

Erin Davis Shedd

Proponent Testimony on House Bill 172

House Health Committee

October 18, 2017

Chairman Huffman, Ranking Member Antonio and members of the House Health Committee, my name is Erin Davis Shedd. I'm Senior Assistant General Counsel at OhioHealth. OhioHealth is a family of nonprofit hospitals and healthcare facilities, including numerous physician practices, urgent cares, home health, hospice and other provider entities serving patients in central Ohio and surrounding counties. In my role with OhioHealth, I am the primary legal liaison for OhioHealth's information technology department, cybersecurity program, and marketing teams. I have also served as the primary legal liaison for Doctors Hospital in Columbus and for many of our other business units.

I am here today speaking on behalf of OhioHealth in support of HB 172 which proposes a change to R.C. § 3701.74, which is commonly referred to as the "medical records statute."

The existing statute was written in a health care environment where medical records were maintained in paper form. The current language and interpretation of the statute are (1) unworkable in the electronic medical record context, (2) inconsistent with the original intent of the statute, and (3) detrimental to patients and their care. Thus, we, along with other hospitals and providers, are asking for the changes proposed in HB 172 to align the statute with the current electronic medical record environment and the modern practice of medicine.

To demonstrate the need for the changes proposed in HB 172, let me give an example. A patient comes to the hospital medical records department asking for a copy of their medical record to take to a new primary care physician. Assume the patient has only been to the hospital once for a stroke followed by a 10-day stay in the ICU and step-down units.

In the paper record world, the physician would generally instruct the nurse which information and documentation is clinically relevant and should be maintained in the "medical record." When patients came to the hospital and requested a copy of their medical record, they would be provided with a copy of that paper medical record. Other documentation or information about the patient may have been maintained by the provider, but was not included as part of the "medical record." This is not to say that the information was not available to a patient or his or her litigator if requested, it was simply not automatically produced as part of the medical record.

Applying the existing statute and its recent court interpretations in the current electronic medical record world is unworkable. Electronic medical record systems maintain extraordinary amounts of patient information—significantly more information than is maintained in a paper record. Much of this information is duplicative or resides in the background (as so-called "metadata") and is simply not pertinent to patient care. Further, reducing the contents of an electronic record into a paper format to give to a patient is not as an easy task. Electronic record systems are not created in a way that contemplates printing the record for the patient. In fact, printing the entirety of an electronic medical record for a particular patient often ends up creating thousands of printed pages. Under the current statute, not only we would be required to print out the entire record contained in the electronic medical

record system (including these thousands of duplicative pages and pages of code that is indecipherable by most patients and providers), but we would also be required to print a copy of every piece of information maintained throughout the hospital pertaining to the patient.

For a stroke patient, this information could include hundreds of hours of EEG monitoring of brain activity and any other information stored on medical equipment during the patient's ICU stay, including smart pumps and other procedure equipment. For a 10-day stay, as in our example, the number of pages for EEG monitoring alone could reach the tens of thousands. The patient and his or her primary care doctor only need a summary of the relevant EEG findings and/or the portions of the EEG monitoring that show an abnormal reading or some other information of clinical importance. Instead, under the current statute and interpretation, our stroke patient could be walking out with thousands upon thousands of pages of information to give to the new primary care physician. This can significantly jeopardize the patient's care at the next stop in the treatment pathway. The new primary care physician could easily miss relevant information concerning the patient because the physician must sift through thousands of pages of totally irrelevant information. Alternatively, the new primary care physician may simply ignore the thousands of pages of documents and order a series of redundant tests, adding unnecessary expense to the patient and health care system.

In our experience, patients seeking their medical records under R.C. § 3701.74 don't want or understand this extraneous information. They want a readable version of their relevant clinical information to better understand their care and be able to share that information seamlessly with other providers.

If the legislation is passed and patients request their medical record under the revised statute, our hospitals' trained medical records department in conjunction with appropriate clinicians would determine what is needed for a "complete medical record." Based on this information, the hospital then would have a set policy defining what is included in the medical record. Then, when a patient comes to the hospital requesting a copy of his or her record, that person will walk away with a standard set of documentation including everything the patient needs to review or share about his or her medical stay to ensure transparency and appropriate transition of care to another provider. In addition, our hospitals have had and will continue to have a procedure for requests for information that is not part of the standard document set to allow patients and their representatives a way to get other appropriate information they might want or need about their stay.

In conclusion, we believe HB 172 provides a relevant update to the medical records statute to align with electronic capabilities while still providing patients with a valuable right of access to their medical information. This legislation will not undercut the ability of the patient to (1) have transparency into their care, (2) request specific information about their care that is not included in the standard "medical record" such as procedure equipment data and/or metadata, or (3) access any documentation that is discoverable in a litigation proceeding. Further, nothing in this bill alters the hospital's obligation under numerous other state and federal laws to maintain records about patients for many and varied purposes, including HIPAA. The intent of hospitals when providing medical records to patients has always been to ensure that patients walk away from their care with an easy-to-understand, manageable, comprehensive record of his or her stay. We believe the revisions proposed in HB 172 accomplish that goal, and we urge you to enact it.

Thank you for your time and consideration, I would be happy to answer any questions.