





Learner Outcomes/Objectives

- Define and explain the EHR Audit Trail and its use in the medical malpractice field.
- List 3 data points collected within the EHR Audit Trail
- Identify a complete EHR Audit Trail vs alternative documents produced as audit trails
- List 3 benefits to EHR Audit Trail utilization in the medical malpractice field

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EHR Audit Trail: History, Uses and Misconceptions

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What is an Audit Trail?

- Audit Trail is defined as “a record that shows who has accessed a computer system, when it was accessed, and what operations were performed during the access period.”

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What is an EHR Audit Trail?

- In the medical field it identifies the who, what, when and where of actions occurring within the chart
- Each action creates a data point in the EHR
- The data points are referred to as metadata
- The metadata is then queried to produce the Audit Trail

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Name 3 "actions" within an EHR

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What is an EHR Audit Trail?

- For the EMR or EHR this means each time a provider enters a chart and performs an auditable action such as:
 - View
 - Modify
 - Delete
 - Create
 - Print
 - Export

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Why do EHR Audit Trails exist?

- > In the early 2000's electronic medical records (EMR) became more popular
- > American Recovery and Reinvestment Act of 2009
- > Eventually regulations were put in place regarding this data collection.
 - Code of Federal Regulations
 - HIPPA
 - ASTM Standards
 - ONC Certification
- > **Currently any facility that receives funding from Medicare/Medicaid MUST utilize an EHR system that has the ability to produce an EHR Audit Trail**

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Audit Trail Use in Med-Mal Cases

- Validate the integrity of the printed records
- Verify the timeline of events
- Identify potential witnesses
- Validate or refute deposition/trial testimony
- Identify additional discovery requests
- No opinions, just facts identified within the metadata
- Plaintiff and Defense

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Give me your best "arguments" or "misconceptions" about EHR Audit Trails...

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Common Misconceptions.....

- “It’s a fishing expedition.”
- “Not every med-mal case needs an audit trail review.”
- “Audit trails only benefit the plaintiff side.”
- “It will take too long to produce the audit trail.”
- “The EHR can’t produce the audit trail.”

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Standards, Data Points & Identifying an Audit Trail

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Standards for Audit Trail Production

- ASTM E2147-18: Standard Specification for Audit and Disclosure Logs for Use in Health Information Systems
- ONC Certification
- HIPPA
- CMS
- Code of Federal Regulations
- HITECH – Health Information Technology for Economic and Clinical Health Act of 2009

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Data Points per ASTM Standards

- Date and time of access
- Date and time of activity
- Duration of access
- Access device
- Location of access or activity or both
- Patient identification
- User identification
- Type of actions: examples creations, additions, deletions, changes, queries, accesses, copy, print and copy and paste
- Identification of the patient data that was accessed
- Source of access



Access Log vs Audit Trail

- The access log only identifies who ACCESSED to the record
- Actions seen = View
- You will not see other actions such as:
 - Print
 - Modify
 - Create
 - Delete



