# Legal Focus: eDiscovery and Healthcare Record Retention

White Paper

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# Welcome

On behalf of Harmony Healthcare IT and Warner Norcross & Judd LLP, we are pleased to share this paper about the legal issues for healthcare providers to consider when planning and updating their medical record retention policies. In this paper we'll take a look at:

- Mitigating Legal Risks – Being prepared for eDiscovery in case of litigation and the possibility of an audit.
- Retaining Data and Replacing Systems– The kinds of data that needs to be retained and the main issues with long-term legacy data management, especially in the case of system replacement.
- Governing Data with Technology – The importance of a cross-functional team to define a long-term data management plan which uses technology to secure records in a searchable and HIPAA-compliant format.

This information is meant to serve as a preface to the insights and observations our teams have experienced in our work with many healthcare organizations. Your feedback is important to us as there are many opportunities for collaboration in the healthcare information technology space. We welcome the opportunity to provide you with a deeper look into these trends and recommendations that may benefit your organization.

Dawn Garcia Ward, Senior Counsel at Warner Norcross & Judd LLP

James E. Hammer, PMP, Vice President,
Product & Program Management at Harmony Healthcare IT

# The Big Picture from a Legal Perspective

Nearly 35 years ago, Mary Lou Fox sued the doctors and the medical center she claimed had negligently lost, destroyed or misplaced EKG tracings and reports that deprived her of the evidence necessary to meet her burden of proof in a wrongful death lawsuit. Upon appeal, the court found a duty upon the hospital to maintain its patients' records (Fox v. Cohen, 84 ILL App/ 3d 744, 406 N.E. 2d 178 (1980)).

Over the years, the laws surrounding healthcare data retention have increased only slightly behind the skyrocketing rate at which data is being created. What remains a constant is that in most professional negligence actions against a hospital, the institution must show that the care it provided was consistent with acceptable medical practice at the time and that the care was reasonable under the circumstances. The hospital's medical records usually are essential to its defense of such actions.

As mountains of healthcare information continue to grow, successful healthcare data management today relies on a collaborative, enterprise-wide approach to data retention, mitigating legal risks and utilizing current technology solutions that will meet future needs.

# Legal Snapshot – Court cases that have shaped medical record retention laws

While recent cases do not appear to engage in an in-depth discussion on duty the way *Fox v. Cohen* does, many states now impose a statutory duty to retain medical records. Fewer courts imposed a common law duty to preserve records when *Fox v. Cohen* was decided. *See Foster v. Lawrence Memorial Hosp.*, 809 F. Supp. 831 (Dist. Kan. 1992) (noting that five states recognized a civil action for spoliation of evidence such as medical records).

Whether imposed by courts or by statute, the duty to preserve medical records is now present in many states. *See, e.g., Howard Reg'l Health Sys. v. Gordon*, 925 N.E.2d 453 (Ind. Ct. App. 2010) (holding that Indiana statute imposes "a duty [on applicable healthcare providers] to maintain their health records, and that a breach of that [statutory] duty is negligence *per se.*") (*vacated on transfer*, 940 N.E.2d 823 (Ind. 2010)); *Gray v. Jaeger*, 17 A.D.3d 286 (N.Y. App. Div. 2005) ("Defendant breached his ethical and statutory duty to retain plaintiff's medical records for at least six years."). The primary focus of many cases addressing the statutory duty is on whether breach of duty creates a civil cause of action. *See, e.g., Proske v. St. Barnabas Medical Center,* 712 A.2d 1207, 1211–12 (N.J. Super. Ct. App. Div. 1998) (declining to find tort liability for failure to comply with New Jersey statute requiring record retention).

