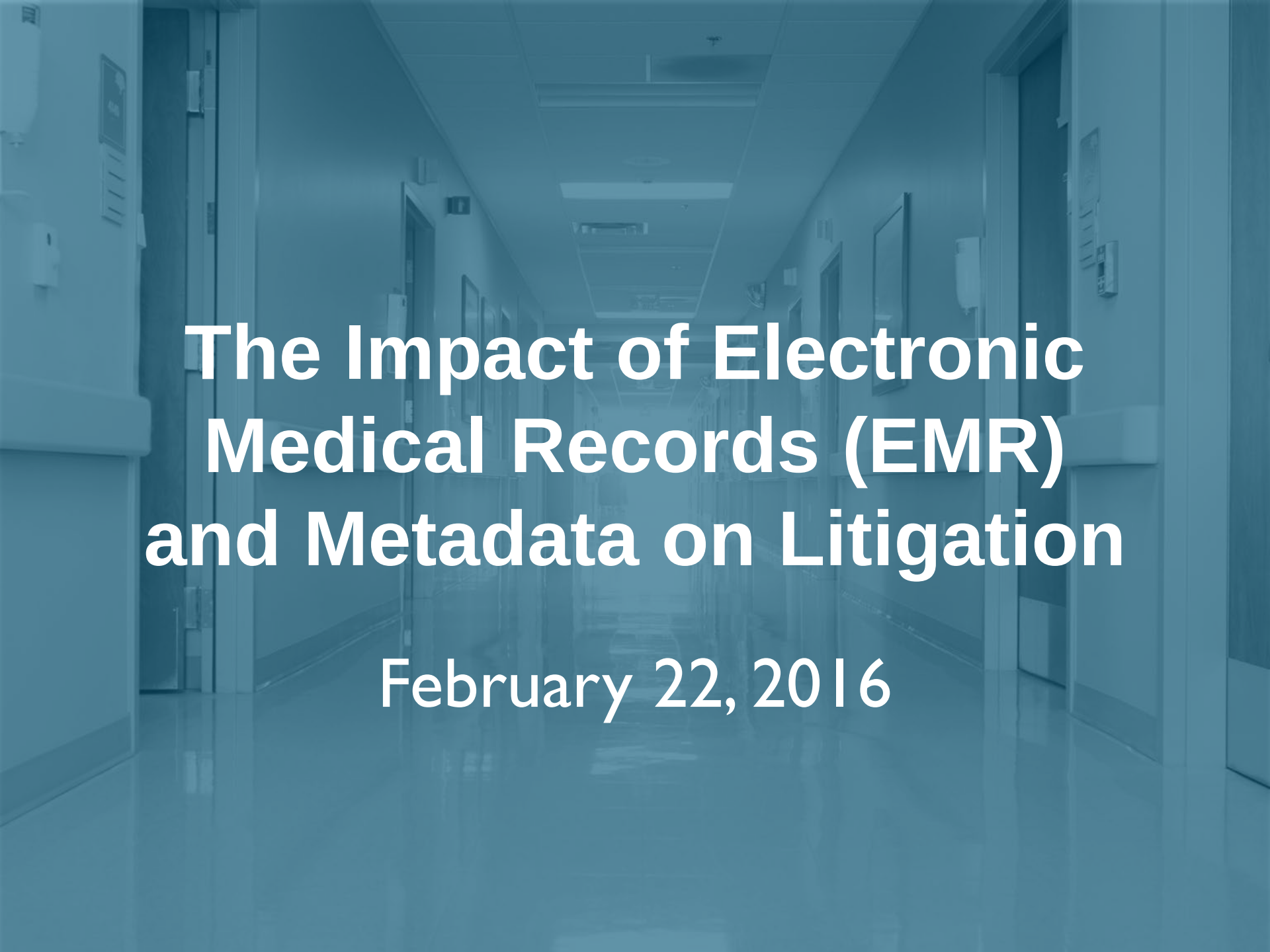

The Impact of Electronic Medical Records (EMR) and Metadata on Litigation

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Meet The Panel

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Session Agenda

I. Transition to EMRs and Record Collection
II. Challenges with EMRs and Record Production
III. Discovery of Metadata
IV. Questions & Answers

Why Digital Medical Records?

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The Medical Record Transition

EMRs and Electronic Health Record Systems (EHRs)

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Transition to EMRs Introduced Metadata

Metadata is data that describes and gives information about other data

Three common types:

1. Substantive
2. System-based
3. Embedded

Obtaining Complete Medical Records

1. Plaintiff Information
2. Provider Research
3. Record Request Document Preparation
4. Verification of Records Received

Record Request – Scope

"Any and all inpatient and outpatient medical records including, but not limited to, front and back (unless blank) of reports, E.R. records, consultations, physician progress notes, physician orders, nursing notes, medication manufacturer identification, notes , test results, diagnoses, prognoses, office records, clinic records, surgery records, Lab reports, diagnostic test results including Doppler examinations, tracings, graphs, tapes, and CD's, radiology reports, therapy records, pharmacy records, pharmacy patient profile information, pharmacy activity reports, vials and size information, package description and contents, lot numbers, medication cabinet reports, correspondence, 'sticky' notes, phone messages , insurance cards, intake forms, admission and discharge summaries, medical history forms, patient background forms, treatment and flow sheets, e-mails, memos , and any of the records mentioned above that are in storage or at another facility/provider."

