Template, 7.24.17
Restraint Orders Reminder
In-House Support Reminder

'Copy and Paste' in EHR – use with caution

We continue to identify Provider documents created with PowerNote that contain misinformation as well as excessive and irrelevant information. Most of this is due to use of 'Copy and Paste' functions.

According to a January 2017 report from National Institute of Standards and Technology "'Copy and paste' functionality is intended to allow medical practitioners to easily and efficiently reuse information in patient EHRs without having to retype the information. However, in practice, **current implementation of this functionality has introduced overwhelming and unintended safety-related issues into the clinical environment.**"

Copy and Paste functions include, but are not limited to, the following:

- Population of note with information from Problem List, Procedure List, Social History, etc.
- Use of pre-completed notes, auto-text, and macros
- Copy-forward of previously created notes

Per Columbia-St. Mary's policy, Copy and Paste Functionality for Documentation in the EHR, "All Clinician Authors documenting in an EHR (as with other records) are responsible for the accuracy and integrity of their documentation whether the content is original, copied, pasted, imported from another source, reused, or created by voice recognition."

The following actions can help improve the integrity of our electronic notes:

- Closely review your notes before signature. Do not sign until you have confirmed that your documentation supports the patient's current clinical situation.
- Do not clutter your note with excessive information.
- As soon as you identify errors in your note, correct the errors (see **PowerNote Correct Functionality** below).
- If you notice errors in the documentation of others
    - Notify the note author and identify the error that needs correction.
      Or
    - Notify HIM (Medical Records Department) or EHR Support (see **In-House Support** below) for assistance with notification of the note author.
- If you identify a specific Provider with recurrent documentation issues, please notify Dr. Mitch Carneol or me, or refer directly to the Quality Document Committee (QDC).

The aim of the QDC is to help optimize clinical documentation by Providers throughout the system via a pro-active, collaborative, and non-punitive process. QDC meets monthly and reviews submitted documentation.

We are asking that Providers to submit either their own notes or those of colleagues that may benefit from improvement efforts. Submissions made via the secure e-mail inbox QDC@columbia-stmarys.org should include the following:

- Reason for referral
- Provider Name
- Date(s) of Service
- FIN or MR # or Name and DOB of the patient

Referrals are confidential and the process is protected by standard peer review procedures in terms of confidentiality, legal protection, and discoverability. We want to reiterate that this endeavor is non-punitive, exists in the spirit of collaboration and is meant to improve the care we deliver to our patients through improved communication.

If you have an interest in joining the committee or have general ideas for Provider documentation improvement, please contact Mitch Carneol, MD at Mitchell.Carneol@ascension.org.

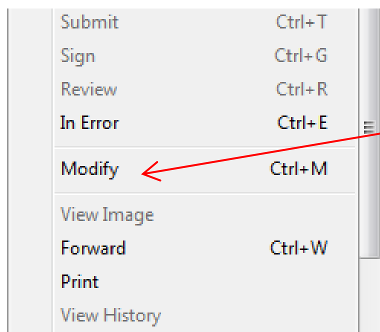
Nuance eScription Update

Through prior communications from the Medical Staff office, you are aware that Nuance, which hosts our transcription functionality, was affected by global malware on 6.27.17. This required taking many of their systems offline. Though we maintained our ability to dictate, our ability to transcribe documents in a timely manner was significantly impacted.

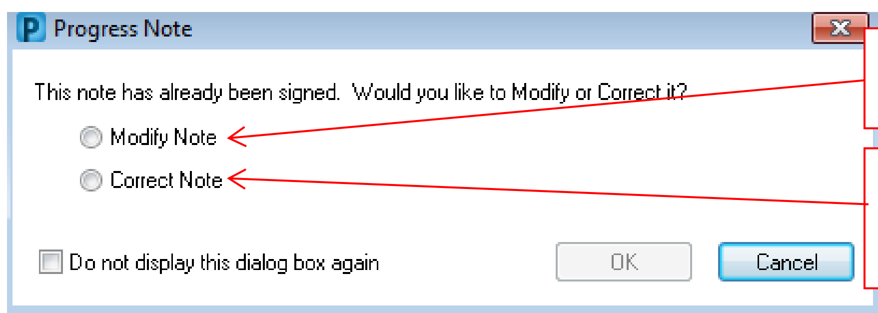
I am happy to report, that as of Friday July 14th, we caught up on all transcription. Previously recommended restrictions for dictation are no longer necessary.