# Mitigating Legal Risks and the Cost of eDiscovery

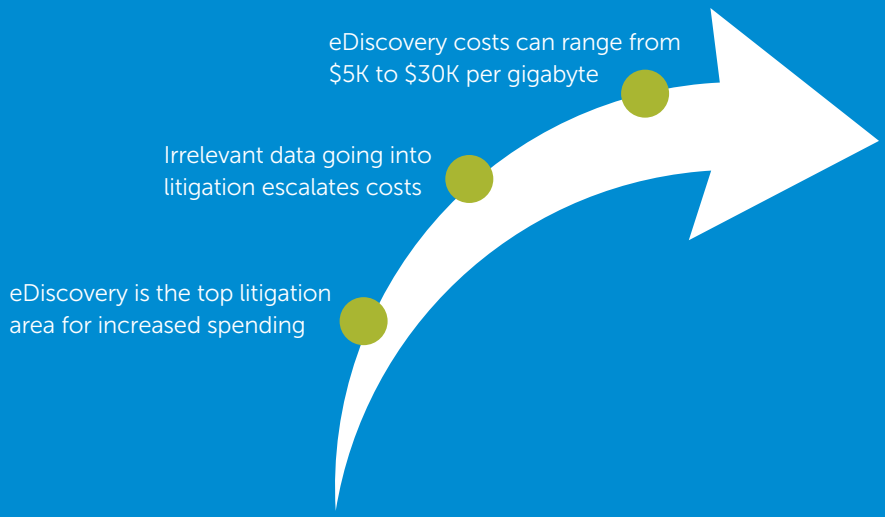
The legal implications for data retention center on the need to access historical records quickly and efficiently for years to come. Healthcare organizations need to be prepared for an audit and possible litigation. For many organizations, it is difficult to determine what is being stored, or perhaps even more troubling, if the information stored should be retained at all.

One of the biggest concerns in data retention from a legal perspective is the escalating cost of storage and eDiscovery. High discovery costs are due in part to large portions of irrelevant data going into litigation. Duke University estimated, in major cases going to trial in 2008, the ratio of pages discovered to pages entered as exhibits at 1000 to 1.
(Duke University, Litigation Cost Survey of Major Companies, 2010)

These costs are only growing: electronic discovery is consistently cited as the top litigation area for increased spending among corporate litigants in Fulbright and Jaworski's annual Litigation Trends Report. (http://www.nortonrosefulbright.com/knowledge/publications/115605/9th-annual-litigation-trends-survey-report)

There also are concerns with over-retention of data. The regulations vary by record type, state and other conditions which make it difficult to maintain a consistent retention schedule. Some healthcare organizations over save in an effort to be safe. However, depending on how the data is stored, over saving can create more issues in terms of cost, storage capacity and having non-essential records that must be considered during times of litigation.

The expense of eDiscovery alone includes collection, preservation, processing, culling, review, production, and hosting. These costs can be staggering: expert estimates for eDiscovery costs range anywhere from $5,000 to upwards of $30,000 per gigabyte.
(Degnan D. Accounting for the Costs of Electronic Discovery.
Minnesota Journal of Law, Science & Technology.
2011;12(1):151-190.)



"We recommend our clients ensure their healthcare records are readily available, searchable and maintained in a secure system for the required timeframe for each specific type of record," said Dawn Garcia Ward, senior counsel at Warner Norcross & Judd LLP in Holland, Michigan. "We highly recommend a data audit to ensure they are not over saving records which could result in unnecessary data management and labor costs. It makes sense to involve legal, compliance and IT in this process so that every aspect of data management and retention requirements is included in the organization's long-term plan."

**Dawn Garcia Ward, senior counsel at Warner Norcross & Judd LLP in Holland, Michigan**, is a graduate of Notre Dame and co-chair of the firm's Data Solutions Practice Group. She is a pioneer in the field of data record information management (RIM) and information governance. The former litigator has spent more than a decade advising Fortune 500 corporations and other businesses how to properly manage data – a practice that saves money and helps reduce legal risk. She creates legally defensible document management programs that stand up in court and stand out on the bottom line.

# Six Tips for Managing Cost and Risk.

1. Reduce discovery costs by getting rid of Redundant, Obsolete and Trivial (ROT) data
    - On average, 1,000 pages have been preserved for every page entered as an exhibit - too often, too much unnecessary data has been preserved and drawn into discovery
    - Discovery costs can range from $5,000 to $30,000 per gigabyte
2. Conduct audits to validate or refine your record retention process
3. Maintain a solid retention schedule to avoid guesswork and unnecessary risk
4. Preserve records for the proper length of time (duty to preserve medical records can range from five to 25 years, depending jurisdictions and records types)
5. Maintain a solid legacy data archive to provide easy and efficient retrieval
6. Plan carefully to avoid unexpected expenses. Approximately 80 percent of policy implementation cost is for change management which can be controlled with early planning.

# Save, Save, Save... the Story of Healthcare Data Retention

There are many factors involved in determining which records must be preserved and for what length of time. A number of federal statutes and regulations impose a duty to preserve medical records. Institutions and practitioners subject to the Health Insurance Portability and Accountability Act (HIPAA) are required to preserve "documentation related to their medical records for a period of six years from the date of its creation or the date on which it was last in effect, whichever is later." WILLIAM R. ROACH, MEDICAL RECORDS AND THE LAW 41 (4th ed. 2006). In contrast to previous regulations that incorporated by reference each respective state's statute of limitations, the Medicare Conditions of Participation require record retention for at least five years. *Id.* (citing 42 C.F.R. § 482.24).

