EpicTogether

TITLE: CHART ETIQUETTE AND OPTIMAL USE OF THE SHARED EHR

GUIDELINE:

Establishment of chart etiquette guidance and a common set of principles and accountability for shared EHR use and clinical note documentation, including a focus on appropriate versus inappropriate uses of copy/paste, copy forward, and documentation cloning.

PURPOSE:

The shared use of the electronic health record (EHR) and the creation of quality clinical documentation requires precision by the clinician to determine the timely and relevant information to be included.[1] The shared EHR is the core information system that facilitates the safe and collaborative care of all patients receiving professional services at the tripartite organizations of NYP, CUIMC, and WCM. In recognition that a fully-utilized, integrated EHR is an important component of a high-functioning health system, this guideline defines optimal use of the shared EHR. All members of these tripartite organizations and related staff who are eligible to use the shared EHR are expected to use the system optimally.

Specifically, the use of copy/paste, copy forward, and documentation cloning may lead to excessive clutter and inaccurate information, which can create extra work for the readers of notes and has potential for serious errors and adverse effect on patient safety, liability, billing compliance, and continuity of care.

The purpose of this guideline is to set forth chart etiquette and accountability, including documentation principles, in order to:

1. Support the fundamental purpose of documentation to enable care team members to provide high quality and safe care and improved outcomes.[1–3]
2. When patients request access to their records, which they have the right to do and are increasingly doing, provide patients with more easily comprehensible notes .[4]
3. Maintain adherence to professional standards and accountability.
4. Aid clinicians' effective utilization and benefits of the shared EHR.
5. Confirm that the health record accuratelyreflects the care or level of service provided on the date of documentation.
6. Maintain compliance with CMS Conditions of Participation, Joint Commission, HIPAA, New York State Department of Health, prohibitions against fraud, waste, abuse, and other applicable laws, regulations, and accreditation standards.
7. Support quality, data integrity, and accurate professional and facility billing.

APPLICABILITY:

All health professionals from the tripartite organizations of NYP, CUIMC, and WCM that use the shared EHR in both inpatient and ambulatory care settings.

GUIDELINE STANDARDS:

A. Guiding Principles for Optimal Use of the EHR

i. All users who receive EHR access must complete necessary system training (including applicable HIPAA or billing compliance), demonstrate competency, and possess an active user account from the EHR system.

ii. All clinicians and staff will document all relevant services and supervision encounters rendered at any NYP/CUIMC/WCM clinical site within the EHR including clinically significant telephone encounters and other non-visit encounters. Documentation provided by Provider delegates (i.e., scribes, transcriptionists) should be verified by the clinician provider. Documentation will be completed in accordance to all organizational Billing Compliance policies. Clinicians with read-only access will review charts when appropriate for patient care.

iii. Structured, patient-specific clinical information in the EHR will be actively recorded, updated, and reviewed to maintain accuracy and relevance. All clinicians will meet the EHR chart etiquette standards defined by the tripartite organizations of NYP/CUMC/WCM for accurate entry and maintenance of key shared clinical data, including:
   - Medication reconciliation and documentation and review of patient allergies[1]
   - Maintenance of problem list[2]
     Problem lists will reflect significant, active, ongoing medical problems
   - Maintenance of the medical and surgical history list utilizing accurate diagnostic coding.
   - Documentation of health maintenance items and vaccines in appropriate locations.

iv. All documentation will be accurate and succinct, without cloning. *Please see sections B through E of this document for further details on documentation cloning and appropriate use of copy/paste and copy forward in the EHR.*

v. All patient orders, whenever possible, will be placed in the shared EHR, including laboratory and pathology orders, radiology studies, referrals, and prescriptions. The exception is for use of paper orders during EHR system downtimes.

vi. All clinicians will use the shared EHR's secure messaging system (inbox) to review results, document appropriate clinical interactions such as significant telephone encounters, and send intra and inter-practice clinical communications. All inbox messages (from staff, colleagues and patients)

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[1] Full medication reconciliation (discontinue, add new & confirm) will be done at all transitions to facilitate patient safety;

[2] Problem lists will be updated with new active problems added, and inactive problems in the domain of the specialty removed.

will be read by the receiving user or user's coverage and acted upon within 2 business days.

vii. Clinicians will document plans for follow-up in the shared EHR when follow-up is needed, such as:
- Confirming that all clinically significant ordered tests have been performed and results have been received and reviewed.
- Documenting that test results have been reviewed and/or released to patients on the shared EHR's Patient Portal.

Clinicians will utilize overdue results tracking in the EHR and will have a workflow for confirming that all clinically significant ordered tests have been performed and results have been received and reviewed as above. Results should be communicated to the patient by their preferred method of communication, preferentially via the Patient Portal. When email is used there must be patient consent for communication and this communication will be copied to the EHR. Clinicians will track unread patient messages so that patients timely receive important clinical information. Messages that are unread will be followed by repeat messaging, phone call or letter, as appropriate to the clinical circumstances.

viii. All clinicians will participate in eligible quality initiatives as required by their institution or necessary for shared savings contracts. All members of the healthcare team will update and maintain the necessary documentation in the appropriate locations in the shared EHR in order to facilitate accurate reporting and capture of quality metrics.

ix. All EHR encounters will be closed as required by their organization's encounter closure policy or other applicable policies in place.

x. All relevant paper patient data from internal or external sources will be either summarized in the EHR or indexed and scanned into the patient's record within 1 week of receipt. Outside results that impact quality reporting and health maintenance tracking, such as colonoscopies and mammograms, will be scanned appropriately to satisfy these measures. When appropriate, the paper copy of the clinical information should be destroyed.

