

ALTERNATIVE LWG ISSUES LIST
July 28, 2006

- **Possible statutory/rule changes**
 - Clarify consent requirements
 - Define “current treatment”
 - Define “related health entities” (?)
 - Does definition of “provider” in 144.335 cover all parties that should be covered?
 - Cost of copy of medical record
 - Which state law controls when services are provided near a state border?
 - Minnesota Rules 9505.2175, subparts 3 and 5 need to be changed so that paper prescriptions and paper orders for medical equipment and supplies are no longer required (Medicaid program/DHS)
 - Can/should all laws (private sector and government) related to health records be consolidated in one place?
- **Liability issues**
 - Health Information Network/RHIO issues
 - How to organize the Health Information Network
 - How much data would the Health Information Network store
 - How would the Health Information Network identify patients who use an alias name?
 - How would the Health Information Network address cultures that don’t recognize a date of birth or other identifying data element
 - Standards for making “matches” between patient and health records (the “Bob Johnson” problem)
 - What centralized administrative services are provided through the ?
 - Only point to record(s)?
 - Would the Health Information Network translate electronic health record formats among providers?
 - Would health data flow through Health Information Network?
 - What access does an authorized user get?
 - How is user authenticated/credentialed?
 - Only to record locator service?

- Portion of electronic health record, possible through a provider portal (e.g., lab results, medications, etc.)
 - All of the electronic health record
 - Record issues
 - Who owns the record in a networked environment?
 - What does the record look like?
 - How do you restrict sharing to only relevant data/information?
- Audit logs
 - For electronic health record at provider
 - Log what? All disclosures? Some disclosures? More than HIPAA?
 - How long should logs be kept?
 - Accessible to patient?
 - How much monitoring for security purposes?
 - For Record Locator Service
 - Log what? All transactions? Some transactions?
 - How long should logs be kept?
 - Accessible to patient?
 - How much monitoring for security purposes?
- Release of records
 - Honor patient request to limit sharing?
 - At what level? By record? By portion of record? By provider?
 - Need written consent?
 - Reasonable alternatives – Uniform Electronic Transactions Act (chapter 325L). Others?
 - Use as documentation – prevent “he said, she said”
 - Use to help patient review and understand
 - Who can give consent?
 - How identify parent of a minor?
 - Situation where incapacitated adult – no one available to give consent
 - Does HER or Health Information Network compel the sharing of records?
 - Emergency situations

- Acceptance of another's determination of "emergency"
 - Patient risk versus organizational risk
 - Realistic, clear security measures
 - Reasonableness
- **Other issues**
 - Exercise of patient rights
 - Does implementation of EHR make it easier for patient?
 - Can patient access records of Provider A held by Provider B?
 - Patient education
 - How is patient education about EHR made meaningful?
 - How is patient education about EHR made manageable in terms of quantity?
 - Effective sanctions
 - Who disciplines inappropriate access to health records through the Health Information Network?
 - Should licensing boards have more involvement?
 - How is responsibility for misuse or unauthorized disclosure apportioned among providers?
 - Restitution for patient
 - Concerns with inappropriate or unauthorized disclosure
 - Discrimination
 - What proof is required?