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Challenges with EMR

1. Gag Clauses in Software Licenses May Prevent Disclosures of Known Bugs in the System

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Gag Clauses:

- Politico.com investigation revealed 10 of 11 contracts with health systems in New York City and Florida have gag clauses

Gag Clauses:

- Doctors, Researchers & Congress say gag clauses stifle disclosures of problems and can lead to lethal results

- EPIC SYSTEMS, CERNER, SIEMENS, ALLSCRIPTS, ECLINICALWORKS & MEDITECH

Challenges With EMR

2. Consistency in Obtaining Full and Complete Copies May be a Challenge

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Challenges With EMR

3. Medical Standards of Care Established

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EHRs and malpractice

Factors behind 97 medical malpractice cases involving electronic health records resolved from 2007 to 2014:

CAUSED BY EHRs

10%	Failure of system design
9%	Electronic systems/technology failure
7%	Lack of EHR alert/alarm/decision support
6%	System failure—electronic data routing
4%	Insufficient scope/area for documentation
3%	Fragmented EHR

CAUSED BY USERS

16%	Incorrect information in the EHR
15%	Hybrid health records/EHR conversion
13%	Prepopulating/copy and paste
7%	EHR training/education
7%	EHR user error (other than data entry)
3%	EHR alert issues/fatigue
1%	EHR/computerized provider order entry workarounds

Note: Percentages add up to more than 100 because of rounding

Source: The Doctors Co. a physician-owned medical malpractice insurer

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EMR Related Lawsuits

- Frequency of EMR-related lawsuits doubled between 2013 and 2014
- Faulty voice-recognition software
- Misinterpretation of EMR drop-down menus
- Reliance on outdated or incorrect information
- Typos leading to medical errors
- Design prompted errors
  - (automatically entered data if cursor hovers over a specific item for too long)

Discovery of Metadata

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Is Metadata Available?

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The Role of the HIPAA Privacy Rule and Security Rule

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The Impact of Hospital Policies and Procedures

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REQUEST: Produce the complete audit trail, maintained pursuant to the requirements of 45 CFR § 164.312, for Plaintiff's entire medical record, for all dates of service.

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Metadata Sought in Discovery

- Audit log
- Audit trail

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Audit Log:

Who Accessed the EMR and When?

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Audit Trail:

- User identity
- Time of access
- The terminal or computer used for access
- Actions taken by the user
- The substance of any changes to the EMR

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Be Proactive!

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Tips For Obtaining Complete Medical Records

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Preparing to Send a Request for Records

- ✓ Obtain all names used by the plaintiff (including a/k/a's) and dates of service/treatment
- ✓ Confirm the facility's retention period (e.g. seven years) and disposition policy (disposition to off-site storage vs destruction following retention period)
- ✓ Verify the following information with the custodian of records:
  - What is the legal name of the facility/provider?
  - What is the facility's physical address/mailing address (if different)?
  - What are the appropriate contact numbers for follow-up (fax/telephone)?
  - Is an advance payment required to search for records?
  - Are there any authorization/subpoena requirements (provider/dept. specific)?
  - Are any record types maintained by another department, partner facility or other location?
  - Is the physician retired or no longer in practice?
    - If yes, verify the location of the records
  - Is the facility/practice permanently closed?
    - If yes, check the state department of health and/or state statutes to identify preservation requirements

      Ex: http://www.healthinfolaw.org/topics/60

Drafting and Sending the Request for Records Documents

(e.g. Authorizations, Subpoenas, Record Request Letters, etc)

- ✓ Send a preservation letter or include records preservation language in the documented request for records
- ✓ Use broad scope language in the request for records ("any and all") and list on the requesting documentation specific record types and sources of records to be released
- ✓ Submit requests for the official medical record copy to the custodian of records, and submit requests for Metadata and Audit Log copies to the facility's legal counsel
- ✓ Request records by the facility name, not the physician's name

Verifying Completeness of Records Received

- ✓ Confirm accuracy of certification documents (first step, not the last!)
  - Does the certification document have a signature confirming true and correct response? (Y/N)
  - Do the pages reported include any and all records in possession, including:
    - All electronic files: (Y/N)
    - All paper files: (Y/N)
    - Both electronic and paper files: (Y/N)
    - All archived records: (Y/N)

Verifying Completeness of Records Received Cont'd

- ✓ Compare Certification of No Records and Certification of Authenticity documents to other sources of records where provider information could be referenced
  - If a Certification of No Records statement is received, verify that both electronic and paper files were searched for thoroughly and no records exist. The custodian should certify one of the following reasons:
    - o Records are destroyed after *(custodian must insert #)* years
    - o Records for patient are the same as the following facility/institution: *(custodian must insert facility/institution name)*
    - o Original records are in the possession of: *(custodian must insert facility/institution name)*
    - o Facility/Custodian has no records of any sort in response to the request, as patient cannot be located
    - o Other: *(custodian must provide reason)*
- ✓ Review dates of services on insurance and billing records and compare with dates of services on the medical records received
- ✓ Confirm receipt of lab/diagnostic reports where references to lab or other medical tests exist in medical records
- ✓ Compare sources and information from plaintiff produced records, plaintiff questionnaires and/or other plaintiff forms to original source records
- ✓ Confirm dates of records received against known facility retention policy

Q&A

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