Communication Technology and EMRs: Maximizing Patient Care, Minimizing Legal Liability, and an Overview of Emerging EMR Related Discovery Issues

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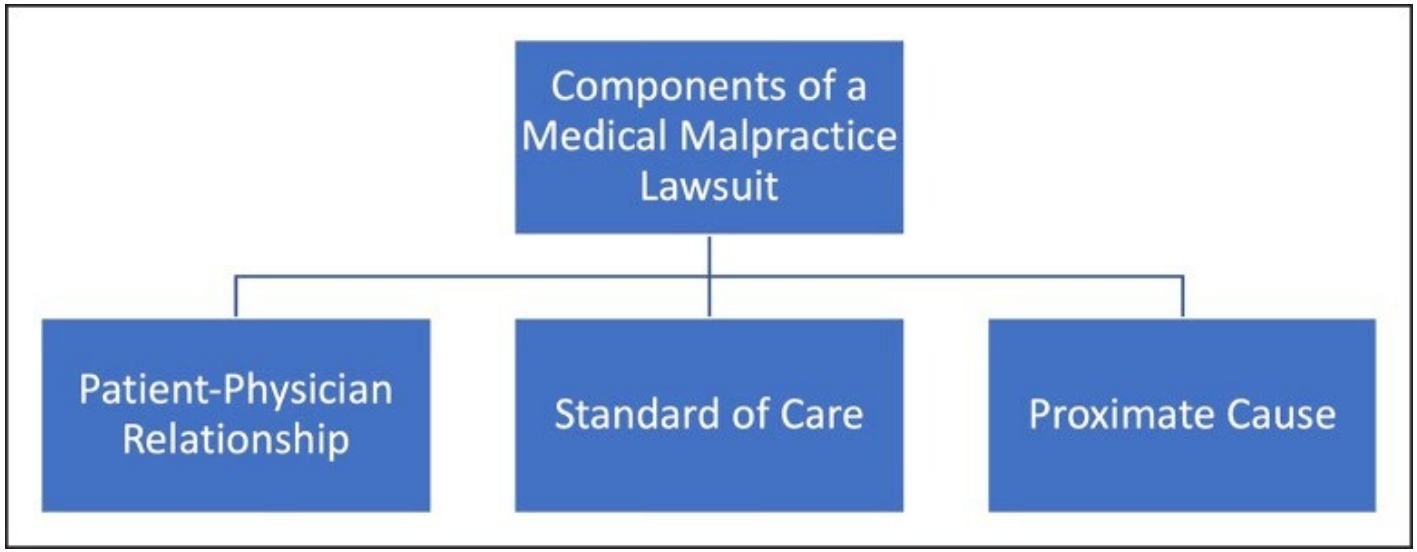




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Components of a Medical Malpractice Lawsuit
Patient-Physician Relationship
Standard of Care
Proximate Cause

→ Injury



File Suit, Answer, and then: Discovery



- ✓ **Bill of Particulars**
- ✓ **Initial Discovery Demands**
- ✓ **Medical Records**
- ✓ **Defense witness/client interviews**
- ✓ **Depositions**
- ✓ **Post Deposition and Ongoing Discovery Demands**

Patient Charts:
An Important and Mandated Part of Care that is Critical to Litigation Defense



•Providers are legally required to maintain a record for each patient which actually reflects the evaluation and treatment of the patient. Education Law §6530.

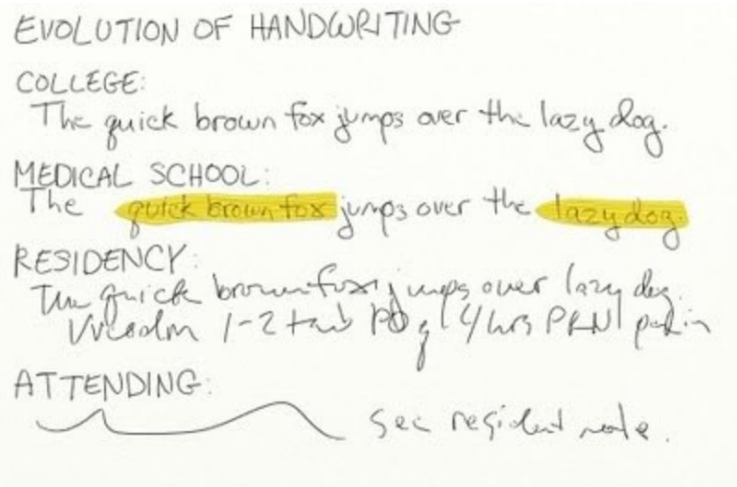
•The best defense against a lawsuit is a well documented chart.

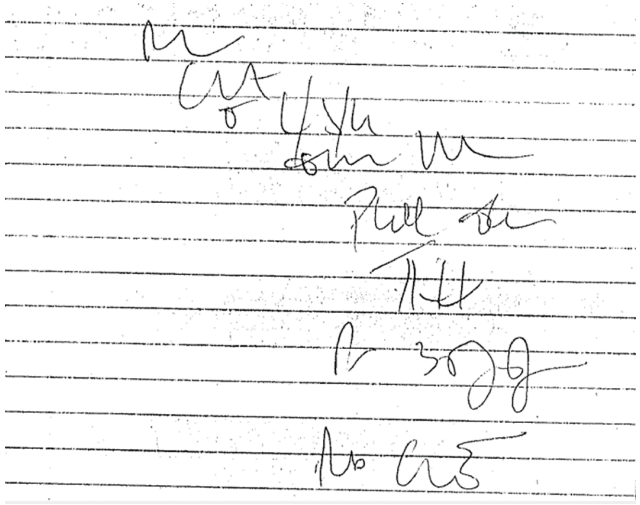
•If it's not in the chart, it didn't happen. Custom and Practice can only go so far.

