Navigating electronic records has added another dimension of challenge and intrigue to developing legal cases. In the course of her legal work in multiple states, handling hundreds of different patient’s records in many different formats, Ms Jackson was forced to develop methods to obtain, then manage these records, in order to make them accessible and useful to the legal team. She hopes to share some techniques she has developed over the past decade of handling EHRs.

This presentation aims to address topics relevant to firms dealing with the challenges of obtaining and navigating electronic health records in acute care facilities, nursing homes, physicians’ offices ... and hopes to answer some of the questions that makes the evolution to EHR so difficult, such as:

- What is the current status of the statutory mandates for health facilities to provide medical records to their patients and their advocates?
- What is a complete medical record?
- How much should you be paying for your clients’ records?
- Do you really need an audit trail, and if you do, how might you actually get one?
- What are your options when you do not get the records you need?
- Medical records then and now (differences between paper and electronic, why a printout of the EMR is not “the same” as the EMR itself, etc)
- What is audit information?
- How does auditing work?
- Statutory authority — why they keep audit info, what they have to keep, where it is kept
- Data storage v. Data Display — where the information really is and how this affects the types of experts you need
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- Experts you may need
- Documents you will need for the experts you hire and how to get those documents
- Common roadblocks and how to overcome them (is it complete? is it really an audit trail? objections)
- What does audit information look like (examples)
- Assorted case law and resources to review