

## SOLUTIONS AND OPTIONS FOR ADDRESSING PRIVACY AND SECURITY BARRIERS TO THE ELECTRONIC EXCHANGE OF HEALTH INFORMATION

### INTRODUCTION

In the initial phase of the Minnesota Privacy and Security Project, the Variations Work Group and the Legal Work Group spent a significant amount of time discussing and reviewing issues associated with the exchange of health information – both electronically and on paper. The Work Groups' activities included:

- Analyzing situational-based scenarios, which investigated organizations' policies, practices, and mechanisms for exchanging health information;
- Discussing privacy and security issues identified by organizations as part of their internal implementation of electronic health records;
- Describing privacy and security issues encountered when organizations have attempted to electronically exchange health information with other organizations;
- Examining current and emerging models of health information exchanges and identifying privacy and security concerns related to the exchange of information in these models; and
- Investigating thoroughly organizations' interpretation and implementation of Minnesota's patient consent requirements.

The Work Groups' activities revealed that the privacy and security concerns impeding the electronic exchange of health information are universal, overarching issues that impact all types of health care organizations and apply to all types of health information. Throughout all of the project's activities, the same issues were repeatedly identified as the major privacy and security concerns that represent serious impediments to advancing the automated, real-time electronic exchange of health information. Additionally, the impediments are the result of organizations not having any fully adequate mechanisms to address the issues/concerns.

The overarching privacy and security issues that must be solved to advance the automated, real-time electronic exchange of health information can be grouped into three general categories:

1. **The implementation of Minnesota's patient consent requirements within a health information exchange.** This issue has two parts. First, there are significant and irreconcilable differences in organizations' interpretations of Minnesota's patient consent requirements. These differences make it impossible for health care providers to agree on "when" and "how" patient consent is required. Second, the patient consent requirements were designed for the paper-based exchange of information or for early electronic data base systems and are not conducive to a real-time, automated electronic exchange of information. The Minnesota's patient consent requirements are particularly significant because they apply to all health information, to all health care providers, and to all exchanges of information, including treatment.
2. **Operational difficulties in first providing, and then limiting and monitoring external organizations' electronic access to patient data.** This issue is identified as one general issue, because it is a set of interconnected security problems that must be addressed concurrently to successfully implement a health information exchange. To give external health care providers

appropriate access to electronic health records and patient data, organizations need to address four security topics:

- a. Mechanisms to establish and maintain a list of individuals authorized to access patient data;
  - b. Methods to authenticate authorized individuals when accessing patient data;
  - c. Information system access controls and coordinated access control policies to limit authorized individuals' access to patient data appropriate to the individual's functions and needs; and
  - d. Mechanisms for coordinated auditing across organizations to identify authorized individuals who may have inappropriately accessed health information.
3. **Liability concerns with the inappropriate disclosure of patients' health information.**  
Health care organizations face liability from various sources for the inappropriate disclosure of patient data. Consequently, health care organizations are cautious in their approach to exchanging data. Health care organizations explicitly consider organizational risk as a factor in their decision to participate in a health information exchange. That is, they want to be confident that the health information exchange has appropriately addressed privacy/security issues to minimize their organization's liability from inappropriate disclosures of patients' data.

A complete discussion of these three privacy and security issues can be found in the project's first report titled, "*Privacy and Security Barriers to the Electronic Exchange of Health Information.*" A copy of the report is available at: <http://www.health.state.mn.us/e-health/mpsp/>

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### **OVERVIEW OF BARRIERS TO THE ELECTRONIC EXCHANGE OF PATIENTS' HEALTH INFORMATION CAUSED BY MINNESOTA'S PATIENT CONSENT REQUIREMENTS**

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Minnesota law requires patient consent for the release of health information even if the disclosure is to another health care provider for patient treatment and certain statutory exceptions are not met. Therefore, any health information exchange developed to facilitate the automated, real-time electronic exchange of health records between health care providers must address two fundamental issues:

1. When is patient consent required to disclose data to another health care provider for patient treatment?
2. How should patient consent be obtained?

These questions not only need to be addressed, but providers must agree on the answers for a health information exchange to succeed. If providers cannot agree when consent is needed, then they will not have a common foundation for agreeing on other essential issues such as:

- Determining the policies and procedures that health information exchange participants need to collectively implement to appropriately protect the privacy of patients' health information;
- Determining how Minnesota's patient consent requirements will be operationally implemented in the health information exchange to ensure that patients' desires are honored;
- Determining if any particular exchange of health information is appropriate and permitted under Minnesota law;

- Communicating with patients about the mechanisms that permit them to control the disclosure of their health information; and
- Explaining to patients when and how their health information can be disclosed.

In the project's examination of the two fundamental issues, it was clear that providers do not all have the same interpretation of existing statutory language. In particular, they do not agree on when consent is needed or how the consent should be obtained. Specifically, different interpretations of the following undefined terms and ambiguous concepts lead to fundamentally different interpretations of Minnesota's statutory requirements:

- Health Records - including whether or not patient identifying information part of a health record
- Medical Emergency
- Related Health Care Entity
- The appropriate application of Minnesota's patient consent requirements to a record locator service, which also requires a common understanding of the concept of a record locator service.
- Current Treatment as reference in Minnesota Statutes § 144.335, Subdivision 3a, (c)(1)
- The ability of a health care provider to rely on another provider's representation of having obtained patient consent to disclose health records – including mechanisms to transfer/share responsibilities and liability for patient consent between the disclosing and requesting providers

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## ANALYSIS OF SOLUTIONS AND OPTIONS FOR ADDRESSING BARRIERS CAUSED BY MINNESOTA'S PATIENT CONSENT REQUIREMENTS

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This portion of the report examines nine specific patient consent issues that impede health care providers' ability to achieve automated, real-time electronic exchange of health information to deliver patients the best possible health care. For each of the nine issues, the Patient Consent Subgroup identified options to reduce or eliminate the barrier. The Subgroup also described the advantages and disadvantages for each possible solution.