Access Log vs Audit Trail

Date	Access By Name	Action	Object Area	Type	Encounter	Associated Data
10/12/2017 09:34:41 AM	Prohask, Trishy, DHA	Report with patient data printed	Reporting	Expert	N/A	Report viewed 453 Patient Encounters (10/12/2017) Encounter Patient Data Audit trail None Report ID
10/12/2017 09:35:36 AM	Prohask, Trishy, DHA	Related encounters requested	Workflow	System	Office Visit on 10/12/17	Brown, Charles (10/12/17) Report viewed Patient Encounters (10/12/17) Encounter
10/12/2017 09:35:33 AM	Brink, Bg, MD	Patient flag/shot entered	Patient Clinical Info	View	Office Visit on 10/12/17	Report viewed PATIENT ENCOUNTER (10/12/17) Encounter
10/12/2017 09:35:33 AM	Brink, Bg, MD	Patient flag/shot entered	Patient Clinical Info	View	Office Visit on 10/12/17	Report viewed PATIENT ENCOUNTER (10/12/17) Encounter
10/12/2017 12:10:27 AM	Brink, Bg, MD	Patient flag/shot entered	Patient Clinical Info	View	Office Visit on 10/12/17	Report viewed PATIENT ENCOUNTER (10/12/17) Encounter None HSA/PA Reg. on 10/12/17 Encounter None None Patient Chart Chart Review Tab None (10/12/17) Office Review Tab None (10/12/17) Order ID Program ordered on 10/12/17 - N/A LIMBIAK DRUG KIT CONTAINED Encounter
10/12/2017 12:10:28 AM	Brink, Bg, MD	Print clinical notes	Clinical Notes	Modify	Office Visit on 10/12/17	Report viewed Patient Chart Chart Review Tab None (10/12/17) Office Review Tab None (10/12/17) Order ID Program ordered on 10/12/17 - N/A LIMBIAK DRUG KIT CONTAINED Encounter
10/12/2017 09:30:33 AM	Moore, Candice, MD	Chart Review Medications tab selected	Medications	View	N/A	Report viewed Patient Chart Chart Review Tab None (10/12/17) Office Review Tab None (10/12/17) Order ID Program ordered on 10/12/17 - N/A LIMBIAK DRUG KIT CONTAINED Encounter
10/12/2017 09:30:33 AM	Moore, Candice, MD	Chart Review Medications tab selected	Medications	View	N/A	Report viewed Patient Chart Chart Review Tab None (10/12/17) Office Review Tab None (10/12/17) Order ID Program ordered on 10/12/17 - N/A LIMBIAK DRUG KIT CONTAINED Encounter
10/12/2017 09:30:33 AM	Moore, Candice, MD	Results acknowledged on R	Orders	View	Office Visit on 10/12/17	Report viewed Patient Chart Chart Review Tab None (10/12/17) Office Review Tab None (10/12/17) Order ID Program ordered on 10/12/17 - N/A LIMBIAK DRUG KIT CONTAINED Encounter

Other Produced Documents

- "Partial" or "incomplete" audit trail
- Access log with some additional actions
- Altered audit trail
- Lots of documents in between

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Other Produced Documents



Key Takeaways

- ✓ Audit Trails exist outside of medical-legal world
- ✓ If an Audit Trail is requested, the produced document should meet ASTM Standards
- ✓ Identifying production of an Access Log when an Audit Trail was requested is valuable to your attorney clients
- ✓ Audit Trails are a query of the metadata that is collected in the background of the EHR
- ✓ Can be beneficial to both Plaintiff and Defense

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What are the Top 3 most utilized EHR systems in the US?

<https://powerpoint.ahaslides.com/slide/87825530>

100%
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- Meditech, Cerner, Allscripts
- Cerner, Epic, Allscripts
- Epic, Athena Health, Cerner
- Meditech, Cerner, Epic

What are the most widely utilized EHR systems?

MEDITECH

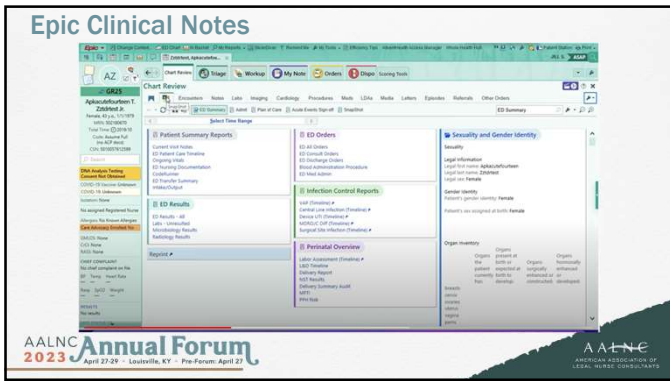
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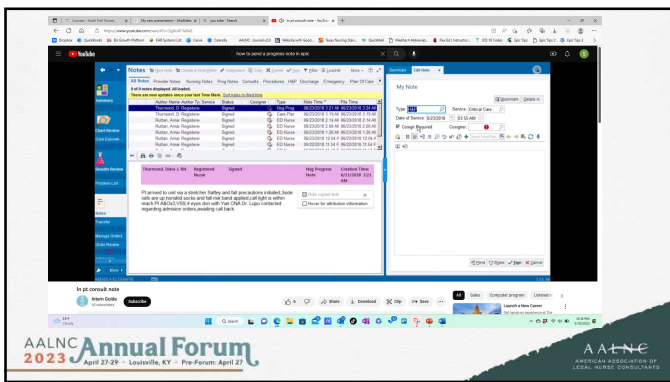
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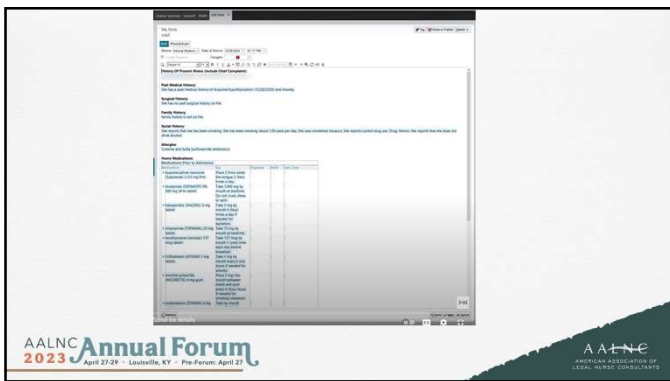
Epic General Overview