Meaningful Use:
Enhancing Healthcare Through Electronic Health Records

The enactment of the Health Information Technology for Economic and Clinical Health (HITECH) Act, legally mandated the adoption and meaningful use of Electronic Health Records (EHRs) and necessitated compliance by January 1, 2014.

The law does not categorically outlaw the use of paper records. It promotes a "meaningful use" of an EHR system to promote efficient, safety enhancing and quality improving care.





Legal Health Record (Designated Medical Record Set) vs. Electronic Health/Medical Record

The American Health Information Management Association (AHIMA) defines the legal health record as "the record that contains information used in the healthcare decision-making process." What is discoverable is not just the Designated Medical Record Set.

Typical Certified LHR/DMRS often includes:

- Patient demographics
- Medical history
- Clinical encounter notes
- Test results (imaging, labs, pathology)
- Diagnoses
- Treatment plans
- Patient care instructions
- Possibly EKG and FHR strips

*Does not always include data from different systems

Items discoverable that are usually not included:

- Physician e-mails
- Phone Notes
- Secure chats/In basket/Flags
- Tiger Text or equivalent
- Media files
- Outside records
- Pharmacy and Insurance authorization paperwork
- Communications within patient portal
- Personal texts between providers and to patient/family
- Call Center documentation
- Intra-op video
- Audit trails

Audit Trails and EMR Live Inspections



The plaintiff's bar is more frequently appreciating the complexities of the information contained in the EMR and that it is different than the Legal Health Record aka the Designated Medical Record set. We are seeing an increase in frequency of discovery demands for:

- Screenshot of tabs, drop down lists, templated language
- Patient encounter lists
- Audit trails
- EMR live inspection with a HIM present who can navigate EPIC

EMR Audit Trails



- An audit trail is a record that identifies who has accessed an EMR, the date and time of access, the portion of the record that was accessed, and the action that was taken once the record was accessed (i.e. view, create, edit, delete).

- Requests for audit trails are becoming more commonplace as part of parties' routine initial discovery demands

- Despite this, there have been only a few Appellate decisions to date re: their discoverability

  (1) *Vargas v. Lee* (2d Dep't 2019)

  (2) *Harms v. TLC Health Network* (4th Dep't 2023)

  (3) *Strauss v. Valkenburg* (2d Dep't 2024)

- Lower Courts have been less discriminate than the Appellate Courts with respect to mandating the production of audit trails

- Standard: "material and necessary" to the prosecution or defense of a matter pursuant to CPLR 3101(a)

- Courts generally do not accept the argument that the production of an audit trail is unduly burdensome