Some state regulations require significantly longer retention periods. Connecticut requires hospitals to preserve records for 25 years, CONN. AGENCIES REGS. §19-13-D3(d)(4), and New Jersey requires a retention period of 20 years for certain specified documents, N.J. REV. STAT. § 26:8-5, with original medical records being retained for 10 years. *Id.* About half of all states require a retention period of 10 years for medical records, while many remaining states impose retention periods between five and seven years. ROACH, MEDICAL RECORDS AND THE LAW 42 (4th ed. 2006). Other states refer to the statute of limitations for negligence claims as the minimum retention period. IOWA ADMIN CODE R. 641–51.6(1).

Some accreditation associations promulgate their own guidelines for medical records retention. ROACH, MEDICAL RECORDS AND THE LAW 46 (4th ed. 2006). The American Health Information Management Association adopted retention requirements ranging from five years for diagnostic images to permanent retention for registers of surgical procedures and other records. *Id.* Most other associations incorporate by reference state statutes of limitations as the retention period. *Id.*

Ultimately, there is a broad duty to preserve medical records. In most states that duty is for at least five years; others require periods of 10 years and others still require a 25 year retention of *records.*

# System Replacement Issues could be Roadblock for Efficient eDiscovery

While most healthcare organizations do have a data retention policy and are familiar with the types of records that must be preserved; the question of the day is - How often is the policy revisited and is the organization prepared for efficient eDiscovery in possible litigation and/or an audit?

Many early adopters to EHR now are replacing and consolidating older systems which sparks emerging issues for managing legacy data. There likely are paper records, electronic records, records from acquired or obsolete practices and several different legacy systems within each healthcare organization's data landscape. The constantly changing technology creates additional challenges, because:

Within a decade, most operating systems and application software change significantly. Security requirements change as well, and storage media may lose their integrity. In short, electronic records stored for 10 years or more may be in jeopardy. This is troubling because, up to 20% of records fit in the category of needing to be retained for more than 10 years (Future Watch: Strategies for Long-Term Data Preservation, Gordon E.J. Hoke, CRM, May/June 2012, Information Management)

There are records that must be kept for the short and long-term based on state and federal laws, but the method to maintaining records with access to the information is a consistent challenge faced by nearly every healthcare provider.

As healthcare providers continue to move forward managing historical data and planning ahead for future data needs, there is a growing need to develop a plan that includes a past, present and future approach. In terms of being prepared for potential litigation and eDiscovery needs, a legacy data management solution is a must.

# Best Practices for EHR Solutions - Archive Supports Efficient eDiscovery

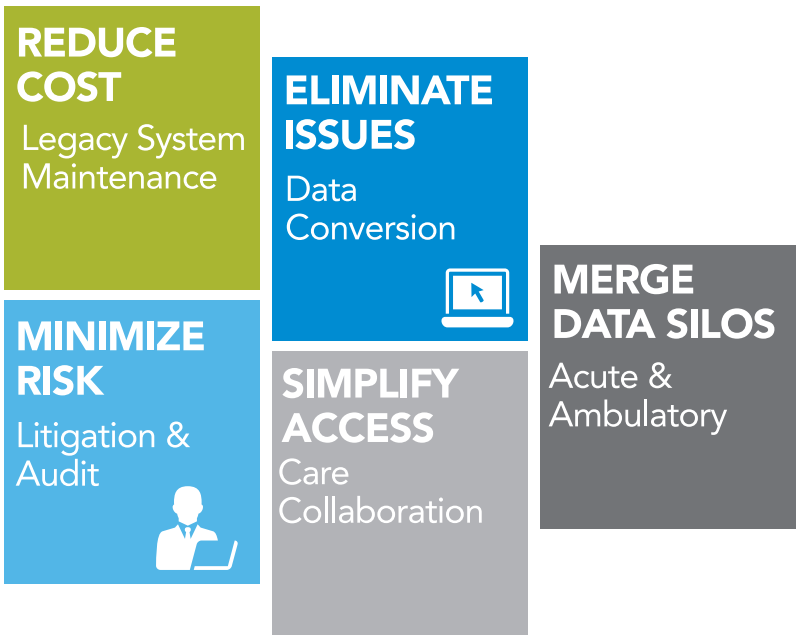
Having a solid legacy data archive is a smart step forward in managing historical patient and operational data well into the future. This solution offers compliance with the numerous local, state and national regulations and a single, easy to use solution for historical information. As healthcare systems streamline their go-forward systems to integrated solutions, having a single archive provides an easy, one-stop-shop access to historical records which supports easy and efficient record retrieval for eDiscovery or an audit.