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Epic Red Flags....

- Pended notes that were not signed
- Pended notes that were signed weeks or months later
- In Basket Messages between defendants
- Abnormal or inconsistent behaviors in the EHR
- Key witnesses or defendants not listed in the audit trail
- Deletions related to the timeframe in question
- Deletions that involve the timeframe in question
- Abnormal signing actions

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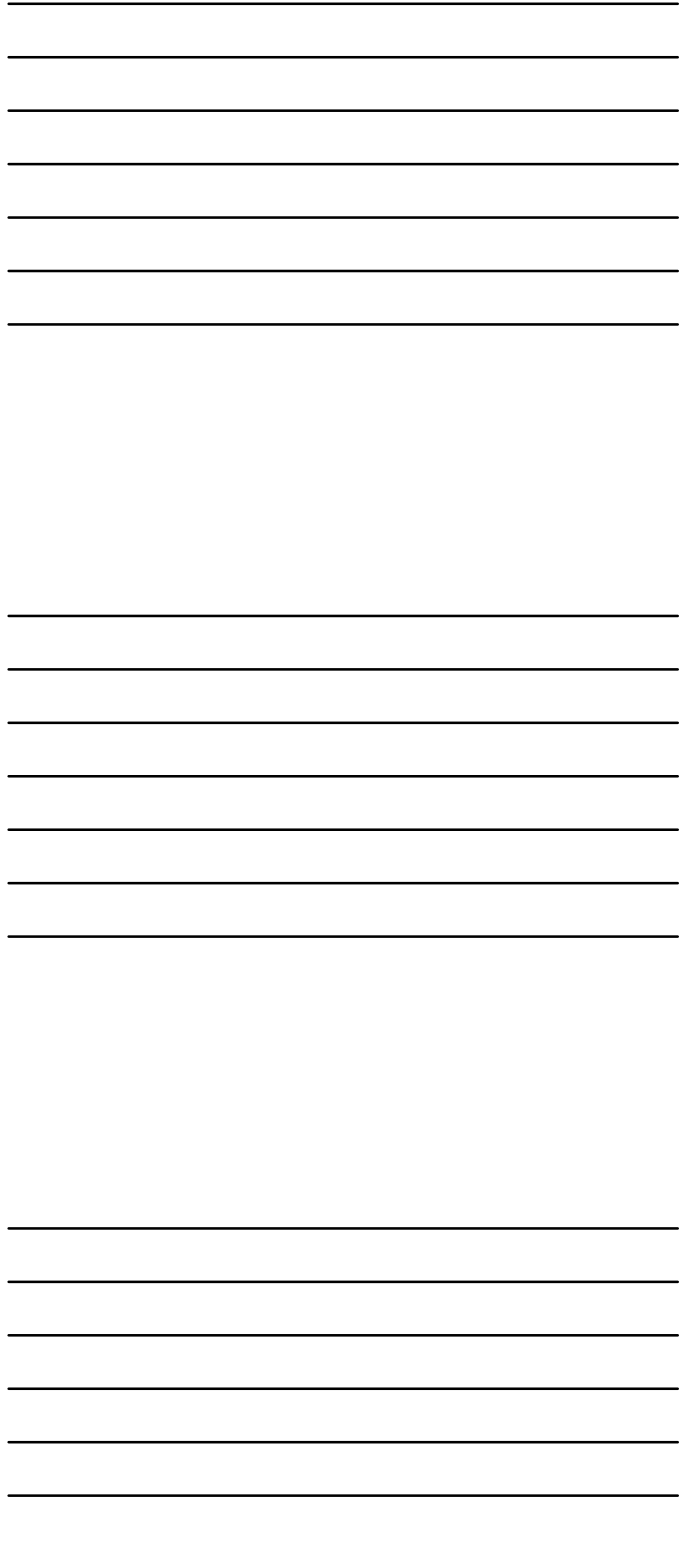
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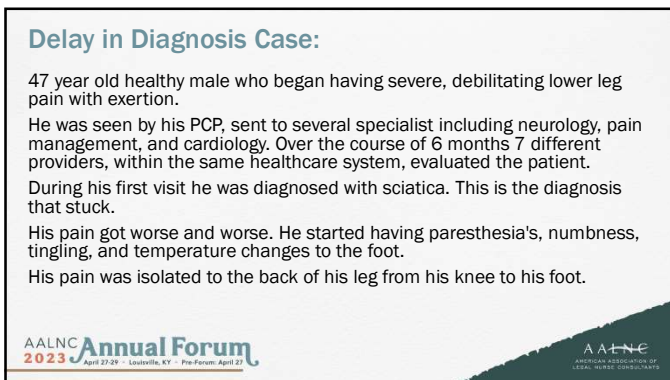
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070517-08-26	Chief Complaint	Admission HMP	TEST, Nurse Practitioner SQH	070517-08-26	TEST, Nurse Practitioner SQH
070517-08-26	Chief Complaint	Initial Daily Progress Note	TEST, Nurse Practitioner SQH	070517-08-26	TEST, Nurse Practitioner SQH
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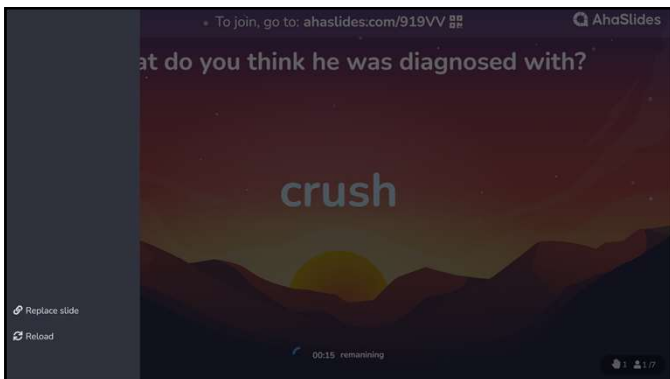
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Delay in Diagnosis Case:

