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Hospitals Use NLP, Policies to Reduce Unedited Copy/Paste

By Nina Youngstrom

When the electronic medical record says the patient "will start antibiotics" or is "febrile" seven days in a row, it's a telltale sign the physician is using copy and paste without updating the entry. Although the indiscriminate use of copy and paste is driving compliance officers and physician advisors to distraction because it swells the chart and may erode its integrity, some of them have developed ways to identify and circumscribe its use. Without controls on copy and paste and other documentation shortcuts, charts may become increasingly estranged from the patient's clinical reality, putting quality of care and payment at risk,[1] experts say.

"It looks like a virus because of the amount of replication growing daily," said David Reed, M.D., medical director of case management and utilization at Stamford Hospital in Connecticut, at a Jan. 7 Finally Friday presentation sponsored by the Appeal Academy. "When you are buried in a morass of duplicative stuff—a four-day stay can have 200 pages—it's absurd," and important information may be overlooked.

A study[2] reported in the September edition of *JAMA Network Open* found that only 38.5% of the reviews of systems and 53.2% of the physical examination systems documented in the electronic health record for 180 patient encounters "were corroborated by direct audiovisual or reviewed audio observation."

Because the unedited use of copy/paste is threatening the integrity of documentation, hospitals are trying various strategies to cut down on the use of inappropriate copy/paste and to ensure physicians edit their notes. They include natural language processing to identify repetitive phrases and policies that limit its use. The goal is to improve the accuracy of the documentation and reduce its volume.