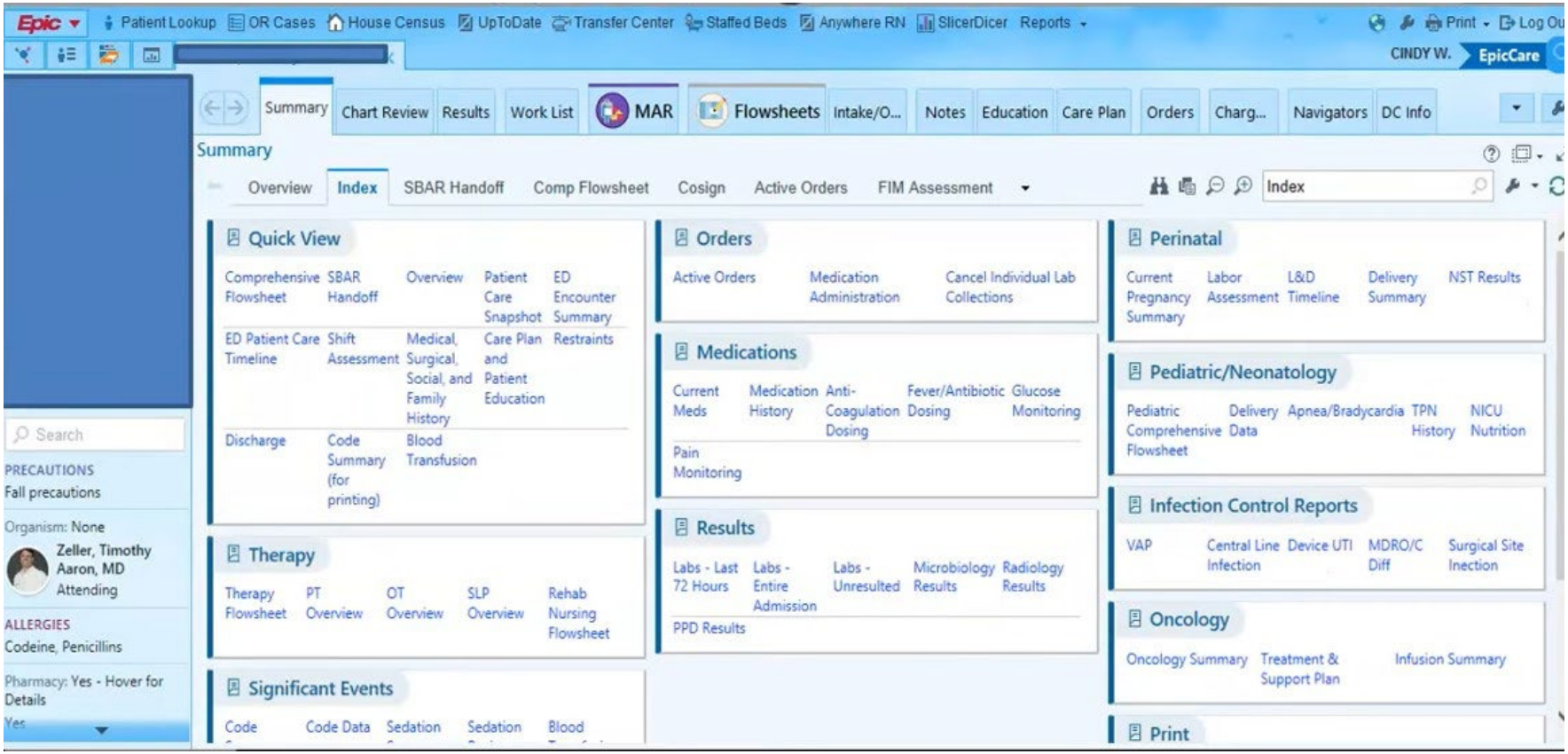


Timestamp	Access By Name	Event	Event Area	Type	Patient Name	MRN	Encounter	Login Dept	Associated Data
10/17/2019 02:40:58 PM EDT	*****	FYI activity exited	Patient Clinical Info	View	*****	*****	N/A	MEDICAL RECORDS	
10/17/2019 02:40:53 PM EDT	*****	FYI flag changed	Patient Clinical Info	Modify	*****	*****	Admission (Discharged) on 09/24/19	MEDICAL RECORDS	Patient Flag Legal Review
10/17/2019 02:40:23 PM EDT	*****	FYI activity accessed	Patient Clinical Info	View	*****	*****	N/A	MEDICAL RECORDS	
10/17/2019 02:40:21 PM EDT	*****	Chart Central report tab accessed	Patient Management	View	*****	*****	N/A	MEDICAL RECORDS	Report ID HIM Open Episodes-Chart Central
10/17/2019 02:40:21 PM EDT	*****	Patient selected from Patient Lookup	Patient Demographics	View	*****	*****	N/A	MEDICAL RECORDS	From duplicate warning No

Live Inspections



EMR in practice looks completely different than the Designated Medical Record Set.



Relevant Case Law Re: Inspection of the EMR beyond the Designated Medical Record Set

**Broad discretion is afforded to the trial courts to adjudicate discovery issues. To date, there have been no Appellate decisions addressing this issue in New York. There a four recent Supreme Court decisions.*

Baez v. N.Y.. Health & Hosps. Corp., Hon. Alicia Gerez Bronx County Supreme Court – "At this stage in the discovery process, where it is undisputed that the full medical records have not been exchanged, and with consideration given to the risks of an in-person review of data sought, an onsite review of the medical records via EPIC system is premature. Access to the EPIC system with the requisite supervision is unduly burdensome to defendants at this juncture and could result in a HIPAA breach." (9/28/22)

Jimenez v. Balasubramanian, Hon Alicia Gerez Bronx County Supreme Court – "The data on the EPIC system is material and necessary to this matter. It provides important information on the vital values dispensed prior to and during plaintiff's resuscitation…the data should be made available for inspection…plaintiff's are permitted to conduct a live video or in-person audit of decedent's EPIC electronic medical data from her September 21, 2019 procedure." (8/9/23)

Relevant Case Law Re: Inspection of the EMR beyond the Legal Health Record

Coachman v. Askin, Hon Peter O'Donoghue, Queens County Supreme Court – "Plaintiff's demand for inspection of the decedent's EMR by an Information Technology (IT) employee or other employee familiar with accessing information from the All Script and Epic systems, who shall be put under oath and be subject to questioning during the inspection, is granted, to the extent that plaintiff is directed to designate the IT expert to enter the premises and inspect the decedent's EMR from ACP stored on the All Script and Epic systems, including their menus from November 17, 2009 through February 17, 2017. Plaintiff may question the witness under oath in front of a terminal with printing capabilities." (3/1/22)

London v. Mount Sinai Hosp., Hon. John Kelley New York County Supreme Court – "Production of handoff documentation and the remainder of the EPIC electronic record file is material and necessary to the prosecution of the action." This decision also granted audit trail, audit logs, and meta data of the EPIC electronic records. (7/24/23)

Commonly Utilized Communication Methods within the EMR and beyond:

The vast majority of providers, like many of us, are communicating with each other and their patients much less frequently via telephone.