Over the course of his treatment he was sent from provider to provider and ultimately diagnosed with chronic pain syndrome.
 His numbness, temperature change and pain continued to worsen.
 It took 3.5 months for any provider to order a doppler study or PT/PTT.
 Once the studies were done, the patient was found to have clots from his ankle to his groin.
 Surgical intervention was required and he now has long term complications with the possibility of amputation below the knee.

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So, what did the audit trail show?

- ❖ Disputed the claim by the providers that they viewed each others notes
- ❖ Corroborated testimony that the providers were aware of the visits with other providers
- ❖ Identified In Basket Messages between providers
- ❖ Disputed the one providers testimony that "he was not aware of the doppler results until he was notified of the case."
- ❖ Identified key changes in a providers note

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Surgical Case Review

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Surgical Case Review:

38 year old female who had a "Mommy Makeover" with laser treatments procedure at a freestanding surgical center. She is allergic to skin glue.

Post op she began to have intense pain to her surgical site. She stated she contacted the on-call provider and let them know about the pain.

She removed her bandages noticed what appeared to be a burn around her incision.

She reported she was spoke with the provider multiple times over the course of 1 week before she was seen in the clinic.

Wound care was initiated and was ongoing for 3 months with little to no improvement.

The wound care nurse discretely told the patient to go to the ER. The patient was found to be septic, was admitted to the ICU and underwent multiple procedures to debride the wound.





Surgical Case Review:

She suffered from a reaction to skin glue that was used during the procedure.

The primary surgeon denied using the skin glue and claimed his surgical assistant must have done it.

The surgeons operative note does not indicate any type of skin glue was used but the note was signed 3 months after the procedure.

Nursing documentation identifies the allergy to skin glue.

Nursing documentation done during the procedure indicates skin glue was used.



So what did the audit trail show?

- ❖ Alteration in records related to the skin glue allergy.
- ❖ Alteration in the operative note by the provider.
- ❖ Alteration in the nursing documentation.
- ❖ Staff messages sent months after the procedure which the facility refused to provide.