PowerNote Correct Functionality Enhancement, 7.31.17

Currently *Final Report* PowerNotes can only be modified with an addendum.
Starting 7.31.17, you will have the option to **Correct** signed PowerNotes with changes to the body of the note.



Right click over Final Note and select "Modify."



"Modify Note" allows creation of an addendum.

"Correct Note" allows changes to be made within the body of the note.

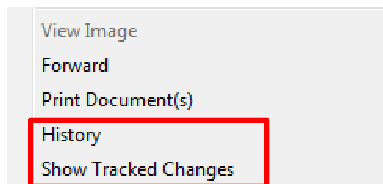
Any user can correct any note for 30 days; after 30 days, the correct functionality is no longer an option and the modify with addenda option should be used.
Documents that have been Corrected will be identified as follows:

*** Final Report ***
Document Has Been Updated

Documents that have been Modified will continue to be identified as follows:

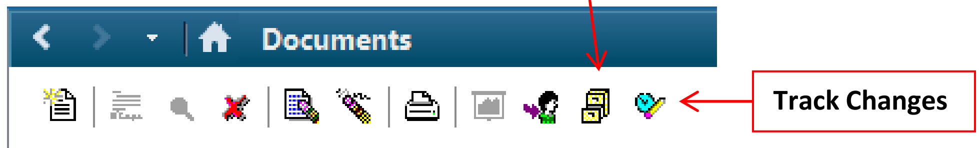
*** Final Report ***
Document Contains Addenda

Right click over document to show document History or to Track Changes.
History allows visualization of each version of the document.
Show Tracked Changes colors portions of the note that were corrected and tags with user's name and date and time stamp of correction



History

Icons in Documents are also available.

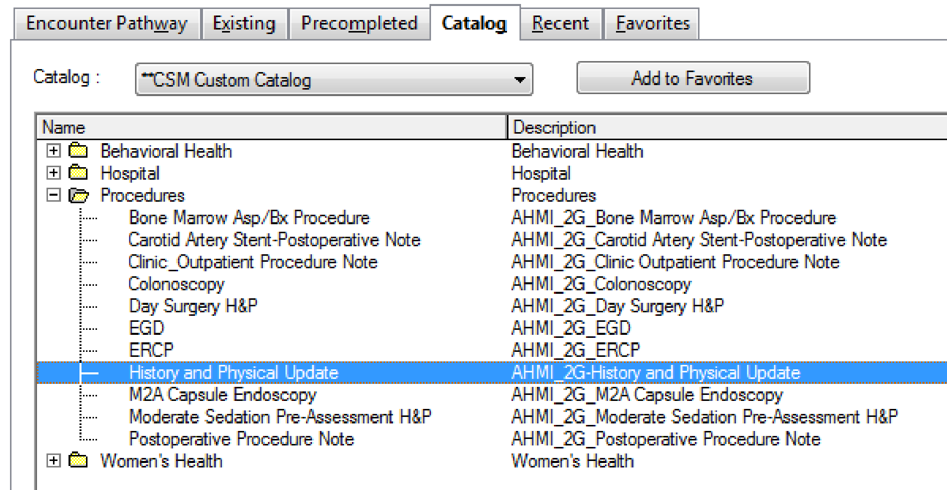


"History and Physical Update" - New PowerNote Template, 7.24.17

Currently a paper form is used to update physicals that were completed within 30 days of a procedure.

A new PowerNote template will be an available option starting 7.24.17. The "History and Physical Update" PowerNote template can be used in place of the paper update form.

The template can be found in the Procedures folder of the CSM Custom Catalog.