### Patient Consent Issue #1

*The term "Health Record" is not defined in Minnesota Statutes § 144.335.* The patient consent requirements in Minnesota Statutes § 144.335 give patients a measure of control over the disclosure of information contained in their health records. However without an agreed upon the definition or understanding of the content of a "health record," patients and health care organizations will not know or concur on what information patients can control. The inability to agree on what information is within patients' control results in disagreement about "when" and "how" patient consent is required to disclose/exchange patients' information. This disagreement has three practical considerations:

1. Different interpretations of the term "Health Record" leads to inconsistencies in patients ability to control their information;
2. Disagreement about what information requires patient consent makes it more difficult to properly automate the exchange of patients' information between health care providers; and

3. Disagreement about the definition of "Health Records" causes disagreement about whether or not patient consent is required to include information about the location of patients' health records in a record locator service.

A number of options were initially discussed to address this issue. The Patient Consent Subgroup considered the following two options in more detail as methods of addressing this issue:

**Patient Consent Issue #1 - Option #1: Leave the term "Health Record" undefined.**

By not defining the term "Health Record," this option continues the current practice in Minnesota. This option was considered because some Patient Consent Subgroup members questioned if the issues that arise from not having a definition are sufficiently serious to warrant developing a definition.

**Advantages of Option #1**

- This option is consistent with current practice in Minnesota and health care organizations would not need to modify their procedures to adapt to a new, explicit definition of the term "Health Record."
- The lack of a definition for the term "Health Record" has not created a significant barrier to the exchange of patients' health information for organizations using paper health records.
- In addition, not defining the term means that no decision needs to be made whether to include or exclude identifying information from the definition.

**Disadvantages of Option #1**

- Without a definition, it will be difficult to achieve consistency across health care organizations on the meaning and scope of the term "Health Records." This lack of consistency on patient consent makes it more difficult to properly automate the exchange of patients' information between health care providers.
- This option does not address inconsistencies in patients ability to control their information from different interpretations of the term "Health Record."
- This option does not help in determining if identifying information (e.g., name, address, date of birth and other non-clinical data) are part of a health record. This is an important issue because identifying information is needed to help health care providers to find the location of patients' health records. Likewise, it is anticipated that this issue will increase in importance as health care organizations form health information exchanges and need to develop mechanisms to locate patients' health records.
- Unless the term "Health Record" is clarified either through definition or other method, there will be on-going disagreement and confusion about how Minnesota's patient consent requirements apply to creation and use of a record locator service.

**Patient Consent Issue #1 - Option #2: Amending Minnesota Statutes, section 144.335, subdivision 1 by adding:**

"Health record" means any information, whether oral or recorded in any form or medium, that relates to the past, present, or future physical or mental health or condition of a patient; the provision of health care to a patient; or the past, present, or future payment for the provision of health care to a patient.

This option is an adaptation of the definition of the term "Health Information" in the HIPAA Privacy Regulations in 45 CFR 160.103.

#### **Advantages of Option #2**

- Health care organizations currently use this definition as part of their organizations' implementation of the HIPAA Privacy Regulations. Hence, organizations have experience in applying this definition in situations related to patient privacy.
- Health care organizations have general agreement about what information is covered by the term "Health Information" under the HIPAA Privacy Regulations. Therefore, this option would significantly reduce disagreement about what information is included, or contained in a "Health Record."
- Because the HIPAA Privacy Regulations provide some measure of consistency across states, this definition allows Minnesota to be more consistent with other states' definitions of health information and health records.
- Increased consistency and agreement on the meaning of the term "Health Records" supports the real-time, automated electronic exchange of health information, because it helps to clarify "when" and "how" patient consent is needed to exchange patients' information.
- This definition is generally consistent with the definition of "Health Record Information" in Minnesota Statutes 72A.491, Subdivision 10. which reads: *"Health record information" means personal information that: (1) relates to an individual's physical or mental condition, health history, or health treatment; and (2) is obtained from a health professional or health care institution, from the individual, or from the individual's spouse, parent, legal guardian, or other person.*

#### **Disadvantages of Option #2**

- Although this definition is consistent with HIPAA, the definition may not be consistent with the de facto definition of "Health Records" that health care organizations currently use in applying Minnesota's patient consent requirements.
- Health care organizations may need to modify some of their patient consent processes to ensure that the activities are consistent with this definition. The need to modify organizational processes would represent a cost to health care organizations.
- The broad and inclusive definition of health information in HIPAA is balanced by the ability to disclose health information for the purposes authorized in 45 CFR 164.512. Because Minnesota law does not provide the authority for the same purposes 45 CFR 164.512, this option may have unintended consequences affecting the releases authorized in 45 CFR 164.512. For example, under 45 CFR 164.512(2)(i), a health care organization can release the name, address, date of birth, etc. on a patient for the purposes of identifying or locating a suspect, fugitive, material witness, or missing person. Yet under this option, patient identifying information would be part of the health record and require patient consent to disclose. Thus, Minnesota law would be more stringent than HIPAA and health care organizations would need to follow Minnesota law and not disclose the information. This example is an example of an unintended consequence that is at odds with health care organizations current practices.

#### **Other Issues Related to Option #2**

- Under this definition, the type of information that would be included in a record locator service (e.g., patient identifying information and record location) would be considered a health record. Therefore unless there is a specific exception, patient consent would be needed to populate and/or use a record locator service or other index that facilitates the electronic exchange of patients' health information.