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Test Your Knowledge

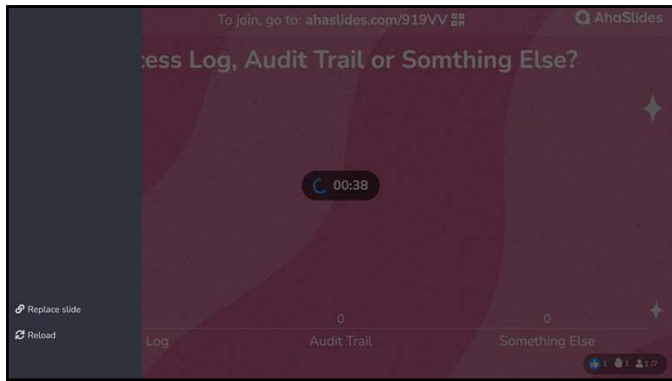
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Access Log, Audit Trail or Something Else

Timestamp (GMT)	Account By Name	Event	Event Area	Type	Encounter	Workstation	Associated Data
05/12/2017 09:34:41 AM	Pocket, Polly CMA	Report with patient data printed	11 apr 14.2		N/A	K3254FM03W58071	KS PREVIEW: SUMMARY REPORT viewed ADDENDUM Retrieved Data: Audited action: View Patient ID
05/12/2017 09:35:16 AM	Pocket, Polly CMA	Related encounters requested	Test View		Office Visit on 05/12/17	K3254FM03W58071	Brown, Charles [2009825] Report viewed
05/12/2017 10:15:13 AM	Birk, Big, MD	Patient Snapshot viewed	of data set of data of time of time		Office Visit on 05/12/17	K3254FM03W57880	PATIENT SNAPSHOT (HTML/CSS) [90008054] Report viewed
05/12/2017 10:16:10 AM	Birk, Big, MD	Patient Snapshot viewed			Office Visit on 05/12/17	K3754H402W58040	PATIENT SNAPSHOT (HTML/CSS) [90008054] Report viewed
05/12/2017 11:52:07 AM	Birk, Big, MD	Patient Snapshot viewed			Office Visit on 05/12/17	K3754FM03W58108	PATIENT SNAPSHOT (HTML/CSS) [90008054] Chart Review: Tab Made [90008054]
06/02/2017 08:30:35 AM	Monster, Cookie, MD	Chart Review Medications tab selected	Medications	View	N/A	K3754FM03W58108	Chart Review: Tab Made [90008054]
07/12/2017 10:46:19 AM	Monster, Cookie, MD	Chart Review Medications tab selected	Medications	View	N/A	K3254FM03W57883	Chart Review: Tab Made [90008054] Order ID Imaging ordered on 07/12/17 - MR

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Access Log, Audit Trail or Something Else

EDMS Encounter Events

Patient	Data/Time	Event	Event Info	Logged by	Workstation
	Tue Aug 13 04:30:03 2019	Encounter Creation			BVE022
	Tue Aug 13 04:30:49 2019	Responsible Dept Assignment	Automatic - Unassigned		BVE022
	Tue Aug 13 04:30:49 2019	Patient Arrival			BVE022
	Tue Aug 13 04:30:49 2019	Patient Move	Waiting		BVE022
	Tue Aug 13 04:30:49 2019	Bed Assignment	27		BVE022
	Tue Aug 13 04:30:49 2019	Patient Move	27		BVE022
	Tue Aug 13 04:30:49 2019	Responsible Dept Assignment	Automatic - Acute		BVE022
	Tue Aug 13 04:30:49 2019	Chief Complaint Modified	Rhabeto Transfer		BVE022
	Tue Aug 13 04:34:22 2019	Medical Exam	Emergent		BVE0P3
	Tue Aug 13 04:37:52 2019	Patient Visited	27		BVE0P3
	Tue Aug 13 04:38:30 2019	Triage Complete			BVE022
	Tue Aug 13 04:38:30 2019	Acuity Assignment	3-Urgent		BVE022
	Tue Aug 13 04:38:30 2019	Method of Arrival Changed	EMS/Acadian		BVE022
	Tue Aug 13 04:38:22 2019	Vital Signs Modified	Abnormal Values present		BVE022
	Tue Aug 13 04:40:57 2019	IHS Merge Complete			BMREDR19RANT
	Tue Aug 13 04:40:57 2019	Vital Signs Modified	Abnormal Values present		BVE020

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