Record Disclosure and the EHR: Defining and Managing the Subset of Data Disclosed upon Request

by Kelly McLendon, RHIA

Ensuring that electronic health records are sound business records is key to EHR development, implementation, and use. The mere specter of legal ramifications concerning EHRs should get everyone to take notice of this important issue.

Health information managers should use this opportunity to make their case for EHR system attributes that support the myriad tasks they perform every day as their organizations' leading record custodians. This article focuses on what EHR documents an organization should produce when it receives a subpoena.

It is important to remember that formal record management, though performed by the HIM department, is actually enterprise-wide in nature. Its work is reflected by all who use the medical record. An EHR system must enable the creation and maintenance of a sound business record through the appropriate tools for record management. The fundamental principles of managing medical records remain the same, whether paper based or in an electronic environment.

Data to Documents to Output

EHR data take several forms, and all of them must be managed equally and in conjunction to form the legal EHR. Formats include:

- Structured discrete data within a database (discrete data can be rendered into reports, which are a type of document)
- Unstructured data
- Messages formatted to published standards (e.g., Health Level Seven ADT admit message)
- Documents such as word-processing files and transcription with properties that allow manipulation (update, edit, delete, redact, and amend) and stable, permanent storage

Electronic documents managed within an EHR are many times output representations of structured and unstructured data that can be manipulated within an EHR application itself but cannot live outside the application code. Electronic documents within an EHR can be managed electronically with print output to paper, fax, e-mail, and interfaced messages.

Print and other forms of output are clearly here to stay. There has been some misunderstanding about the continued role of paper and other various forms of EHR output. In fact many parties assume that organizations will no longer print documents once an EHR system is in use. However, it is becoming clear that the system must provide well-developed output functionalities, especially for legal health record management.

Courts that request certified copies of medical records today overwhelmingly use documents. Therefore any EHR system must enable comprehensive and efficient document creation. Typically paper or document formats in Microsoft Word or scanned image format are submitted. Many courts are moving toward electronic filing, but they work with formalized documents, not simply a view of data from an EHR system database.

Defining the Record for Disclosure

The legal health record is created by a healthcare facility as its business record, and it will be disclosed upon appropriate legal request. The legal health record does not affect discoverability, given that appropriate legal processes deem that much of any EHR's data will be discoverable.

However, during routine legal requests for medical records (such as subpoenas), the actual set of data released may be defined by the healthcare organization. HIM professionals should catalog and define with policies and procedures exactly what

will be divulged upon initial legal request.

The best way for an organization to begin defining its legal EHR is to build upon existing paper record policies, procedures, and principles. HIM professionals should then list all documents and data that comprise the designated legal health record. Follow with a catalog of the details of EHR systems that feed it (both EHR system and source systems).

Finally, identify experts for each source system that may have to assist with record release if deep discovery is undertaken during litigation. It behooves HIM professionals to understand some details about the systems that contain their EHR data. They should not assume all systems are equal or even good at the required record-management attributes.

HIM professionals should create a matrix of all included (and excluded, perhaps) data, documents, and reports that comprise the organization's legal EHR that will be delivered upon subpoena. On a facility basis, the following data and documents must be examined for inclusion or exclusion in the legal record:

- Audio and video
- Picture-archiving communication system
- Telemedicine
- E-mail and secure messaging
- Alerts, reminders, and pop-ups (decision support)
- Continuity of Care Records
- Personal health records
- Sample legal EHR component matrix

Legal Processes

Similar to paper-based records, there are many sources for the legal foundations that EHR concepts, policies, and procedures must directly or indirectly address. The new Federal Rules of Civil Procedure (FRCP) concerning e-discovery and electronic records are the first formal changes we have seen at this level dealing with the evolving legal EHR subject.

An organization's record custodian defines the attributes of the legal EHR and manages its storage, access, release, and retention. The custodian presents the records into evidence when necessary, typically through the use of certified copies of documents. The custodian must attest that the records were kept in the normal course of daily business and that they are essentially accurate, trustworthy, and reliable.

Managing Disclosure

Upon any legal request (a subpoena is just one type), the healthcare organization first examines the request and determines from the context of the request and its own policies what is to be disclosed. Legal requests specifying any and all information are beginning to be limited due to burdens placed on providing the huge set of data and documents that would be covered.

Discovery during a lawsuit or criminal trial is a process where nonprivileged, relevant information can be requested and is discovered. The new FRCP speaks at length about e-discovery. It should be anticipated that initial legal EHR disclosures are defined by the healthcare organization but subsequent e-discovery steps may be undertaken that will require production of other data, documents, or reports.

Maintaining the Legal EHR

There are attributes of any EHR system and supporting processes that are used to validate data; document, and report accuracy, trustworthiness, and reliability; and perform ongoing maintenance of these factors. Performing ongoing maintenance ensures the following functionalities are being met:

- User authentication and nonrepudiation
- Authorship and authentication
- Timeliness of entries
- Legibility of entries and data

- Corrections, errors, addendums, amendments, annotations, and redactions
- Freeze data, snapshots at point in time
- Version management
- Searchable, archived audit logs
- Security architecture and processes
- Access controls
- Output formatting and rendition
- Permanent archiving and retention
- System and network security
- Disaster recovery and business continuity

The legal EHR is a subset of all EHR documents, data, and content. Your organization must formally define it with policies, procedures, and components.

Resources

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