### **Patient Consent Issue #2:**

***The term "Identifying Information" is not defined in Minnesota Statutes § 144.335.*** It would be useful to define a set of non-clinical data elements (e.g., name, date-of-birth) that can be used to uniquely identify patients. Clearly, health care organizations need to be able to distinguish and uniquely identify their patients' records. Similarly when exchanging patients' health information between health care entities, it is critical to be able to uniquely identify patients to ensure that organizations are exchanging information about the same patient. The exchange of health information is only effective if the provider who needs the health information gets the data associated with the patient who needs the care. There are three specific reasons that it might be useful and/or beneficial to define the term "Identifying Information:"

1. It may be useful to exclude non-clinical, patient identifying information from the definition of the term "Health Record." This may help to avoid some of the unintended consequences described in Patient Consent Issue #1 - Option #2;
2. Non-clinical, patient identifying information is a critical to the ability to create and use a record locator service in a health information exchange and a definition would clarify what identifying information could be included in the record locator service (see also - Patient Consent Issue #6); and
3. It may be useful to have different consent requirement for patients' non-clinical identifying information and their clinical data.

The Patient Consent Subgroup considered the following two options as methods of addressing this issue:

#### **Patient Consent Issue #2 - Option #1: Amending Minnesota Statutes, section 144.335, subdivision 1 by adding:**

**"Identifying information" means the patient's name, address, date of birth, gender, parent's or guardian's name regardless of the age of the patient, and other non-clinical data which can be used to uniquely identify a patient.**

#### **Advantages of Options #1**

- This definition provide flexibility in the exact data elements to be used in identifying patients and meets the requirements of a record locator service within a health information exchange.
- Conceptually, the definition allows patients' identifying information to contain sufficient data elements to uniquely identify patients.
- This definition would be consistent with many potential methods of identifying patients across health care organizations.

#### **Disadvantages of Options #1**

- The inclusion of "other non-clinical data" may be considered too broad and vague. Patients could be concerned that this portion of the definition encompasses too much information.

- Health care providers often do not have, or collect, some of the information listed in the definition (e.g., parent or guardian information for adults).

#### Other Issues Related to Option #1

- A national patient identification number would be helpful in accurately and uniquely identifying patients and link them to their health records. This definition does not rely on a national patient identifier, but would be consistent with such an identifier.

#### Patient Consent Issue #2 - Option #2: Amending Minnesota Statutes, section 144.335, subdivision 1 by adding:

"Identifying information" means the patient's name, address, date of birth, gender, parent's or guardian's name regardless of the age of the patient, and a number from a government-issued identification card; driver's license or tribal identification card.

#### Advantages of Option #2

- This option provides a more definitive list of data elements that make up patients' identifying information than Option #1. The more definitive nature of this list allows patients to better understand what is considered "Identifying Information."
- The data elements that are included in this definition are not generally considered health/medical information.

#### Disadvantages of Option #2

- The inclusion of "a government issued identification card" may be considered too broad and would include government-issued numbers such as a Social Security number. Patients are generally concerned about the use of their Social Security number as a form of identification. Likewise, most health care organizations have stopped using Social Security number as an identifier in response to feedback from patients. However, this reference could be narrowed to be more selective about the types of government-issued identification.
- This definition may not allow patients' identifying information to contain sufficient data elements to uniquely identify patients.
- This definition may not have sufficient data elements to be consistent with many potential methods of identifying patients across health care organizations.

#### Other Issues Related to Option #2

- A national patient identification number would be helpful in accurately and uniquely identifying patients and link them to their health records. This definition does not rely on a national patient identifier, but would be consistent with such an identifier.

#### Patient Consent Issue #3:

*The term "Medical Emergency" is not defined in Minnesota Statutes § 144.335.* Patient consent for the release of health records is not currently required in a medical emergency where the provider, due to circumstances, cannot obtain the patient's consent. Utilizing this exception to Minnesota's patient consent requirements requires that health care organizations agree when a particular situation is a "medical

emergency." While health care organizations generally agree, there is some variation in organizations' assessment of situations. Some of the difference may be due to the fact that liability for the inappropriate disclosure of health information rests with the disclosing organization and the disclosing organizations are cautious about disclosing patients' health information without consent. Adding a definition to Minnesota's patient consent requirements would help clarify "when" this exception to patient consent is applicable.

A number of options were initially discussed to address this issue. The Patient Consent Subgroup considered the following three options in more detail as methods of addressing this issue:

**Patient Consent Issue #3 - Option #1: Leave the term "Medical Emergency" undefined.**

**Advantages of Option #1**

- o This option is consistent with current practice in Minnesota and health care organizations would not need to modify their procedures to adapt to a new, explicit definition of the term "Medical Emergency."
- o The lack of a definition for the term "Medical Emergency" has not created a significant barrier to the exchange of patients' health information for organizations using paper health records.

**Disadvantages of Option #1**

- o This option does help in resolving differences in those instances where health care providers do not agree if a situation is a medical emergency.
- o The lack of a definition for the term "medical emergency," may make it more difficult to articulate rules that automate the electronic exchange of patients' health information in medical emergencies.

**Other Issues Related to Option #1**

- o As noted in the introduction to this problem, current law places all liability for inappropriate disclosure on the disclosing provider. Therefore, variation in assessing a situation as a medical emergency can often be because of a reluctance to rely on a third party's determination that a medical emergency exists. This definition does not address a disclosing providers' ability to rely on another providers' determination that a medical emergency exists. Likewise, this option does not address any documentation requirements for the determination of a medical emergency that would provide accountability and a record if the determination is later challenged.