- Text messages with patients
- Text messages with colleagues
- Secure chat/Tiger Text intra-institutional messaging
- Email with patients
- Email with providers
- Call center
- Patient Portal
- Whats App
- Phone conversations

Case Examples:

Communication not included in the Designated Medical Record Set

E-mail



Subj: [redacted]
Date: [redacted] Eastern Standard Time
From: [redacted]
To: [redacted]

[redacted]

-----Original Message-----
From: [redacted]

Date: [redacted]
To: [redacted]
Subject: RE: [redacted]

So I'm glad the CT done yesterday showed no worsening....the heparin does seem to be working. How was last night? Hopefully better. You're right, I wish we did a CT sooner...this is so very rare.... Please keep me posted-

[redacted]

-----Original Message-----
From: [redacted]
[mailto:[redacted]
Sent: [redacted]
To: [redacted]
Subject: [redacted]

[redacted] appeared much more alert today than he has since the surgery. The heparin is hopefully working. They r doing a ct scan tomorrow. Fingers are crossed. I only wish a ct scan as done sooner and we found this sooner.

We ll be in the hospital at least one more week.

[redacted] and I trying to figure out how to take the next two weeks off from work

[redacted]

[redacted]

From: [redacted]
Sent: [redacted]
To: [redacted]
Sub [redacted]

Hi Rheumatology and IBD teams,

I wanted to start a discussion regarding a plan for [redacted] who is now inpatient with [redacted] Joint flare up. He has been on [redacted] until recently that has worked well for his GI symptoms but has not helped his joint disease. Now that he has been off for the last 3.5 weeks - if we were going to make a change I think now would be the appropriate time. I wanted to get your opinion and hopefully decide as a team on the best options for

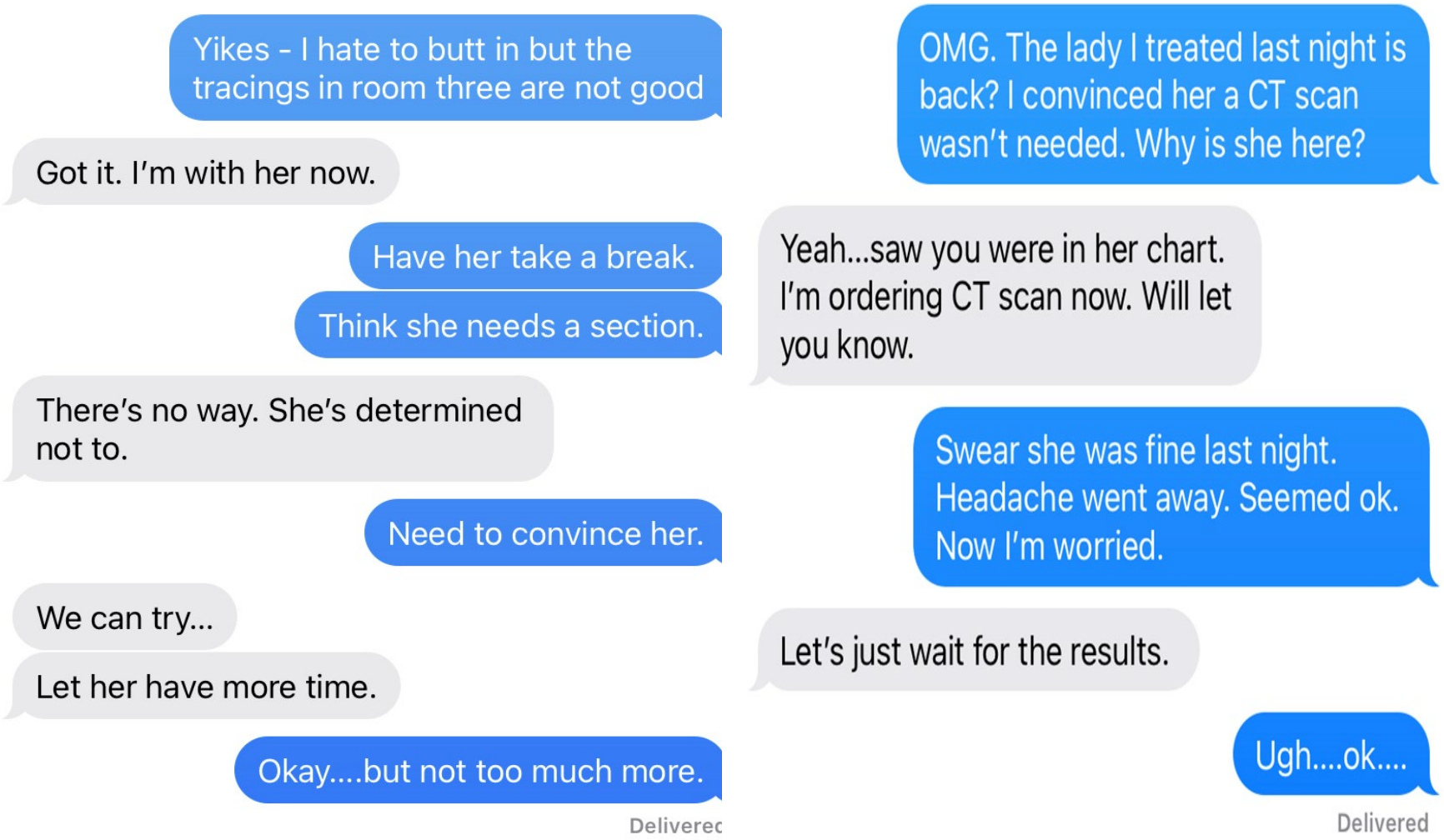
him going forward. As I see it he can restart [redacted] will help his GI symptoms but will need something new for his joint disease - in talking with Jennifer it seems that a retrial of methotrexate or imuran were options that had been discussed from the rheum perspective (though I am not sure given possible history of DILI with MTX). Are there any other options? Alternatively, we could consider starting Stelara which should work for his GI symptoms and possibly his joint disease - though I am not sure about its efficacy in axial disease.

