JOHNS HOPKINS
UNIVERSITY & MEDICINE

TO: The Honorable Heather Bagnall, Chair
Health Committee

HB316
Unfavorable

FROM: Leslie Ford Weber
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RE: HB316 Confidentiality of Medical Records – Definition of Medical Record

Johns Hopkins opposes **HB316 Confidentiality of Medical Records - Definition of Medical Record**.

This bill would make a substantial change to Maryland's definition of a "medical record" by requiring hospitals and providers to treat any information recorded through written, electronic, audio, or video means as part of the official medical record rather than that which is entered into the paper or electronic health record (EHR) system.

Providers throughout Johns Hopkins use Epic as their EHR to contain information needed to support the patient's diagnosis and condition and justify the patient's care, treatment, and services. It does not include, for instance, business records such as staff schedules or food delivery logs.

The proposed concept would be nearly impossible to implement and would decrease the value of the medical record to both clinicians and patients.

Medical records are designed to document care and treatment of a patient, so patients can better understand their healthcare, and providers can share medical records with other providers for continuing care and treatment. The medical record is meant to be curated, not an unfiltered repository of tangentially related information, reflecting the final assessment and plan of care. Any knowledge-based field has innumerable steps between the initial collection of information and the final plan. In medicine, this includes communication with colleagues, referencing evidence-based texts, and using those steps to finalize the actual plan implemented for the patient. The rationale for arriving at a treatment plan should always be documented in the medical record, as it is today – including noting where other care teams have weighed in, but HB316 goes further to presume that all activity related to arriving at final assessment and plan is part of the legal medical record.

Impact on Patient Care and Safety

Historically and functionally, the medical record exists to: (1) document clinical care provided to a patient; (2) support continuity of care among providers; (3) serve as the basis for a legal and billing record of diagnosis and treatment; and (4) enable patient access to information relevant to their health. Quality patient care is dependent on the availability and quality of patient information. Including all the information contemplated by this bill will greatly increase the volume of documents and material

contained within a single medical record and will distract from what is most pertinent for clinical care and treatment.

For example, the following could be deemed medical records under the proposed language:

- Recorded phone calls regarding scheduling or other incidental matters;
- Messages between staff coordinating scheduling or transport;
- Security camera footage;
- Draft documentation or documentation by trainees;
- Research documentation;
- Raw, uninterpreted output from AI and other medical decision support tools;
- Communications containing incomplete or inaccurate information later clarified elsewhere; and
- Other meaningless operational or administrative communications that mention a patient incidentally.

Requiring both patients and treating providers to sift through thousands of pages of potentially insignificant communications to find information relevant to the treatment and clinical picture of the patient will lead to confusion by patients, misses of significant information by providers, and delays in the delivery of healthcare services.

Increased Litigation Risk Without Corresponding Patient Benefit

Including all electronic communications in the medical record would dramatically expand the volume of materials subject to mandatory release to patients and other health care providers outside of the context of litigation where rules of discovery govern disclosure of relevant business records. Such access could encourage patients in malpractice and regulatory actions to engage in "fishing expeditions" resulting in a chilling effect on rapid and candid communication that occurs between and amongst health care providers that are valuable and necessary for the treatment of the patient.

Importantly**,** patients would not benefit from access to raw internal communications that are speculative, incomplete, or inaccurate. Transparency is best served by clear, accurate clinical documentation.

Operational and Compliance Burdens

From a practical standpoint, the approach mandated by the proposed legislation would create unworkable compliance obligations. Some consequences of expanding the types of documentation that would need to be made part of the official medical record include:

- Every email, chat message, or internal note mentioning a patient could be construed as part of the medical record;
- Providers would struggle to determine retention, amendment, and access rights;
- It will be nearly impossible to store and share video and audio records through existing technical mechanisms, thus imposing expensive technical changes;
- It will dramatically increase the time needed to produce medical records, as well as the cost to produce and/or receive medical records without added value to the requestor; and
- Data retention requirements and costs would be astronomical, leading to a significant increase in costs to individual physicians, practice groups, and health systems that are not recoverable nor billable.

The Johns Hopkins Health System receives over 1,000 requests for medical records per day. Many of these requests are made through automated electronic mechanisms, such as health information exchanges and application programming interfaces (APIs). Given federal information blocking regulations, all medical records must be accessible through these automatic mechanisms, which means all of the information proposed to be added to the medical record must be in a centralized location and segmented by patient, so it can be sent electronically with no human involvement.

Requiring the culling of all of these separate systems and platforms would require dozens more staff, and Maryland limits what we can charge for medical record production, so this would all be at a huge financial burden (assuming it could even be done).

Requiring all of this documentation to be maintained centrally and produced with every request for "medical records" would be devastating from an operational and systems perspective and would divert time, resources, and funding away from patient care and toward administrative triage and legal risk management, not to mention would dramatically increase irrelevant questions and unnecessary concern from patients. This approach would also have an impact on the extent of information that would need to be made available in the patient portal and would detract patients and their proxies from being able to focus on the patient's healthcare needs.

Conflict with Federal Frameworks and Industry Standards

Federal law, including HIPAA, distinguishes between the *designated record set* (records used to make decisions about individuals), and internal operational, quality, and other materials.

Most healthcare compliance frameworks, accreditation standards, and EHR system designs rely on this distinction. A broader statutory definition would:

- Create inconsistency with federal law;
- Complicate multi-state operations; and
- Increase the risk of regulatory confusion and noncompliance.

This breadth creates substantial ambiguity about what must be retained as part of the medical record, what must be produced in response to patient requests or subpoenas, and what is privileged material and can be withheld. This presents significant challenges to consistent compliance application of this proposed definition across providers and health systems. No meaningful limiting principle exists in the proposed statutory text, exposing providers to compliance uncertainty and litigation risk.

Conclusion

Expanding the definition of "medical record" to include all electronic communications, video and audio records relating to a patient's health care, including quality improvement and health care operations activities, is a blunt and counterproductive solution. It undermines patient safety, erodes the purpose of the medical record, increases costs, and creates confusion and unnecessary concern, while offering little meaningful benefit to patients. Sound healthcare policy requires preserving a clear boundary between clinical care documentation and internal processes.

Accordingly, Johns Hopkins respectfully requests an **UNFAVORABLE** committee report on HB316. Thank you.