"We've helped hundreds of healthcare providers - both acute and ambulatory - save their data in an easy to use archive and reduce costs in terms of maintenance, infrastructure and alleviating the additional personnel required to keep multiple legacy systems alive," says James E. Hammer, PMP, Vice President, Product & Program Management at Harmony Healthcare IT. "From a legal perspective, there are significant benefits to having historical records in one archive that are easy to access and information that is searchable and relevant."

**James E. Hammer, PMP is Vice President,**
**Product & Program Management at Harmony Healthcare IT**
Hammer is a proven leader with more than 20 years of Health IT experience ranging from implementation, support, P&L, program/project management and strategic and tactical planning to provide practical and actionable solutions solving real problems. Hammer and the Harmony Healthcare IT team are bending the cost curve for health systems and practices daily by helping clients with data migration and the retirement of replaced HIS, PM, EHR, General Accounting, HR/Payroll systems as healthcare organizations move to their new solutions. A graduate of Millikin University and a certified project manager, Hammer's expertise provides clients with timely and cost efficient solutions to these challenges, so the healthcare provider can work on their integrated solution, yet remain compliant with retention and regulatory requirements around the old system data.

# The benefits to building a long-term data archiving solution into a healthcare IT portfolio, include:

- Cost Reduction - Streamlining the long-term storage of historical PHI now will save money in the long-run. Not only will it reduce costs paid for the support and technical maintenance of an antiquated system, but, it will save on training new staff on how to access information over the next 7-25 years.
- Eliminating Risk - Preserving historical patient data is the responsibility of every provider. As servers and operating systems age they become more prone to data corruption or loss. The archival of patient data to a simplified and more stable storage solution ensures long-term access to the right information when it's needed for an audit or legal inquiry. Incorporating a data archive avoids the costly and cumbersome task of a full data conversion.
- Compliance - Providers are required to have data for nearly a decade or more past the date of service. Check with your legal counsel, HIM Director, medical society or AHIMA on medical record retention requirements that affect the facility type or practice specialty in your state.
- Simplified Access To Data - We all want data at the touch of a button. Gone are the days of storing historical patient printouts in a binder or inactive medical charts in a basement or storage unit. By scanning and archiving medical documents, data and images, the information becomes immediately accessible to those who need it.
- Merging Data Silos - Decades worth of data from disparate legacy software applications is archived for immediate access via any browser-based workstation or device. Also, medical document scanning and archiving provides access to patient paper charts.



# Legal, IT, and Compliance Team Approach Best to Developing and Refining EHR Policies

It is no secret that the EHR industry is on a rapid growth trajectory. Research company Kalorama Information expects the nearly 25 billion-dollar market for electronic medical records (EMR) to grow well past the period where there are incentives for US healthcare providers, according to a recent report. Training and upgrading, optimization and ongoing support will be growth areas. It is expected that growth will be influenced by providers either switching their current EMR for a different one or upgrading as technology advances.

$25 Billion EMR Industry

Kalorama's report said that approximately 80% of the work of implementation must be spent on issues of change management, while only 20% is spent on technical issues related to the technology itself. Such organizational and social issues include restructuring workflows, dealing with physicians' resistance to change, as well as IT personnel's resistance to design and implementation flexibility needed in the complex healthcare environment. This year's report, *EMR 2015: The Market for Electronic Medical Records*, can be found at: http://www.kaloramainformation.com/redirect.asp?progid=87377&productid=8917410

As the report demonstrates, there are many factors to consider when developing and updating a healthcare data management strategy. Thinking about the legal issues of data management and retention is one important element of an overall plan. If you haven't already, convene the necessary representatives from compliance, legal, IT and other related departments to review your EHR strategy.

# EHR Strategic Focus

- **Maintain a Solid Retention Schedule** – create and consistently update a retention schedule that includes an audit of the types of records that need to be stored and for the length of time required by the regulations and laws for each type of record. The plan must be executable so it becomes a standard practice. Involve legal, compliance, IT and other key stakeholders in your organization to ensure that the plan meets the enterprise-wide requirements for what needs to be retained and for how long.

- **Plan ahead** – use the current technology tools to create a solid plan for the future that includes an archive with a searchable data function for historical data. It will be less costly over the long term and be less overwhelming should the data be needed for eDiscovery or an audit. Some healthcare organizations have developed stand-alone methods for data management; others rely on vendor developed systems and/or retention models and architecture developed by industry organizations such as the International Council of Archives (ICA).