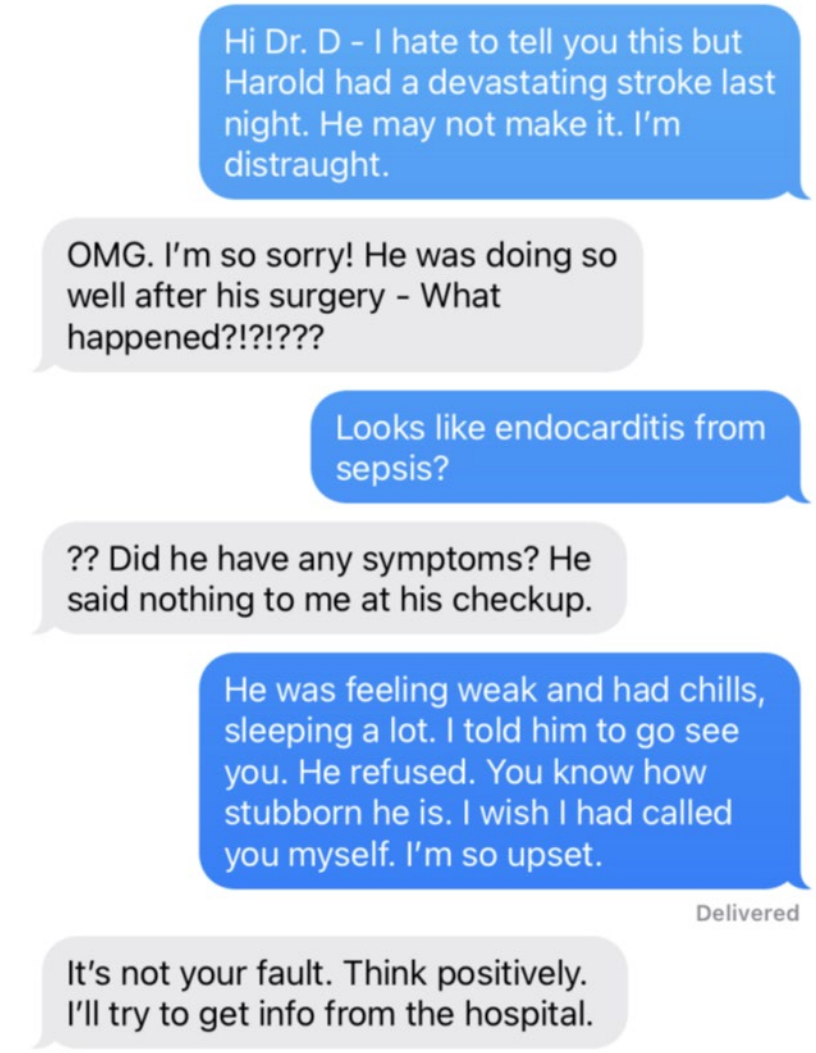
Hopefully, together we can come up with a good plan for him. Please share your thoughts,

Best,
[redacted]

Text Messages (phone and messaging apps)




Yikes - I hate to butt in but the tracings in room three are not good
Got it. I'm with her now.
Have her take a break.
Think she needs a section.
There's no way. She's determined not to.
Need to convince her.
We can try...
Let her have more time.
Okay....but not too much more.
Delivered
OMG. The lady I treated last night is back? I convinced her a CT scan wasn't needed. Why is she here?
Yeah...saw you were in her chart. I'm ordering CT scan now. Will let you know.
Swear she was fine last night. Headache went away. Seemed ok. Now I'm worried.
Let's just wait for the results.
Ugh....ok....
Delivered