**Patient Consent Issue #3 - Option #2: Amending Minnesota Statutes, section 144.335, subdivision 1 by adding:**

"Medical emergency" means medically necessary care which is immediately necessary to preserve life, prevent serious impairment to bodily functions, organs, or parts, or prevent placing the physical or mental health of the patient in serious jeopardy.

This definition comes from Minnesota Rules 4685.0100, Subpart 5(A), which relates to the regulation of health maintenance organizations.

**Advantages of Option #2**

- This definition is very consistent with the implicit definition that many health care providers use today in determining if a situation is a medical emergency. Therefore, this option would not require significant changes in health care providers' activities.
- A common definition for the term "Medical Emergency" may help to eliminate variation in standards people apply in determining if a situation is a medical emergency, which would help to facilitate and automate the electronic exchange of patients' health information in medical emergencies.
- This definition leaves the physician, or other health care provider, with the responsibility of exercising their judgment and determining whether or not a medical emergency exists.

#### **Disadvantages of Option #2**

- This definition may not fully resolve variations in health care providers' assessment of situations as emergencies. It is possible that health care providers may not agree on whether or not a situation is a "serious impairment."
- Some Patient Consent Subgroup members questioned whether any definition that allows health care providers to exercise their judgment could result in agreement about whether or not particular instances are medical emergencies.

#### **Other Issues Related to Option #2**

- As noted in the introduction to this problem, current law places all liability for inappropriate disclosure on the disclosing provider. Therefore, variation in assessing a situation as a medical emergency can often be because of a reluctance to rely on a third party's determination that a medical emergency exists. This definition does not address a disclosing providers' ability to rely on another providers' determination that a medical emergency exists. Likewise, this option does not address any documentation requirements for the determination of a medical emergency that would provide accountability and a record if the determination is later challenged.

#### **Patient Consent Issue #3 - Option #3: Amending Minnesota Statutes, section 144.335, subdivision 1 by adding:**

"Medical emergency" means that immediate medical care is needed to prevent death or a substantial and irreversible impairment of a major bodily function.

This definition is adapted from Indiana Code 16-34-2-1.2.

#### **Advantages of Option #3**

- This definition provides reasonably clear criteria for determining if a situation is a medical emergency.

#### **Disadvantages of Option #3**

- This definition is not very consistent with the implicit definition that many health care providers use today in determining if a situation is a medical emergency. Therefore, this option would require significant changes in health care providers' activities.
- The definition would classify fewer situations as medical emergencies than the implicit definition currently used by most health care providers. Making this exception to patient consent more restrictive may negatively impact health care providers' ability to deliver care.

- Some Patient Consent Subgroup members questioned whether any definition that allows health care providers to exercise their judgment could result in agreement about whether or not particular instances are medical emergencies.
- This definition does not address a disclosing providers' ability to rely on another providers' determination that an emergency exists.

### **Other Issues Related to Option #3**

- As noted in the introduction to this problem, current law places all liability for inappropriate disclosure on the disclosing provider. Therefore, variation in assessing a situation as a medical emergency can often be because of a reluctance to rely on a third party's determination that a medical emergency exists. This definition does not address a disclosing providers' ability to rely on another providers' determination that a medical emergency exists. Likewise, this option does not address any documentation requirements for the determination of a medical emergency that would provide accountability and a record if the determination is later challenged.

### **Patient Consent Issue #4:**

*The term "Related Health Care Entity" is not defined in Minnesota Statutes § 144.335.* Another exception to the patient consent requirements exists when health information needs to be disclosed to a "related health care entity." This exception generally allows multi-provider and multi-site health care organizations to release patients' health information to various providers and facilities within the organization as patients receive care from different providers and locations. While the term is not defined in Minnesota Statutes, most health care providers interpret the term to mean organizations owned, operated or controlled by the same legal entity. However, many providers have suggested other interpretations such as:

- Health care entities that have a contractual relationship are related health care entities; or
- Health care entities that share employees are related health care entities.

Again, the inability for providers to clearly agree on the definition of "related health care entity," means that they cannot clearly agree on "when" patient consent is required for the release of patients' health information. The Patient Consent Subgroup considered the following two options as methods of addressing this issue:

#### **Patient Consent Issue #4 - Option #1: Amending Minnesota Statutes, section 144.335, subdivision 1 by adding two definitions:**

"Affiliate" has the meaning given in section 144.6521, subdivision 3(b).

"Related health care entity" means an affiliate of the provider releasing the health information.

#### **Advantages of Option #1**

- This definition is consistent with the implicit definition for the term "Related Health Care Entity" currently used by most health care providers. Therefore, this option would not require significant changes in health care providers' activities.
- This definition is clear, understandable and built on existing Minnesota law.

- This definition helps to ensure patients' privacy protections because it limits the ability to disclose patient information under this exception for patient consent. Under this definition patients' health information can only be released among providers who are commonly controlled.
- By adding clarity to the meaning of the term "Related Health Care Entity," this definition would increase agree on "when" patient consent is needed to disclose/exchange patients' health information. This clarity would help in two ways. First, it would help to facilitate and automate the electronic exchange of patients' health information. Second, it would help patients to better understand "when" and "how" they can exercise some control over their health information.
- Some Patient Consent Subgroup members believe that the legislative history related to this issue indicates that the Legislature intended this exception to cover situations where there was some common control among the parties exchange patients' information. Hence, this definition may be consistent with the original legislative intent.

#### **Disadvantages of Option #1**

- For health care providers that use a more expansive definition of the term "Related Health Care Entity," this definition would require significant changes in health care providers' activities.

