# Legal EHR FAQs

Save to myBoK

*by Jill Burrington-Brown, MS, RHIA, FAHIMA*

As healthcare organizations implement electronic health records (EHRs), more are re-examining the make-up of their legal health record. They frequently have questions about producing information from EHRs as well as how organizations should begin to define their legal health records.

## What's the difference between discovery and disclosure?

**Disclosure** is defined by the HIPAA privacy rule as the "release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information."[1] Disclosure describes the process of allowing information to be released outside a facility. It is nearly always performed in response to a valid authorization (or as required by law) and generally only regarding the information the organization has defined as the legal health record. Most disclosures are routine and are from an individual's legal health record.

**Discovery** is pretrial access to witnesses or documents, allowing parties to a suit to learn (or discover) facts and possible evidence in a case.[2] Discovery can include oral depositions, examination of documents such as policies and procedures, interrogatories, and a whole host of information that relates to the operation of the facility, appointment of medical staff, and hiring of employees. As the EHR comes of age, discovery might also include voice mail, e-mail, and metadata contained in files. Information produced on paper is easier to quantify; electronic data are much more voluminous and harder to define.

The new Federal Rules of Civil Procedure require that parties in lawsuits brought in federal court have a pretrial conference to agree upon discovery issues before litigation begins. HIM and IT professionals must discuss information and record availability with the organization's attorney prior to a pretrial conference.[3] While these rules apply only to federal cases, some expect that they will become the standard for state and local jurisdictions.

Most HIM professionals keep a sharp eye on the release of information function in their facility, as protecting patient privacy is one of HIM's core values. It is important for all HIM professionals to understand how discovery and disclosure differ and how changes in the new law affect discovery.

### What is a litigation hold? How does it affect the EHR?

A litigation hold is the action of "locking down" a record so that it is not destroyed or altered. When notified of a pending legal action, HIM professionals typically have taken paper medical records and put them in a secure place to prevent them from being lost, tampered with, or destroyed. In the electronic world, this process is more complex.

A litigation hold

> prohibits the documents from being purged or otherwise destroyed, even in accordance with a pre-established destruction/purging process. Custodians of health records must be made aware of any such holds to suspend a purge/destruction process. In addition, the custodian of records must communicate such a hold to the IT director or system administrator for any system that contains patient information that is designated as part of the [legal health record], so that no individual system inadvertently purges or otherwise destroys information under a litigation hold.[4]

To comply with a litigation hold request, organizations must establish how the hold will be accomplished in their EHR systems and how the record will appear in the system once the hold is enacted. HIM professionals may have to coordinate the hold process among the various owners of systems organization-wide. This is another instance when an established definition of the legal health record will assist in outlining such a procedure.

### An Inventory of Patient Data to Help Define the Legal Health Record

| Document/Data Element | Part of Legal Health Record (Y/N) | Source | Medium | Part of EHR as of: | Citations/References |
|---|---|---|---|---|---|
| Patient name | Y | ADT system | Electronic | 010106 | Medicare COP; state licensing laws |
| History and physical | Y | Transcription system | Electronic-interface | 030106 | Medicare COP; Joint Commission standards; state licensing laws |

Source: Servais, Cheryl. The Legal Health Record. Chicago, IL: AHIMA, 2007.

### How should an organization begin defining its legal health record?

Organizations should begin by:

- Researching the applicable laws, rules, and regulations. The September 2006 practice brief "The New Electronic Discovery Civil Rule" guides organizations on the Federal Rules of Civil Procedure requirements.
- Determining what records are kept in the ordinary course of business. This is critical in meeting the hearsay exception rule for using health records as evidence.
- Documenting the location of the organization's data. Inventory all systems that hold patient-related data, determining which system holds what data. A grid can help with the inventory process, as the sample above illustrates.

Organizations should look carefully at system functions such as alerts, pop-ups, and reminders. While the tools themselves are not considered part of the legal health record, any resulting action or treatment rendered to the patient is part of the documentation.

HIM professionals play an essential role in defining their organizations' legal health records. It is a process they should take charge of and lead within their organizations.

## Notes

1. HIPAA. Public Law 104-191. 45 CFR §164.501.

2. Roach, W.H., et al. *Medical Records and the Law,* 4th ed. Boston, MA: Jones and Bartlett, 2006, p. 375.

3. AHIMA e-HIM Work Group on e-Discovery. "The New Electronic Discovery Civil Rule." *Journal of AHIMA 77*, no. 8 (Sept. 2006): 68A–H.

4. Servais, Cheryl. *The Legal Health Record.* Chicago, IL: AHIMA, 2007.

***Jill Burrington-Brown*** *(jill.burrington-brown@ahima.org) is a professional practice manager at AHIMA.*

**Article citation**:
Burrington-Brown, Jill. "Legal EHR FAQs" *Journal of AHIMA* 78, no.9 (October 2007): 77,80.