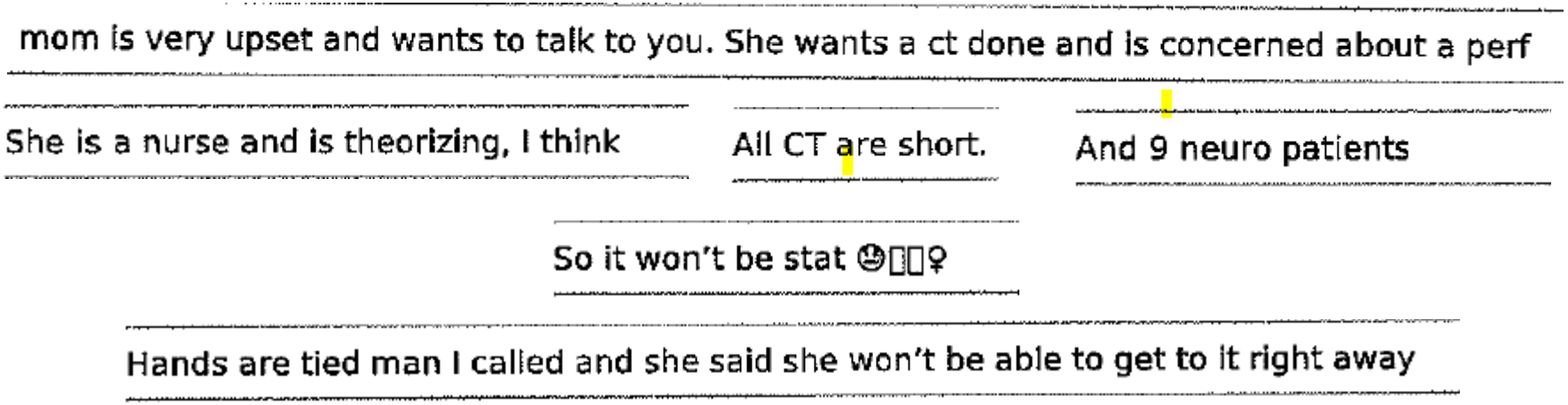

Hi Dr. D - I hate to tell you this but Harold had a devastating stroke last night. He may not make it. I'm distraught.
OMG. I'm so sorry! He was doing so well after his surgery - What happened?!?!???
Looks like endocarditis from sepsis?
?? Did he have any symptoms? He said nothing to me at his checkup.
He was feeling weak and had chills, sleeping a lot. I told him to go see you. He refused. You know how stubborn he is. I wish I had called you myself. I'm so upset.
Delivered
It's not your fault. Think positively. I'll try to get info from the hospital.

Internal Texts, IMs/Flags



What is Secure Chat/TigerText?:

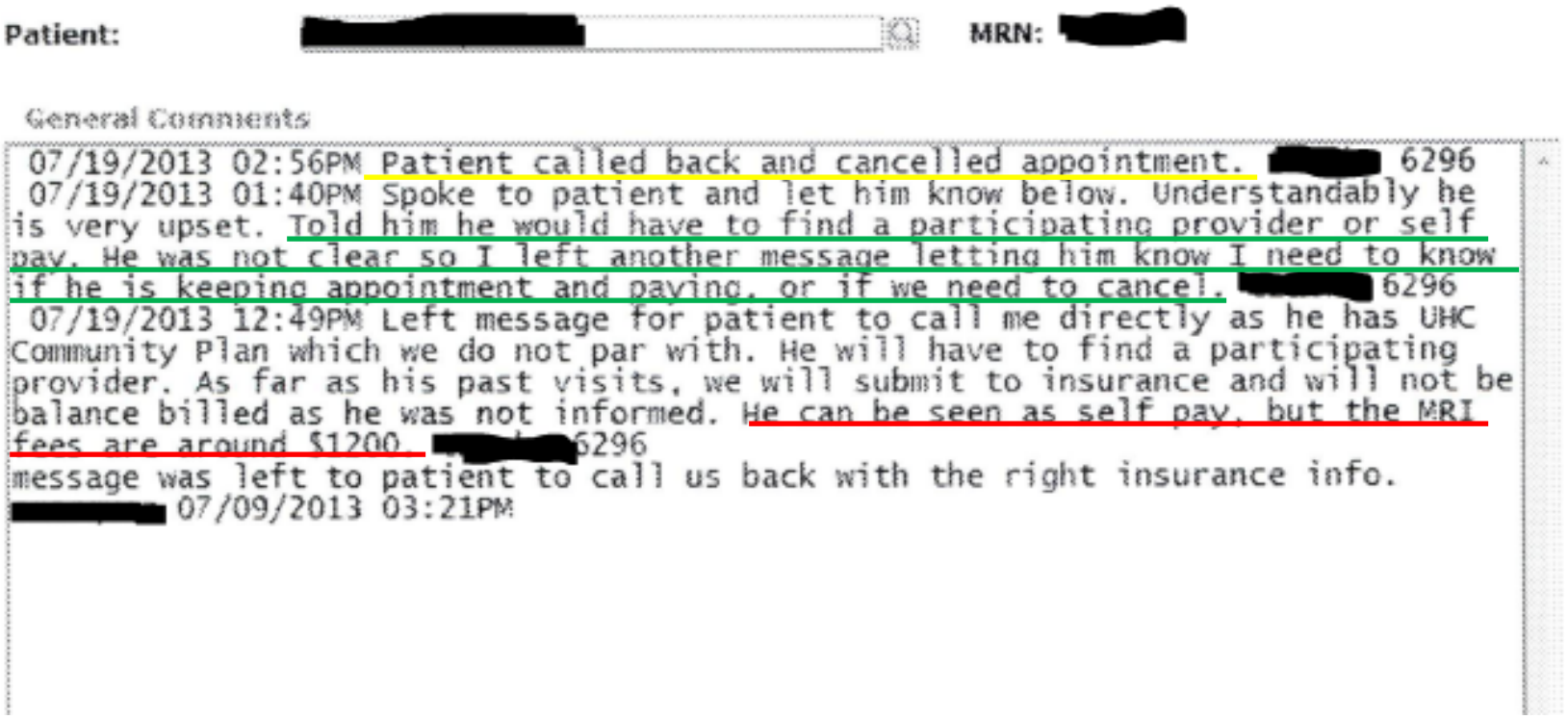
- What is Secure Chat/TigerText?
- ✓ A HIPAA-compliant, secure messaging tool that providers can use to communicate and collaborate with other providers.
- ✓ Practitioners can chat 1:1 or in groups to exchange general messages or discuss detailed patient information, including photos.
- ✓ Intended for non-urgent communication related to daily work activities.
- ✓ User cannot delete messages and they are purged after a time period chosen by the organization.
- ✓ Messages sent using Secure Chat/TigerText are not included in the LMR, but they are stored in the database and might be legally discoverable.



