**Kim Thomas**

**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 Kim Thomas. I work as in-house legal counsel for Blanchard Valley Health System. Blanchard Valley is a non-profit, integrated independent health system based in Findlay, a small community in Northwest Ohio. Like many health care organizations, our organization is self-insured for professional liability (*i.e.*, medical malpractice), so the primary focus of my role is what is traditionally known as risk management. In this capacity, I have had the opportunity to spend a significant amount of time working with patients and their families in assisting with patient relations issues related to the service or clinical quality of medical care provided or providing explanations after adverse outcomes occur.

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

The current language and interpretation of R.C. § 3701.74 undercuts the original intent of the statute and is harmful to patients. 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.

You have already heard from other witnesses about the need for this bill, along with some examples of why the existing statute is unworkable in the current world of electronic medical records. I'd like to use the following example to further demonstrate the need for the changes proposed in HB 172. The most common request for medical records that we get from patients is to obtain a copy of their records in order to provide them to a new health care provider or to obtainthe results of a single test or procedure. I would like you to assume a patient, with a long term chronic illness who has been to our hospital multiple times for treatment, presents to the hospital's medical records' department asking for a copy of their medical record to take to a new primary care physician. In my experience, I can tell you that this patient does not anticipate receiving hundreds or even thousands of pages of documentation from the recent visits.

When we receive a patient medical record request at Blanchard Valley, we typically have a medical records' employee assist the patient to determine exactly what they are looking for in their generally voluminous medical record. Our patients are typically able to articulate what they are looking for when they are requesting their medical record. For example, the information most often sought by our patients are physicians' history and physical reports and discharge summaries, laboratory results, operation or procedural reports, and radiology reports. It is a very rare instance that a patient requests nursing notes, fetal heart monitoring strips, cardiac tracings, or other documentation from their medical record; however, a patient always has the right to select to receive more information.

Blanchard Valley's patient population is over fifty percent (50%) Medicare insured, which means that most of our patients are 65 years of age or older. My organization has found that our patients typically seek very specific information for a particular purpose. Because providing excellent customer service is important to us, we have found that our patients appreciate having an open dialogue about their medical

record and our commitment to ensuring they receive the relevant information for their transition of care or personal knowledge. We have also learned that our patients do not appreciate receiving reams of paper when they are only seeking limited information.

Unless the medical records statute is modernized to reflect the widespread adoption of electronic health records, processes such as the one I just described for working with patients to respond to their request for a copy of their record will not be permitted. Instead, the law would require us to provide patients with reams and reams of irrelevant information that will only confuse them and frustrate their new health care provider. This is true because, though electronic records are excellent for improvements in patient care, accuracy of record-keeping, and other reasons, they are not designed to be provided to patients – printing an electronic medical record results in pages upon pages of meaningless information and codes that do not mean anything to patients or providers. Electronic records are simply not conducive to being provided to patients in their entirety. It is absolutely vital for a provider to distill the electronic record into the clinically relevant information that has traditionally constituted the "medical record."

In our experience, patients seeking their medical records under R.C. § 3701.74 don't want or understand this extraneous information contained in the electronic record. They want to be able to walk away with a readable version of their relevant clinical information to better understand their care and be able to share that information seamlessly with other providers. As a hospital, we want our patients engaged in their medical care, not overwhelmed with reams of documentation that is not useful for their intended purpose.

If the legislation is passed and a patient requests their medical record under the revised statute, our hospital would be able to continue the collaborative process we've developed between patients and providers.

We believe HB 172 provides the flexibility for us to continue having a transparent dialogue with our patients that results in each patient receiving a comprehensive and understandable medical record.

In conclusion, we urge you to enact HB 172. Thank you for your time and consideration, I would be happy to answer any questions.