Digital Disclosure and Discovery: the Sedona Conference Counts the Ways that Electronic Documentation is Different

by Carol Ann Quinsey, RHIA, CHPS

Capturing data digitally is one thing. Producing it later is another. Any organization required to produce electronic documentation for any reason—whether for discovery in a legal proceeding or disclosure in support of ongoing patient care—knows that producing documentation of digital information is very different from producing paper records.

There is far more of it, for one thing, and more can be done with it. Electronic data can be hard to track down, pin down, and present.

The Sedona Conference, a nonprofit legal institute, offers six categories that organize these differences.[1] The Sedona Principles are an excellent tool for education about producing electronic documentation and a helpful framework for addressing the issues.

Volume and Duplicability

Capturing data electronically increases the amount of information available. The relative ease with which healthcare providers can expand clinical notes has caused an explosion of electronically stored data. Back-up copies of data made at prescribed intervals and electronically stored information may be found on the hard drives of personal computers in organizations.

The integration of e-mail into an electronic health record (EHR) adds additional volumes of data. The fact that e-mail can be circulated among many readers with additions or changes made along the way is a factor in defining whether specific e-mail must be produced when responding to a request for information.

Information outside the EHR may also be required. Many organizations now electronically document training and in-service records for staff and providers. If litigation involves questions about whether staff were appropriately trained or credentialed to perform certain procedures or to take specific actions, an organization may be required to produce digital information to support its position that staff members were adequately trained.

Persistence

Organization retention schedules should define how long information is retained and in what state (e.g., paper, microfilm, electronically stored information, etc.). However, it is crucial to remember that multiple copies of electronically stored information may exist.The fact that the â€œlegalâ€ copy of the EHR has been destroyed according to policy does not mean every copy of electronically stored information has been destroyed. Policies and procedures should address this topic, and users should be instructed on the risks to the organization and to them if copies of electronically stored information are stored locally.

Dynamic, Changeable Content

Electronically stored data are more dynamic and changeable than ever could have been conceived in a world where paper documents constituted a patientâ€™s health record. Computer workflows may update files and move data from one location to another.

Electronically stored information may be circulated among healthcare providers who copy the data onto their own computers and manipulate it to view it in a different way to help them evaluate a patient. Content may be copied and pasted from one document to another. Multiple versions of a single document may exist in the same EHR system.

When required to release information about a patient for disclosure or a legal process, it is imperative that organizations have clear guidelines to guide staff members on exactly what data should be produced.

Metadata

Metadata are data about data. Computers are outstanding at capturing details such as the time and date information was created, the user who created it, and the computer at which it was created. Metadata are used by computers to assist in storing and retrieving data. Most users cannot access metadata and may not even be aware that it has been created.

Metadata can clearly show whether information claimed to have been available to clinical care providers was actually available at that date and time. Metadata can also be used to determine whether or not edits were made to information in a way that might reflect more favorably on caregivers or an organization.

Metadata may be associated with specific applications (such as spreadsheets or word-processing software), or it may be associated with the computer system in use. An example of the metadata used by applications would be calculations embedded in spreadsheets that are not typically seen when a document is printed, viewed, or copied. Examples of computer metadata include the file name, size, and date of creation.

Determining whether metadata are accurate or complete can be challenging. For example, if a template is created by one user and copied for use by another user in the same application, authorship of the resulting document may be attributed to the creator of the original template, not the person who later cloned the original template to create a new document.[2]

Environment-Dependence and Obsolescence

Paper documents are generally readable in any setting. However, divorcing electronically stored information from the system that creates and stores it may render the information unuseable. Nearly everyone has received documents or files created with software not installed on his or her computer. Without that application, the document remains unopened. Or if opened, important formatting may be lost.

This can be true even between different versions of the same software. While much software is designed to be â€œbackward compatible,â€ it may not be â€œforward compatible.â€ For instance, a document created in version 3 of a word-processing application can be read by a computer using version 4. However, it cannot be read by a computer using version 2.

Organizations must ensure that information created in earlier versions of software can be used in newer versions. If upgraded applications include new modules that have no counterpart in the previous version of the application, those charged with producing electronically stored information must know when such changes occurred and where the upgraded application stores the data if they were previously found in another location.

Careful planning can also avoid major mishaps in migrating to a new software platform driven by technology changes or evolving organizational needs. Data migrations in such circumstances are common. Decisions must be made early in the planning process for how data in existing systems (so-called legacy data) will be handled. Given that information retention statutes and ongoing patient care needs require access to information over lengthy periods, realistic plans must be made and repeatedly tested as the implementation proceeds.

Dispersion and Searchability

Unlike a paper chart that can be stored in one folder or microfilmed records that can be stored with all fiche in one location, electronically stored information may be stored in many different locations within a system. While this dispersion of data may make for better system utilization, it can make determining completeness something of a challenge for users.

To support disclosure and discovery processes that can be complex due to the dispersed nature of data storage, there are software tools available that can search substantial volumes of data rapidly using specific search criteria. There is no way paper records could be searched with as much accuracy in a similar time period.

Policies and procedures need to be implemented that ensure records produced are complete and accurate. They should address how the EHR system and the tools used to respond to requests for information enable those producing the information to know they have all of the information that is needed.

Surprises can be minimized or avoided if there is clear understanding of the fundamental differences between media in which patient information is stored, whether paper, film, fiche, or electronic.

Notes

1. The Sedona Conference Working Group. *The Sedona Principles: Best Practices, Recommendations & Principles for Addressing Electronic Document Discovery,* 2nd Edition (2007), pg. 2.

2. Ibid. pg. 4.

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