#### **Patient Consent Issue #4 - Option #2: Amending Minnesota Statutes, section 144.335, subdivision 1 by adding:**

"Related health care entity" means any person that has a contractual relationship with a provider.

#### **Advantages of Option #2**

- This definition is a more expansive definition that would permit patients' health information to be exchanged in more situations without patients' consent. This may be helpful in ensuring that health care providers have the necessary health information to deliver appropriate care to patients.
- This definition is consistent with patients' expectations that an admitting physician, who is not a hospital employee, gets information on the patient's hospitalization. However, there may be other portions of Minnesota's patient consent requirements that accomplish the same purpose.
- This definition could make it easier and less expensive for health care organizations' implementation of Minnesota's patient consent requirements, because this more expansive definition would require organizations to document and track fewer patient consents.

#### **Disadvantages of Option #2**

- This definition is not consistent with the implicit definition for the term "Related Health Care Entity" currently used by most health care providers. Therefore, this option could require significant changes in health care providers' activities.
- This definition potentially reduces patients' ability to control the disclosure/exchange of their health information, because contractual relationships between providers could be established to avoid obtaining patients' consent to disclose health information.

- Some Patient Consent Subgroup members believe that this definition yields more opportunities for the inappropriate disclosure and possible abuse of patients' health information, because contractual relationships between providers could be established to avoid obtaining patients' consent.
- Some Patient Consent Subgroup members believe that the legislative history related to this issue indicates that the Legislature intended this exception to cover situations where there was some common control among the parties exchange patients' information. Hence, this definition may not be consistent with the original legislative intent.
- Contractual relationships between providers can be established or dissolved at any time. So while this definition adds clarity to the term "Related Health Care Entity," it may not help patients understand "when" and "how" they are able to control their health information.

#### **Patient Consent Issue #5:**

***Long term care providers have situations where a patient's health information is needed to deliver appropriate care, but it is impossible to obtain the information because the patient is physically or mentally unable to provide consent for the health information to be released to the long term care facility.*** This issue is linked to Patient Consent Issue #4 because many long term care providers have suggested that the term "Related Health Care Entity" should have a more expansive definition in order to address a specific need of long term care facilities. Specifically, long term care providers often need to transfer residents to a hospital for treatment or emergency care. When it is time for the patient to be released from the hospital and return to the long term care facility, the patient's consent is needed for the hospital to provide the long term care facility with health information necessary for continuing care. However, as many as 40% of long term care facility residents suffer from varying degrees of dementia and are incapable of providing consent for the release of health records. Yet, the long term care facility cannot deliver appropriate care without receiving the patient's health information.

During Patient Consent Subgroup meetings, it was suggested that this issue could be better addressed directly, rather than through the definition of the term "Related Health Care Entity." The following option reflects the subgroup's discussion of this issue:

#### **Patient Consent Issue #5 - Option #1: Amending Minnesota Statutes, section 144.335, subdivision 3a as follows:**

(b) This subdivision does not prohibit the release of health records:

(1) for a medical emergency when the provider is unable to obtain the patient's consent due to the patient's condition or the nature of the medical emergency; or

(2) to other providers within related health care entities when necessary for the current treatment of the patient; ;

(3) to a health care facility licensed by this chapter, chapter 144A, or to the same types of health care facilities licensed by this chapter and chapter 144A that are licensed in another state when a patient:

(i) is returning to the health care facility and who is unable to provide consent; or

(ii) who resides in the health care facility has services provided by an outside resource under 42 CFR section 483.75(h) and is unable to provide consent.

#### Advantages of Option #1

- This option addresses the specific difficulties faced by long term care providers in trying to comply with both Minnesota's patient consent requirements and Minnesota's requirements related to delivering appropriate continuity of care. This option will help to ensure that long term care providers are able to obtain patients' health information in order to appropriately deliver care.
- This option addresses cross-border situations by including long term care facilities licensed in other states.
- This option's exception to needing patient consent is limited to situations where the patient is unable to provide consent. Therefore, patients with the physical and mental ability to provide consent retain the ability to exercise control over their information.
- This option is also limited in that it clearly indicates who information may be released to without consent.

#### Disadvantages of Option #1

- This option could be clearer about the meaning of "unable to provide consent." Specifically, does this phrase mean unable to provide consent in the professional judgment of the provider disclosing the health information? Also, is specific documentation needed to note patients' inability to provide consent?
- This language could be used to avoid obtaining consent from a health care agent under a health care power of attorney.

#### Patient Consent Issue #6:

*The term "Record Locator Service" is not defined in Minnesota Statutes § 144.335.* When a health care provider needs to obtain a patient's health information from other providers, their first task is to locate those providers who have the pertinent information. A health information exchange requires some method of locating patients' health information. One seemingly simple method of locating health records is to ask patients to identify the location of their health information. However, there are situations when the patient cannot be of assistance. The patient may be unconscious, not physically present, or unable to accurately remember where health care has been received in the past.

Given that patients may be unable to correctly and effectively identify the location of their records, many health information exchanges contemplate the use of some type of record locator service. A record locator service functions as an index or card catalog for patient records; the record locator service stores sufficient identifying information to uniquely identify each patient and provides pointers to the locations of patients' health information. The record locator service only contains the identifying information necessary to assist providers in finding the location of all pertinent health information; it does not contain the patients' clinical data.

Because a record locator service does not contain clinical data - other than clinic name - there is disagreement about "how" Minnesota's patient consent requirements apply to the information in a record

locator service. To resolve these disagreements and to facilitate electronic health information exchange, it is necessary to:

1. Define the concept of a record locator service;
2. Determine what identifying information can be included in a record locator service (see also – Patient Consent Issue #2); and
3. Clarify if and how Minnesota's patient consent requirements apply to a record locator service.

