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Proponent Testimony on House Bill 172

House Health Committee

October 18, 2017

Good morning, Chairman Huffman, Ranking Member Antonio, and Members of the Committee.

My name is Jennifer Nelson Carney. I am a partner in the health care group of the Bricker & Eckler LLP law firm here in Columbus. In my practice, I represent hospitals on a variety of issues, including the numerous legal and operational issues associated with implementation and maintenance of electronic medical record systems.

I am here today speaking on behalf of the Ohio Hospital Association in support of H.B. 172, which proposes a change to R.C. § 3701.74, which is commonly referred to as Ohio's "medical records" statute.

The Revised Code currently defines "medical record" as data in any form that pertains to a patient's medical history, diagnosis, prognosis, or medical condition, that is generated and maintained by a health care provider in the process of the patient's health care treatment. This definition is very broad and allows no discretion by a health care provider to determine whether the information to be included in the patient's medical record is clinically relevant – such discretion is particularly important as providers have adopted electronic medical records.

When patient medical records existed only in paper form, it was relatively easy to capture all data generated in the course of a patient's care, as that typically included only the physician's notes and evaluation, lab and other test results, and perhaps a few images. However, as medical records have evolved from paper to electronic form, the current definition of medical record and its interpretation by the courts has become increasingly more burdensome and often unworkable.

Electronic medical records (EMRs) maintain enormous amounts of data, but not all of this data is relevant to the patient's medical condition or treatment; much of the data is redundant and/or unnecessary, but because it is easy for EMRs to maintain it, they do.

In addition, the medical equipment industry has continued to evolve, and the sophistication of a variety of electronic monitoring equipment amounts to another large category of data generated and maintained during a patient's care. Some of this data is obviously irrelevant and unhelpful, such as electronic coding data, but there is also extraneous data within the more traditional medical monitoring data. For example, electronic monitoring machines create volumes of records when recording "normal" activity. In the paper record world, a physician could review the activity and then simply note "normal cardiac activity" in the medical record and be done. In today's EMR world and under Ohio's current definition of medical record, if monitoring equipment generates and maintains that data, the data must be somehow made part of the patient's medical record.

Identifying all the data that is generated and stored somewhere in the hospital is a significant and time-consuming task.

The second hurdle for health care providers is to figure out how to extract the data for the patient. In the example given above, days of normal cardiac rhythms result in boxes and boxes full of paper (if the patient requests a paper copy) or huge electronic files that are difficult to transfer (if the patient requests an electronic copy), both of which are unwieldly and make it difficult and confusing for the patient or new treatment providers to find the information they need. Extracting all possible patient data from numerous sources would be extremely resource intensive and costly, and would yield information that is meaningless in the context of what patients desire to receive when requesting their "medical record."

Consider a typical patient request: a patient requests a copy of her medical record to take with her as she moves across the country to a new job. That patient believes this to be a relatively simple request – not a request that will take days, weeks - or even likely, months - to fulfill, nor a request that will result in ten boxes of paper or multiple disks of large electronic files that are too big to electronically transfer and are difficult to decipher. Inclusion of this extraneous data is not helpful to the patient.

Nor is it good for the patient's medical care. A bloated medical record makes it difficult for physicians and other clinicians to find the information they need. The medical record is first and foremost a clinical tool to enable clinicians to provide appropriate care to a patient. Note, the medical record has never been as a repository of all information concerning a patient; clinicians, by virtue of their training and experience, have always been in the best position to determine the clinically relevant information to be included in the medical record. It is crucial that clinicians are able to quickly find relevant data in order to make a diagnosis and create a treatment plan. Inclusion of irrelevant and unusable data in the record results in physicians wasting precious time sorting through the enormous amounts of information, and at worst, leads to clinicians missing vital data that is buried within the mass of information included.

In addition, the unnecessary delay in getting physicians the information they need potentially results in the running of tests, drawing labs, and taking images that have already been completed, simply because the physician cannot find the documentation in the enormous medical record. All of this leads to further delays and added costs to an already expensive health care system. In sum, neither patients nor clinicians are well served by the current definition of medical record.

All of this is why we need a new definition of medical record and one that is workable. The proposed definition, which allows for health care providers to designate any data pertaining to the patient's care as part of the medical record, makes good sense. This change makes clear that the content of the medical record relates to the clinical care of the patient, and that the medical record does not need to include information generated during the course of a patient's treatment which is not relevant to informing the clinical decision-making of providers. Instead, the proposed definition allows for interdisciplinary teams of health care providers to determine the contents of a medical record by considering what information provides insight as to the patient's medical history, care, and treatment.

Importantly, however, this change does not in any way limit the information available to a patient. Proposed section D(3) explicitly states that this definition does not limit the information that must be provided by a health care provider during litigation. And if a patient requests information not contained in their medical record (and unrelated to litigation), a hospital can certainly give that information to the patient.

The revised definition allows for a patient medical record that includes relevant patient data which is usable by physicians and other clinicians and is expected by patients.

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