After reviewing the original H+P in the EHR, enter the date of that H+P and select appropriate supportive sentence regarding your review. If you have changes you need to document, free text box is available with that selection.

Assessment
I have examined the patient and reviewed the history and physical dated=== / OTHER
There appear to be no significant changes in the patient's current medical status. / OTHER
The following changes have been noted in the patient's condition: === / OTHER

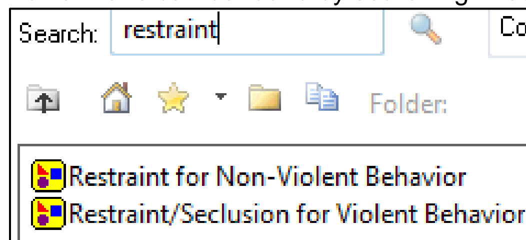
The final note should be saved with a History and Physical note Type so it can easily be identifed by nursing and HIM (Medical Records) staff.

*Type : History and Physical
*Date : 07/21/2017 1303 CDT
Title: History and Physical Update

Restraint Orders Reminder

Powerplans are required for all patients requiring Physical Hold, Restraint, and/or Seclusion . The PowerPlans contain elements required for orders as well as nurse monitoring and documentation.

PowerPlans can be found by searching "Restraint."



The **Non-Violent Behavior PowerPlan** contains restraint order and justification related to disruption of medical treatment.

The **Restraint/Seclusion for Violent Behavior PowerPlan** contains orders for for 5-point Restraint, Physical Hold, and Seclusion and justification related to risk of harm to self or others.

In-House Support

In-house support is available Monday through Friday from 8am to 4pm on both Ozaukee and Milwaukee campuses from Caitlin and Kevin of the Clinical Informatics Team. They have offices on each campus and can provide both in person as well as over the phone assistance. Please do not hesitate to contact them directly during these hours.

Connect to them directly by dialing Vocera and requesting "**EHR support.**"
Ozaukee Vocera Phone: 262-243-6707
Milwaukee Vocera Phone: 414-585-1995

For urgent/emergent EHR technical assistance outside of the above hours, contact the Help Desk at 414-326-2400. When asked for an extension, choose "7" for expedited transfer to a service desk analyst.

Effective:	*06/2015*
Approved:	*06/2015*
Last Revised:	*06/2015*
Expiration:	*06/2018*
Owner:	*Barbara Pilliod: Director Clinical Informatics*
Department:	*Document Imaging*
References:	
Applicability:	*Columbia St. Mary's Hospital Milwaukee* *Columbia St. Mary's Hospital Ozaukee* *Sacred Heart Rehabilitation Institute*

Copy and Paste Functionality - CPF for Documentation in the EHR

COPY

POLICY STATEMENT:

Copy and Paste Functionality (CPF) for Documentation within the Electronic Health Record (EHR)

PURPOSE:

For the purpose of this policy and unless otherwise specified, "Copy-Paste Functionality" (CPF) will be used collectively to cover the following terms: Auto-populate, Auto-text, Copy-Paste, Copy-Forward, Macros, Imported Documentation, Pre-completed Notes, and Templates.

This policy provides guidance on the use of the "copy-paste" functionality (CPF) in a manner that allows practitioners to benefit from the efficiency potential of the CPF without jeopardizing the integrity and accuracy of the content of clinical documentation.

BACKGROUND

1. The appropriate use of CPF within the EHR ensures integrity of documentation for:
   A. Patient care and safety
   B. Billing Services
   C. Research
   D. Business and legal record documentation
2. If not used appropriately, Copy-Paste Functionality may pose risks to the patient, the provider/clinical staff, and the organization which include, but are not limited to:
   A. Inaccurate or outdated information that may adversely impact patient care
   B. Inability to identify Authors or original intent of documentation
   C. Inability to identify when the original information was created and documented
   D. Inability to accurately support or defend ICD-CM and Current Procedural Terminology (CPT)

Evaluation and Management (E/M) codes for professional or technical billing

E. Propagation of false information in the patient's health record which may be further disclosed to other providers, health plans, agencies, etc.