The Patient Consent Subgroup considered the following two options as methods of addressing this issue:

**Patient Consent Issue #6 - Option #1: Amending Minnesota Statutes, section 144.335, subdivision 1 by adding:**

"Record locator service" means an electronic index of patient identifying information that directs participants in a health information exchange to the location of patient health records held by providers as defined in section 144.335, subdivision 1(b) and group purchasers as defined in section 62J.06, subdivision 6.

This option also assumes that the term "Identifying Information" has been added to Minnesota Statutes § 144.335, Subdivision 1.

**Advantages of Option #1**

- o This definition is flexible enough to encompass a variety of different models for a record locator service, including different data elements to be used as identifying information. This definition is linked to the possible definitions of "Identifying Information" described in Patient Consent Issue #2.
- o This definition limits the information that can be included in a record locator service to non-clinical, patient identifying information and the location of the health record. By not including clinical data in the record locator service, this definition helps to protect patients' privacy and limit the possibility of inappropriate disclosures of patient health information.
- o This definition of the term limits its use to participants in a health information exchange.
- o This definition allows the record locator service to point to health records held by providers, as well as health records held by group purchasers (e.g., health plans). By including both providers and group purchasers this definition would point to a more complete set of health information. It is necessary to include group purchasers to get a complete health record, because health plans have more complete records than health care providers in some areas (e.g., medication history).

**Disadvantages of Option #1**

- o Even though this definition does not include clinical data in the record locator service, it is possible that simply identifying the name of the clinic could reveal health information about a patient (e.g., mental health or substance abuse treatment facility).
- o This definition is limited to Minnesota providers and group purchasers. This limitation may have a negative effect on patients living near Minnesota's borders because care may be delivered across state lines. If the definition is broadened to include providers in other

states, there is no guarantee that the other states have the same privacy protections for information in a record locator service.

- This definition does not clearly include some entities that would have health records that may be useful for providers treating patients. Specifically, there may be other types of health care providers than those defined in Minnesota Statutes § 144.335, Subdivision 1. The definition of provider under HIPAA would include other types of providers not included in this definition. Similarly, some governmental entities, such as the Department of Health, may not be covered by this definition.
- Allowing a record locator service to identify the location of health records held by group purchasers may foster suspicion or concern with patients, because group purchasers hold patient information beyond that information needed for treatment. However, this disadvantage is reduced by the fact that this definition does not include clinical data in the record locator service.

**Patient Consent Issue #6 - Option #2: Amending Minnesota Statutes, section 144.335, subdivision 1 by adding:**

"Record locator service" means an electronic index of patient identifying information that directs participants in a health information exchange to the location of patient health information held by providers as defined in section 144.335, subdivision 1(b).

This option also assumes that the term "Identifying Information" has been added to Minnesota Statutes § 144.335, Subdivision 1.

**Advantages of Option #2**

- This definition is flexible enough to encompass a variety of different models for a record locator service, including different data elements to be used as identifying information. This definition is linked to the possible definitions of "Identifying Information" described in Patient Consent Issue #2.
- This definition limits the information that can be included in a record locator service to non-clinical, patient identifying information and the location of the health record. By not including clinical data in the record locator service, this definition helps to protect patients' privacy and limit the possibility of inappropriate disclosures of patient health information.
- This definition of the term limits its use to participants in a health information exchange.
- By not allowing a record locator service to identify the location of health records held by group purchasers, this definition may help to alleviate patients' suspicion or concern about non-treatment, patient information held by group purchasers.

**Disadvantages of Option #2**

- Even though this definition does not include clinical data in the record locator service, it is possible that simply identifying the name of the clinic could reveal health information about a patient (e.g., mental health or substance abuse treatment facility).
- This definition allows the record locator service to point to health records held by only providers. By limiting this definition to just providers, the record locator service would

point to a less complete set of health information. It is necessary to include group purchasers to get a complete health record, because health plans have more complete records than health care providers in some areas (e.g., medication history).

- This definition is limited to Minnesota providers. This limitation may have a negative effect on patients living near Minnesota's borders because care may be delivered across state lines. If the definition is broadened to include providers in other states, there is no guarantee that the other states have the same privacy protections for information in a record locator service.
- This definition does not clearly include some entities that would have health records that may be useful for providers treating patients. Specifically, there may be other types of health care providers than those defined in Minnesota Statutes § 144.335, Subdivision 1. The definition of provider under HIPAA would include other types of providers not included in this definition. Similarly, some governmental entities, such as the Department of Health, may not be covered by this definition.

### **Patient Consent Issue #7:**

*It is unclear if patient consent is needed to place data (i.e., identifying information and provider name) in a "Record Locator Service."* Health care providers have traditionally collected, maintained, and exchanged patients' health records in a paper format, and the concept of a record locator service was never developed. Now that providers are looking to develop electronic, health information exchanges capable of automated, real-time information exchange, there is a need to automate the process of identifying the location of patients' health information through a record locator service. However, because the concept of a record locator service is new to electronic exchange, there is disagreement about how Minnesota's patient consent requirements apply to the implementation of a record locator service. That is, there is no agreement about "when" and "how" patient consent is needed to create and/or use a record locator service. This issue is also important to patients, because it determines "how" they are able to control disclosures of their identifying and health-related information.