Call Center Notes



Call Center Logs



Patient: [redacted] MRN: [redacted]

General Comments

07/19/2013 02:56PM Patient called back and cancelled appointment. [redacted] 6296
07/19/2013 01:40PM Spoke to patient and let him know below. Understandably he is very upset. Told him he would have to find a participating provider or self pay. He was not clear so I left another message letting him know I need to know if he is keeping appointment and paying, or if we need to cancel. [redacted] 6296
07/19/2013 12:49PM Left message for patient to call me directly as he has UHC Community Plan which we do not par with. He will have to find a participating provider. As far as his past visits, we will submit to insurance and will not be balance billed as he was not informed. He can be seen as self pay, but the MRI fees are around $1200. [redacted] 6296
message was left to patient to call us back with the right insurance info.
[redacted] 07/09/2013 03:21PM

Patient Portals



Patient Portals

A patient portal is a secure online website that gives patients convenient, 24-hour access to personal health information from anywhere with an Internet connection. The goal is to improve patient access and experience. Patients can view health information such as:

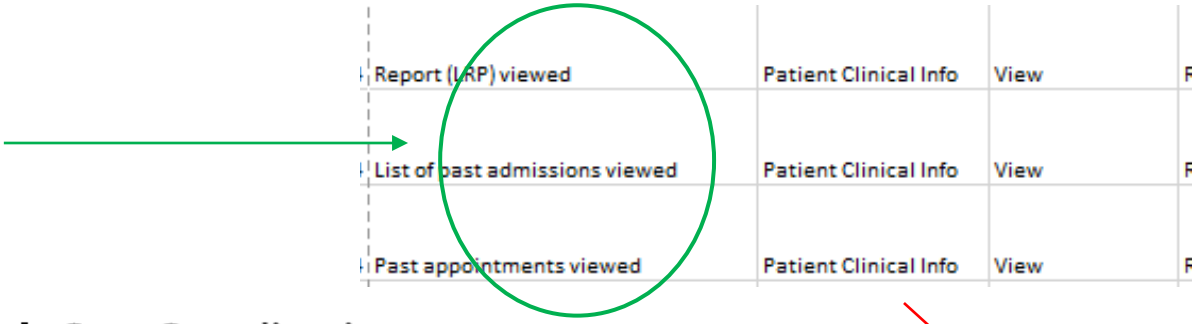
- Recent doctor visits
- Discharge summaries
- Medications/Immunizations
- Allergies
  Lab results

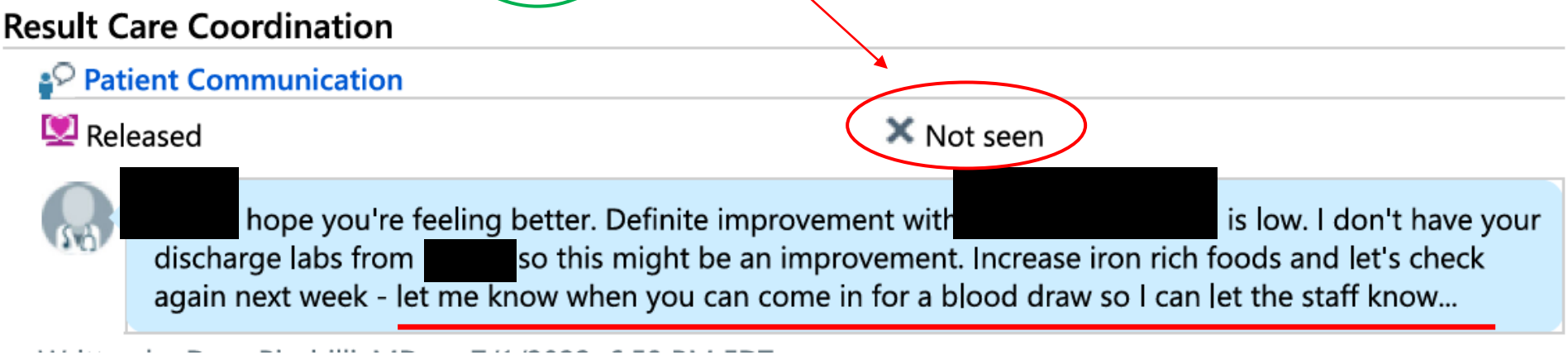
Some patient portals also allow you to:

- Securely message your doctor
- Request prescription refills
- Schedule non-urgent appointments
- Check benefits and coverage
- Update contact information
- Make payments
- Download and complete forms
- View educational materials

What are we seeing or not seeing?

