Patients, Attorney's and the EHR: What is the role of Nursing Informatics?

Patricia J. Mook, MSN, RN, NEA-BC, CAHIMS
Chief Nursing Information Officer

Kimberly Ellis Krakowski, MSN, RN, CAHIMS
Associate Chief Nursing Information Officer

Maruf Haider, MD, FACMI
Director of Medical Informatics

Objectives

1. Examine Federal Rules and anticipate how attorney and patient's request will change based on increasing public knowledge about Electronic Health Record tools. Explore the benefits and pitfalls to giving open access of metadata.
2. Understand the role of Informatics in litigation.
3. Identify key terms needed to understand legal implications of the EHR.

Situation

Patient’s and their lawyers are becoming more and more savvy about Electronic Health Records. They are recognizing that a printed medical record may not be a comprehensive reflection of patient care. We will discuss our initial experience about a discovery process request from a patient's attorney while we explore Federal and State rules and the line of being helpful and protecting your institution's interests.

Informatics has an increasingly important role in legal cases as they partner with the attorneys to discover, explore Federal and State rules and toe the line of being helpful and protecting your institution's interests.

Since implementing the EHR, the HIM department has continued to respond to subpoenas for the legal medical record. However, there has been an increasing request for e-Discovery, also. The experts in navigating the medical record is the Information analyst. At Inova Health System, the Informatics Department has become the legal expert in the EHR and has participated in multiple e-Discovery events and complies with the Commonwealth of Virginia § 32.1-127.1 which mandates privacy rules:

“Health record” means any written, printed or electronically recorded material maintained by a health care entity in the course of providing health services to an individual concerning the individual and the services provided. “Health record” also includes the substance of any communication made by an individual to a health care entity in confidence during or in connection with the provision of health services or information otherwise acquired by the health care entity about an individual in confidence and in connection with the provision of health services to the individual.

The scope of the Federal Rules of Procedure (FRCP) is broad stating that the obligation to produce arrives when one party serves a request for production on another party or when a party serves a subpoena on a non-party. Requests are made in writing to the attorney representing the party. The FRCP allows parties to seek discovery of anything relevant to any party's claim or defense. These rules do establish limitations on what information must be produced which conflicts with the ruling of the Commonwealth.

• A party must produce documents as they are kept in the usual course of business or must organize and label them to correspond to the categories in the request.

• If a request does not specify a form for producing electronically stored information*, a party must produce it in a form or forms in which it is ordinarily maintained or in a reasonable usable form or forms.

• A party not produce the same electronically stored information more than one form.

*There is no federal law stating the owner of the EHR. Only one state, New Hampshire, has identified the patients as the owner. 20 states have declared the Provider as the owner and 29 states have no legislation.

Background

Prior to implementing an electronic health record there were only 3 departments involved in litigation between a plaintiff and the provider/health system. These were Risk Management, Health Information Management (HIM) and Legal. While these departments are still very much involved there is an additional department that is essential: Information Technology. Informatics. The HIM team responds to a subpoena or e-discovery request however they do not have the user of the experience to understand the medical record.

“Paper-based and electronic record keeping systems each record valuable information about a patient’s medical care. Electronic systems, however, capture something more - they record information about the record itself. The digital fingerprint never fails” stated Kim Baldwin-Stried Reich.1 And she was accurate. Today we are dealing with not just what you can see, but about what is behind what you see.

We are no longer just custodians of the record now that it is electronic, but we are also stewards of the information within.

Stewardship encompasses not all the security of the information but also the metadata. The reason is because metadata can reveal the integrity and reliability of the record. If just one item is missing or miss-stamped it can send you down a path of concern and no return. In fact, metadata can serve as an expert witness because it can show who documented or viewed a document, what time and if it was changed from its native format. 2

When a subpoena is filed requesting a copy of the EHR, the printed copy is provided. Because it does not look and feel the same way as an authentic paper chart, it can be confusing. If an attorney believes that it is difficult to navigate, a request can be made to view the information electronically. This is where the informatics team has come to be involved in the litigation. We sit with our attorney and risk manager to review all the information entered and the metadata behind this documentation. We also sit with our attorney, the plaintiff’s attorney and the attorney of all named in the litigation at the same time.

Assessment

1. Designate an e-discovery liaison within your organization.3
2. Be familiar with federal and state laws to ensure compliance with metadata.
3. Teach your Risk Management department what is stored in the record so they understand what could be discovered.
4. When reviewing the record with the plaintiff’s attorney ONLY SHOW THE INFORMATION REQUESTED.
5. Keep a list of all systems that contribute to the EHR because E-discovery request can request information from multiple systems, not just the primary EHR.
6. Create a thorough Information Management Plan and policy that includes:
   a) Who will receive and review all subpoenas.
   b) A data response plan and team.
   c) Definition of the record of care.
   d) Definition of how metadata and Clinical Decision Support is measured.
   e) Guidelines for the retention and destruction of electronic data.
   f) Data Governance structure to include custodianship and stewardship.
7. Keep informed of State and Federal laws around Healthcare, Privacy and Metadata such as:
   a) Federal Civil False Claims Act
   b) Food and Drug Act (21 CFR Part 11)
   c) Health Insurance Portability and Accountability Act (HIPAA) Security Rule
   d) Clinical Laboratory Improvement Act
   e) Federal Rules of Civil Procedure (FRCP)
   f) Meaningful Use

Recommendations

1. Examine Federal Rules and anticipate how attorney and patient's request will change based on increasing public knowledge about Electronic Health Record tools. Explore the benefits and pitfalls to giving open access of metadata.
2. Understand the role of Informatics in litigation.
3. Identify key terms needed to understand legal implications of the EHR.

Glossary of Terms

• 30 (d) (b) Deposition Notices for Custodians of EHR
• Court orders
• Custodianship of the medical record
• E-discovery
• Electronic Discovery Reference Model (EDRM)
• Electronically Stored Information (ESI)
• Federal Rules of Civil Procedure (FRCP)
• Information Governance
• Interrogatories
• Legal Health Record
• Metadata
• Preservation letters
• Preservation orders
• Proposed order appointing a Special Master
• Proposed order appointing third-party neutral expert
• Requests for Production
• Stewardship of the medical record
• Subpoena ad testificandum
• Subpoena duces tecum
• Third party subpoenas

References