The Patient Consent Subgroup considered the following three options as methods of addressing this issue:

#### **Patient Consent Issue #7 - Option #1: Amending Minnesota Statutes, section 144.335 with a subdivision that states:**

**Subd. Q. [Record Locator Service.] A provider [or group purchaser as defined in section 62J.06, subdivision 6] shall obtain consent to send patient identifying information and information about the location of the patient's health records to a record locator service. Consent from a patient to provide identifying information and information about the location of the patient's health records to a record locator service does not expire. The patient may revoke that consent at any time by providing written notice of the revocation to the provider [or group purchaser as defined in section 62J.06, subdivision 6].**

This option requires patient consent prior to sending information about the location patients' health records to a record locator service. This option also assumes that the terms "Record Locator Service" and "Identifying Information" have been added to Minnesota Statutes § 144.335, Subdivision 1.

#### **Advantages of Option #1**

- This option allows the patient to choose which providers may send information to a record locator service.
- This option would allow patients to know what information is included in the record locator service prior to information being included.
- This option continues to provide patients a measure of control over their information by requiring consent to include information and allowing that consent to be revoked at any time.
- By requiring that patient consent be obtained, this option gives providers an opportunity to inform and educate patients about the benefits of electronic health information exchanges and contributes to a broader understanding of health care reform. It also allows patients to be informed about the record locator service, the benefits of including information, and the risks of including, or not including, information in the record locator service.

#### **Disadvantages of Option #1**

- Under this option a health information exchange may not reach its full potential for improved patient treatment, because the record locator service is incomplete about the location of patients' health records. If the patient has not consented to information being sent to the RLS, then the location of the records will not appear and this would impede the ability of a provider to access those health records, particularly to an emergency.
- For patients who do not consent to information being included in a record locator service, important health information needed for treatment may not be able to be exchanged in real time; that is, providers would likely need to manually exchange patients' health records via paper. One of the advantages of electronic health information exchange is that it can facilitate the availability of needed health information at the time care is being delivered.
- The patient would have to give consent at each provider for information to be sent to the record locator service. Although this allows patients greater control, it places a greater administrative burden on both patients and the providers, because it requires more forms for patients to complete, more pages to read and more time to understand.
- The consent would have to specify who was participating in the health information exchange and using the record locator service. Hence, the patient consent would need to be written and mechanisms developed to handle changes in the organizations participating in the health information exchange to ensure that any changes in the health information exchange participants would not require that new consents be obtained.
- The patient consent process could create an operational burden for providers. Not only would the provider have to obtain the consent, it would have to be stored and records kept so that if a revocation occurs, the provider could take the appropriate action.
- Although requiring that patient consent be obtained gives providers an opportunity to inform and educate patients, it may be difficult for providers to explain a health information exchange and a record locator service in clear, understandable language.
- Under this option, information about the location of patients' health records is less available over the short term. If patients are required to provide consent before information is sent to the record locator service, the information will be filled in slowly

over time. This contrasts with having information about the location of patients' health records available if no consent is required.

- Depending on how the patient consent is drafted, there may be problems when two health information exchanges want to coordinate their activities.

**Patient Consent Issue #7 - Option #2: Amending Minnesota Statutes, section 144.335 with a subdivision that states:**

Subd. Q. [Record Locator Service.] A provider [or group purchaser as defined in section 62J.06, subdivision 6] may send patient identifying information and information about the location of the patient's health records to a record locator service without consent from the patient. Except in the case of a medical emergency, a provider participating in a health information exchange using a record locator service cannot access patient identifying information and information about the location of the patient's health records until the patient has provided consent. The consent does not expire and may be revoked by the patient at any time by providing written notice of the revocation to the provider [or group purchaser as defined in section 62J.06, subdivision 6].

This option allows participants in a health information exchange to construct a record locator service without patient consent, but limits a provider's ability to access information about a patient without obtaining the patient's consent, except in the case of medical emergencies. This option has the ability to include, or not include, information about the location of health records held by group purchasers. This option also assumes that the terms "Record Locator Service," "Medical Emergency" and "Identifying Information" have been added to Minnesota Statutes § 144.335, Subdivision 1.

**Advantages of Option #2**

- This option allows patients to choose which providers may access information about the location of their health records through a record locator service.
- In a medical emergency when the patient is unable to consent, health information about patients can be located because the record locator can be accessed in an emergency without patient consent.
- This option continues to provide patients a measure of control over their information by requiring consent for providers to access information contained in a record locator service and allowing that consent to be revoked at any time.
- Depending on the exact mechanisms used to implement this option within a health information exchange, it may be possible to allow patients to designate that a provider is only able to access a subset of information in the record locator service.
- Under this option, information about the location of patients' health records can be made available through a record locator service immediately. This option permits providers and group purchasers to send information to the record locator service as soon as they become participants in a health information exchange.
- This option continues to provide patients a measure of control over their information by requiring consent for providers to access information included in a record locator service and by allowing that consent to be revoked at any time.

- This option provides an efficient mechanism for provider participating in a health information exchange to create a record locator service, because patient consent does not have to be obtained, tracked or managed to place information in the record locator service. While consent is needed to access the information, that consent does not expire and the operational burden of recordkeeping is reduced.
- There may be fewer problems when two health information exchanges want to coordinate their activities, because this option allows patients to provide consent at the point of care.

#### Disadvantages of Option #2

- Patients' ability to control which providers include information in a record locator service is less than under Option #1. All providers and group purchasers send information to the record locator service and the patient is not be able differentiate which providers or group purchasers are sending information.
- This option may provide patients less opportunity to know what information is being included in a record locator service, because the information is being sent to the record locator service without the patients' consent.
- For patients who do not consent to allowing providers to access information included in a record locator service, important health information needed for treatment may not be able to be exchanged in real time; that is, providers would likely need to manually exchange patients' health records via paper. One of the advantages of electronic health information exchange is that it can facilitate the availability of needed health information at the time care is being delivered.
- Some patients may believe that their privacy has been reduced by the creation of a record locator service, which contains information about them. Thus even if a patient does not consent to allowing any providers to access the information, they may be concerned about the existence of the record locator service.
- Although requiring that patient consent be obtained gives providers an opportunity to inform and educate patients, it may be difficult for the provider to explain a health information exchange and a record locator service in clear, understandable language.