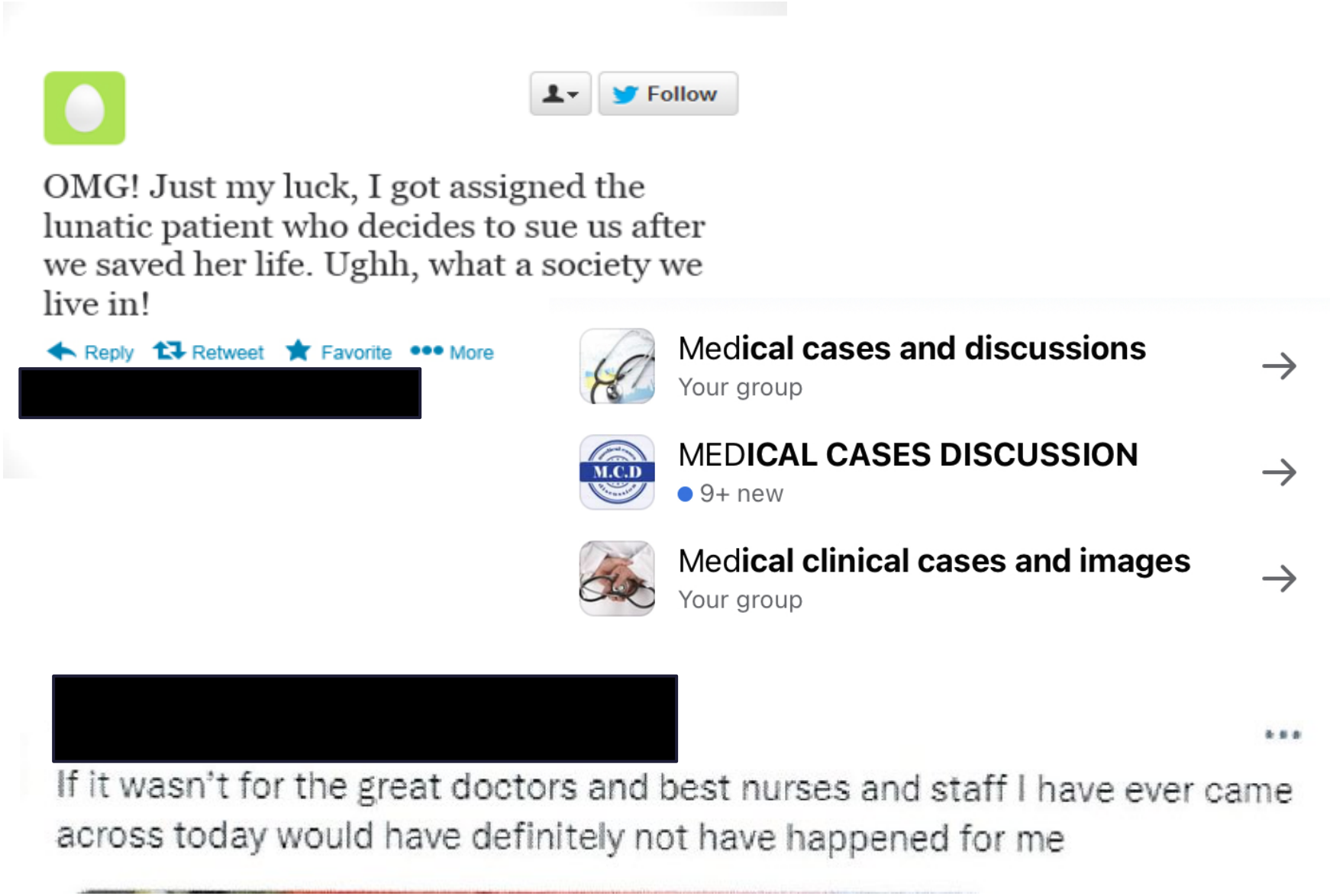
- Inconsistent use within a practice
- Encouragement by admin to use, Practitioners uninterested/unable
- Unpredictable connection with patients
- Patients seeing results not previously communicated
- Audits can show if patients viewed results





Social Media




Follow
OMG! Just my luck, I got assigned the lunatic patient who decides to sue us after we saved her life. Ughh, what a society we live in!
Reply
Retweet
Favorite
More
[redacted]
Medical cases and discussions
Your group
MEDICAL CASES DISCUSSION
9+ new
Medical clinical cases and images
Your group
[redacted]
If it wasn't for the great doctors and best nurses and staff I have ever came across today would have definitely not have happened for me


Thread
[redacted]
for its compassionate, efficient and
superb care. And a special shoutout to [redacted] for performing a
Laterjet to successfully repair my chronically dislocating shoulder with
significant associated bone loss.
1
2
5
[redacted]
Surgery went well and recovery has been very smooth.
One [redacted] down, one to go. I know I could never
find such competence and proficiency at any other
facility or from any other surgeon.
[redacted]
Twitter for iPad

AI



Conclusion –

1) The definition of the Legal Medical Record is an evolving issue in litigation and the Courts are generally uninterested in what has been decided by HIM to include in the Designated Medical Record Set as a defense against disclosure.

2) The Plaintiffs' bar and Courts are recognizing that the EMR is different than the Legal Medical Record or Designated Medical Record set. There are consulting firms/experts devoted to this, it's a national issue.

3) The vast majority of information within the EMR and communication outside the EMR is discoverable. Social Media is friend and foe.

4) All communication and documentation should remain professional and be written with the same sensitivity as if it was part of the formal medical record. Limit slang, overly casual language and emojis. There remains no substitution for good formal documentation.

5) Patient and provider communication critical to the defense is often excluded from the Designated Medical Record Set. Providing comprehensive materials to defense counsel early ensures a more robust analysis of liability and helps better prepare providers for depositions.

6) Each medical institution designs parameters for their EMR/EPIC. Defense counsel is often unaware of how the system is set up, so they are not aware of what type of information to ask for.

7) Courts are starting to grant live EMR inspections. Audit trails are more routinely ordered to be produced.

8) A significant amount of provider and patient communication still occurs outside of formal privacy protected channels.

9) Patient portals can be helpful, but need to be implemented and used consistently.

Questions/Comments –

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