B. Definitions related to Copying of Clinical Documentation

a. *Copy and Paste*
- Generic computing functions used to duplicate selected content from a previously completed note and inserting it into a new note. The source note is left in its original state.

b. *Copy Forward*
- An EHR specific functionality that is programmed to allow specific content to routinely be brought forward and placed into a new note, without altering the content of any previously completed note. The EHR has a built in auditing tool for Copy Forward.

c. *Documentation Cloning*
    - Wholesale copying resulting in entries in a patient's health record worded exactly like or similar to previous entries or healthcare documentation that is essentially the same from patient-to-patient.
    - **Documentation Cloning should not be performed.** Auditor identification of cloning may lead to denial of services for lack of medical necessity and recoupment of payments may result.

References to "copying" in this guideline are inclusive of both Copy and Paste and Copy Forward functionality. When used appropriately, use of the EHR's Copy Forward functionality is preferred over Copy and Paste.

C. <u>Clinician Accountability as Data Stewards Responsible for Quality Notes</u>[5]

a. Clinicians must create quality notes that inform, and do not detract, from care and confirm readability for other care team members and patients.[1,4]
    - Be to the point and succinct.
    - Highlight important clinical information.
    - Diminish note "clutter" and irrelevant information.
    - Limit use of abbreviations by using the EHR's "smart" tools and functionality that support automated expansion of abbreviations.

b. Each clinician is responsible for everything in the clinician's note.
    - Errors in editing may jeopardize the credibility of the entire note.
    - Each clinician's responsibility includes the validity, relevance, and integrity of the signed and authenticated documentation, regardless of the origin of the content.
    - All linked data must be validated, including data linked through use of the EHR's "smart" tools and functionalities, which are not refreshed when using the Copy and Paste function, and therefore may contain old or wrong data.
    - Clinicians are required to author or co-author their own notes using only the shared EHR. The only exception is for paper notes during EHR system downtimes.

c. Each note must accurately reflect care delivered and the patient status *on* the date of service.
    - Clinicians shall base documentation on direct observation or appropriately attributed information.
    - Copying text without attribution to another clinician may constitute plagiarism and, from a billing perspective, fraud.
    - In general, copying of any information from another author should be used with extreme caution.
    - Proofread each note generated by the use of a template to confirm that it is a true representation of services performed.

- Improper use of auto-populating or templates may constitute misrepresentation of the medical necessity requirement for third party coverage of services since clinician documentation is expected to be unique to the patient and the patient's clinical problems.
- Clinicians should sign and finalize notes within 24 hours in the inpatient setting and within 2 business days of services being rendered in the ambulatory setting, as stated per clinical site's policy.

D. <u>Guiding Principles specific to creation of clinical documentation</u>

a. Documentation should facilitate meaningful insights into how a Clinician cared for his/her patients and what information the Clinician believed to be clinically important.[6]
   - Do not include data that is not directly pertinent and unique to the patient or decision making not based on clinical expertise.

b. More is not better - let the medical record speak for itself.
   - Notes should synthesize patient data and only reference pertinent information located elsewhere in the chart.

c. To achieve accurate complexity of care:
   - **Do** include statements that indicate the work and thought of the clinician
     - e.g., "I have reviewed all recent laboratory and radiology results, including a chest x-ray indicating a pneumonia."
   - **Do** include specific documentation elements required to meet regulatory, billing, and quality requirements - after the assessment and plan.
   - **<u>Don't</u>** automatically import primary source data from elsewhere in EHR without consideration of its relevance and suitability for summarization.

E. <u>Acceptable versus Unacceptable uses of Copy/Paste and Copy forward</u>

a. *<u>Acceptable use cases:</u>*
   - Copying of shared lists (e.g. problems, allergies, medications, social history items, health maintenance, immunizations) if reviewed and updated daily.
   - Copying of previous history critical to longitudinal care from your own note and from another's note with attribution if completely reviewed and updated daily.

b. *<u>Unacceptable use cases</u>*
   - Copying your own or another clinician's note, discharge summary, or redundant information provided elsewhere in the EHR in its entirety.
   - Copying without reviewing the content for relevance to the present encounter and modifying where appropriate.
   - Significantly, copying History of Present Illness (HPI) and physical examination.
   - Copying any information without attribution.
   - Wholesale copying of laboratory and radiology reports or other test results in their entirety that are readily available within the medical record.

    - Results or reports should be referenced, not imported, and include result date/time, relevance to the encounter, and actions taken.
    - Excerpting key portions of such reports for the sake of clarity is acceptable with attribution to the author and/or source.
- Under no circumstances should protected health information from one patient be copied to the record of another patient, with the exception of linked records between maternal and neonatal charts.
- Copying student documentation, with the exceptions of doing so for billing purposes with attribution and a label identifying it as a student note or for using a collaborative note template:
    - Copying of the following student documentation for billing purposes **is** permitted: Review of systems, Past family history, Past social history, Past medical/surgical history.
    - HPI must be documented in the presence of the teaching physician clinician or resident.
    - Resident/fellow/attending needs to verify and add either attestation to the entirety of or edits to the medical student's documentation.
    - The teaching Clinician must personally perform (or re-perform) the physical exam and medical decision making activities of the E/M service being billed, but may verify any student documentation of them in the medical record, rather than re-documenting this work.
    - All other uses of student documentation are prohibited.

RESPONSIBILITY:

This guideline sets forth the aspirational expectations for, and includes within its scope, Medical Staff Members, Specified Professional Personnel, Clinical Program Trainees (*i.e.*, students), Nurses, Allied Health Professionals, as well as scribes or medical assistants documenting on behalf of a privileged clinical provider (where permitted by policy).

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