

Testimony of Ronald Buckman in favor (with recommendations) of Senate Bill 1201  
AN ACT CONCERNING PATIENT ACCESS AND CONTROL OVER MEDICAL TEST  
RESULTS.

Thank you to the legislators that raised the bill and the members of this committee for allowing me the opportunity to testify.

I am Ronald Buckman of Coventry. I am a practicing primary care physician. In my practice I have been using Electronic Medical Records since 2004. I am on the Boards of HITE-CT and eHealth-CT. I also serve on the NACCHO Public Health Informatics work group. I am here representing myself, the three physicians I practice with, and the approximately 12000 active patients registered with my practice that have chosen my partners and myself to advocate on behalf of their health and well being.

As you are aware, current laws and regulations in CT do not make it clear that patients have control over their own health information. All too often, I will have a patient with me in the office that had recently been to an emergency room or other physicians office where testing was done. Frequently, these patients were directed to follow up with me regarding those other visits. They assume that since they made the other provider or testing facility aware that I was their primary care physician and that the patient wanted me to have the information that I would have it. Unfortunately that almost never happens. Unless the original order specifies that other providers are to receive the information it is not available either in a timely manner or without a specific written release for that piece of information from the patient. This results in fractured, duplicative, inefficient and at its worst, bad care.

The purpose and intent of this bill, not reflected in the current language, should be to empower and authorize the patient (or their legal representative or guardian) to designate which providers, in addition to the ordering provider, should receive and/or have access to the test results ordered for the purposes of diagnosis, treatment or prognosis of such patient.

Additionally, the bill should authorize the patient (or their legal representative or guardian) to designate themselves as receiving and/or having access to their test results.

Changing the language of the bill to reflect this intent will give the people of CT the ability to control their own medical information and enable CT to receive millions of dollars in federal funds related to the meaningful use of Electronic Health Records.

# Draft Meaningful Use Criteria

<i>Stage 1</i>	<i>Stage 2</i>	<i>Stage 3</i>	
	one electronic note by a physician, NP, or PA	one electronic note by a physician, NP, or PA	etc.
(NEW)	30% of EH medication orders automatically tracked via electronic medication administration recording	80% of EH inpatient medication orders are automatically tracked via electronic medication administration recording	
<b>Engage Patients and Families in Their Care</b>			
Stage 1 Final Rule	Proposed Stage 2	Proposed Stage 3	Comments
Provide electronic copy of health information, upon request <b>(50%)</b>	Continue Stage 1	90% of patients have timely access to copy of health information from electronic health record, upon request	Only applies to information already stored in the EHR
Provide electronic copy of discharge instructions (EH) at discharge <b>(50%)</b>	Electronic discharge instructions for hospitals (which are given as the patient is leaving the hospital) are offered to at least 80% of patients (patients may elect to receive a printed copy of the instructions)	Electronic discharge instructions for hospitals (which are given as the patient is leaving the hospital) are offered to at least 90% of patients in the common primary languages (patients may elect to receive a printed copy of the instructions)	Electronic discharge instructions may include items like a statement of the patient's condition, discharge medications, activities and diet, follow-up appointments, pending tests that require follow up, referrals, scheduled tests
EHR-enabled patient-specific educational resources <b>(10%)</b>	Continue Stage 1	20% offered patient-specific educational resources online in the common primary languages	
(NEW <u>for EH</u> )	80% of patients offered the ability to view and download via the EHR's secure portal or the private and secure service of a business	80% of patients offered the ability to view and download via the EHR's secure portal or the private and secure service of a business	"Uniformly" implies HITSC should pick a single standard for human readable and a single standard for structured. Inpatient summaries

	2013 (HITSC to define; e.g., use of PDF or text)	(HITSC to define; e.g., use of CCD or CCR)	signs; diagnostic test results; clinical instructions; orders; future appointment requests, referrals, scheduled tests; gender, race, ethnicity, date of birth; preferred language; advance directives; smoking status
Provide timely electronic access (EP) <b>(10%)</b> ;	Patients have the ability to view and download (on demand) relevant information contained in the longitudinal record, which has been updated within 4 days of the information being available to the practice. Patient should be able to filter or organize information by date, encounter, etc. Data are available in a uniformly human-readable form by 2013 (HITSC to define; e.g., use of PDF or text).	Patients have the ability to view and download (on demand) relevant information contained in the longitudinal record, which has been updated within 4 days of the information being available to the practice. Patient should be able to filter or organize information by date, encounter, etc. Data are available in a uniformly structured form by 2015 (HITSC to define; e.g., use of CCD or CCR).	<p>“Uniformly” implies HITSC should pick a single standard for human readable and a single standard for structured.</p> <p>The following data elements are included: encounter dates and locations; reasons for encounters; providers; problem list; medication list; medication allergies; procedures; immunizations; vital signs; diagnostic test results; clinical instructions; orders; longitudinal care plan; gender, race, ethnicity, date of birth; preferred language; advance directives; smoking status.</p>
This objective sets the measures for “Provide timely electronic access	EPs: 20% of patients use the EHR’s secure portal or the private and	EPs: 30% of patients use the EHR’s secure portal or the private and	