- **Develop a plan to eliminate Redundant, Obsolete, Trivial data (ROT).** This "eTrash" as it is commonly known can take up valuable storage space and can create discovery headaches down the road. eTrash refers to unstructured content with no business purpose nor continuing need to preserve it for regulatory or compliance reasons. How much eTrash is out there? Research firm, Gimmal estimates on average, 30 percent of all content (total volume) stored on shared drives and SharePoint sites is eTrash. (http://www.gimmal.com/Blogs/Pages/Got-eTrash.aspx)

# Plan for the Future

A solid plan for the future requires systematic management of electronic health records that ensures ongoing access to authentic records that have long term operational, regulatory and legal value.

From a legal perspective, incorporating new standards that adapt to the digital world of electronic medical records is critical. Some organizations are adopting remote, limited access for lawyers to access specific data contained in the EHR systems. This includes another layer of authenticating a user to have read-only login privileges, but may provide efficiencies during eDiscovery or audit.

Another issue that supports efficient medical record retrieval is the continued focus on "commonizing" key patient data that can be exported in a standard format and shared with other healthcare providers, the legal community, etc. This streamlining is in part a reaction to the American Recovery and Reinvestment Act of 2009, which allocated funds to support the transition from paper records to electronic medical records. (https://www.cms.gov/ehrincentive programs/30_Meaningful_Use.asp (last visited Jan. 23, 2012).

In the past few years, the Centers for Medicare and Medicaid Services (CMS) have adopted many incentives to spur more healthcare providers to adopt EHR. To date, more than 400,000 eligible providers have joined the ranks of hospitals and professionals that have adopted or are meaningfully using EHRs. The goal is to increase the millions of patients across the nation who are benefiting from the potential of better coordinated care among professionals, more accurate prescribing, and improved communication. To achieve that goal requires significant planning, policy making, record management and retrieval issues that each healthcare organization must tackle.

The legal issues with EHR and record retention go hand-in-hand with the long term data management priorities of the healthcare organization. Developing and managing a long-term healthcare data management plan needs to be an ongoing project with systematic audits and review by key members of each healthcare organization. Is your organization prepared?

# Legal Snapshot of Electronic Medical Records Industry

*Key Trends at a Glance*

## 400,000+

eligible providers have joined the ranks of hospitals and professionals that have adopted or are meaningfully using EHRs.

## $25 billion-dollars

= Growing market for electronic medical records

## 1000 to 1

= the ratio of pages discovered vs. the number of pages entered as actual exhibits in major trials.

## $5,000 to $30,000 per gigabyte

= current range of eDiscovery costs

## 5 to 25 years

= Duty to preserve medical records, depending on jurisdictions and records types

## up to 20%

of all medical records need to be retained for more than **10 years**

## 30%

of all content stored on shared drives and SharePoint sites is eTrash

## 80%

of the work of implementation must be spent on issues of change management, while only

## 20%

is spent on technical issues related to the technology itself

# About Warner Norcross & Judd LLP

By providing discerning and proactive legal advice, Warner Norcross & Judd LLP builds a better partnership with its clients. Warner Norcross provides full life-cycle support for business data, from data creation to disposition and everything in between, including eDiscovery and data privacy solutions. As a premiere corporate law firm, Warner Norcross attorneys have the business acumen and legal expertise to confront any issue throughout an organization's data life-cycle and provide legally defensible counsel. Warner Norcross is a corporate law firm with 230 attorneys practicing in eight offices. For more information on policies, best practices and litigation, contact the Data Solutions co-chairs: Jay Yelton (jyelton@wnj.com or 269-276-8130) or Dawn Garcia Ward (dward@wnj.com or 616-396-3039).

# About Harmony Healthcare IT

Since 2006, health IT analysts at Harmony Healthcare IT have extracted demographic, financial, clinical and administrative data for hundreds of healthcare providers - both ambulatory and acute. Headquartered in South Bend, Indiana, the company employs experts in data extraction, migration, archival, integration and analytics to provide its clients with trusted and seamless data solutions. Working with hundreds of systems, billions of records and terabytes of data, Harmony Healthcare IT provides clients with access to historical records. Simply. For more information, visit: www.harmonyhit.com. For more information on developing a legacy data strategy, inventorying legacy systems or decommissioning old software; contact Shannon Larkin (slarkin@harmonyhit.com or 800-781-1044, Ext. 109) or Jim Hammer (jhammer@harmonyhit.com or 800-781-1044, Ext. 145).

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