F. Internally inconsistent progress notes

G. Unnecessarily lengthy progress notes

H. Medicolegal and risk management concerns

I. Potential fraud and abuse compliance issues.

SCOPE:

This policy applies to all individuals who have documentation privileges in the electronic health record (EHR); including but not limited to information entered on forms, progress notes, Iview (nursing documentation) etc.

DEFINITIONS:

Auto-Populate: Refers to the placement, automatically by the EHR software, of clinical information into the current clinical record before the practitioner takes control of the documentation process during the current clinical visit.

Auto-Text: Common text phrases stored in software memory available for input into documentation. Auto-text may be created by an individual Clinician Author or have universal availability.

COPY

Cloning: the production of medical records that are the same, or nearly the same, **or appear to be the same**, as previous documentation entries. This term is not synonymous with "copy-paste", and it should be used only in reference to medical record documentation that has been produced by CPF used so excessively and inappropriately that the credibility of the medical record is compromised. Cloning of documentation is considered to be a misrepresentation of the medical necessity requirement coverage services.

Clinician Author: In general, refers to a provider or clinical staff member who has the authority and responsibility for creating and/or authenticating patient health record entries. "Authors" (such as scribes) may assist in the documentation process, but it is noted that they do not have final responsibility for the documentation; this responsibility is assigned to the Author who finalizes or authenticates the health record entry.

Copy-forward: Duplicating contents of previous documentation to use as starting template for a new documentation.

Copy-paste: refers to the process by which selected text or object(s) contained in one digital document is imported into another document.

Electronic Health Record: Portion of the electronic medical record that has been converted to an electronic format.

Imported documentation is information inserted in the medical record by any system interface

Macros: software specific process for populating a note with predetermined information.

Precompleted Note: a template that has been prepopulated with information by the Clinician Author.

Source Document: refers to the document which is the source of the "imported documentation".

System Constraints: refers to software design capabilities within the EHR that allow those charged with

control and oversight responsibility over the EHR to adjust CPF access and applicability regarding individual practitioners and particular elements of the medical documentation. System constraints allow for the maintenance of medical record integrity in the absence of adequate professional constraints.

Template: software or Clinician Author structured and formated documentation. This includes Dragon voice recognition software.

POLICY/GUIDELINES:

1. All Clinician Authors documenting in an EHR (as with other records) are responsible for the accuracy and integrity of their documentation whether the content is original, copied, pasted, imported from another source, reused, or created by voice recognition.
2. Imported documentation serving as documentation of work/care not performed by the Clinician Author of the current note should be annotated to clarify its source. All imported documentation must be edited by the author to ensure that only accurate and medically necessary imported documentation remains in the documentation of the patient encounter.
3. Clinician Authors may never copy information from one patient's record into another. The exception to this is the maternal/infant delivery records where it is common practice to share data between the mother and infant's chart.
4. It shall be the responsibility of CSM Leadership to incorporate a mechanism for review to identify potential misuse of CPF including, but not limited to, cloning, and to implement corrective action processes
5. CSM Leadership can determine EHR CPF system constraints by individual or group in order to protect the integrity of the medical record.

COPY

References and Resources:

1. AHIMA. "Auditing Copy and Paste" Journal of AHIMA 80, No.1: 26-29.
2. AHIMA. "Copy Functionality Toolkit."
3. AH EHR Risk Management Work Group Policy Template: "Use of Copy and Paste Functionality for Documentation Within the Electronic Health Record," 2014
4. "With Auditors Wary of Electronic Shortcuts, Consider a Policy to Manage Copy-Paste," Report on Medicare Compliance, Volume 23, Number 16, March 5, 2014.

Related Policies:

Med Records: CSM Documentation Req. for Med Staff, Allied Health Professionals & Residents-

Attachments:

No Attachments

Approval Signatures

Step Description	Approver	Date
	Gloria Rawski: Policy/Clinical Database Coordinator	06/2015
	Daniel Barr: Senior Manager HIM	06/2015
	Barbara Pilliod: Director Clinical Informatics	04/2015