#### Patient Consent Issue #7 - Option #3: Amending Minnesota Statutes, section 144.335 with a subdivision that states:

Subd. Q. [Record Locator Service.] A provider [or group purchaser as defined in section 62J.06, subdivision 6] may send patient identifying information and information about the location of the patient's health records to a record locator service without consent from the patient. For treatment purposes, a provider may access patient identifying information and information about the location of the patient's health records in a record locator service without consent from the patient.

#### Advantages of Option #3

- This option is the most efficient manner of creating and using a record locator service, because there is no need to obtain, document, or track patients' consent.
- This option would give providers the most complete information about the location of their patients' records, because all providers and group purchasers participating in a health information exchange would be able to send information to the record locator service.

- This option clearly limits providers' use of the record locator service to treatment purposes, which could help to reduce concerns over the fact that consent is not needed to access the information in the record locator service.
- In a medical emergency when the patient is unable to consent, health information about the patient can be located because the record locator can be accessed without patient consent.
- There may be fewer problems when two health information exchanges want to coordinate their activities, because patient consent issues do not need to be addressed.

### **Disadvantages of Option #3**

- This option does not provide patients control over where their information is held or used.
- This option does not seem consistent with Minnesota' culture of protecting patient health related information. Current Minnesota law requires patients to consent for the disclosure of health information, yet these privacy protections are set aside when no consent from the patient is needed to send or access information in a record locator service.
- This option may provide patients less opportunity to know what information is being included in a record locator service, because the information in the record locator service is being sent and accessed without patients' consent.
- Because patient consent is not obtained, this option does not help facilitate providers in informing and educating patients about the benefits of electronic health information exchanges.

### **Patient Consent Issue #8:**

***The concept of "Current Treatment" in Minnesota Statutes § 144.335, Subdivision 3a (c)(1) is not uniformly interpreted and has a significant impact on "when" and "how" patient consent is needed to release health records.*** Minnesota Statutes, section 144.335, subdivision 3a, states that a patient's consent is valid for no longer than one year. However, the statute provides an exception to the one-year time limit in paragraph (c), where it states:

*(c) Notwithstanding paragraph (a), if a patient explicitly gives informed consent to the release of health records for the purposes and pursuant to the restrictions in clauses (1) and (2), the consent does not expire after one year for:*

*(1) the release of health records to a provider who is being advised or consulted with in connection with the current treatment of the patient;*

Almost all health care providers respond to this portion of the statutes in the same way. During a patient's initial visit, providers ask the patient to complete a general consent for the release of health records to providers who are being advised or consulted with in connection with the patient's current treatment. This general consent does not expire, but may be revoked at any time. Unfortunately, the statutes do not define or clarify the term "current treatment." Consequently, health care providers have adopted at least two different interpretations for the term with very different implications for when the general consent permits a health care provider to release health records to another provider.

Without agreement on the appropriate interpretation of section 144.335, subdivision 3a, (c)(1), it will be difficult to get widespread agreement on "when" and "how" patient consent is required within a health

information exchange. The wide spectrum covered by the providers' interpretations of "current treatment" means that Minnesota does not have a uniform foundation on which to build its electronic health information exchange efforts. This lack of a common foundation will complicate and delay the development of electronic exchange and create variability in patients' privacy protections.

The Patient Consent Subgroup considered the different interpretations to identify the advantages and disadvantages of each interpretation:

**Patient Consent Issue #8 – Interpretation #1:** This interpretation holds that the general consent permits the provider to disclose any health information at any time to any provider who is currently treating the patient. Any health information means information not covered by another law (e.g., substance abuse treatment data and genetic data).

This first interpretation reads subdivision 3a, (c)(1) as though the statute were written as:

~~(1) the release of health records to a provider who is being advised or consulted with in connection with the current treatment of~~ currently treating the patient;

#### Advantages of Interpretation #1

- Assuming that most patients will sign the general consent, this interpretation:
  - better facilitates the sharing of health information with any provider that is treating the patient.
  - is operationally easier to implement. The one-time general consent means that there would be fewer specific patient consents to document and track.
  - is more consistent with states along Minnesota's borders.
- This interpretation minimizes the consequences of differences that arise within the definitions of the terms "Medical Emergency and "Related Health Care Entity." The exceptions to needing patient consent that use the terms "Medical Emergency and "Related Health Care Entity" would not be needed for patients who have signed the general consent.
- This interpretation is consistent with some health care providers' current implementation of Minnesota's patient consent requirements.

#### Disadvantages of Interpretation #1

- This interpretation provides patients less detailed control over "when" and "how" their health information is disclosed.
- Patients may not remember all of the times that they have signed a general consent. This point is reinforced by the fact that patients frequently needed to be reminded when and where they signed a consent as part of treatment, particularly when their health information is disclosed to someone or somehow that they did not anticipate.
- Some Patient Consent Subgroup members believe that this interpretation would invite more restrictive statutory language and the need for more specific consents for the release of health information about sensitive conditions such as mental health conditions and HIV status. Other states have found that having many different statutory consent

requirements for various conditions is a barrier to electronic exchange of health information.

- This interpretation is not necessarily operationally easier to implement because it rests on the assumption that most patients will sign the general consent. If patients choose not to sign the consent, then providers will need to obtain specific consents for each disclosure of information. The need to obtain specific consents for each disclosure would be more difficult to implement.
- This interpretation provides the patient with less opportunity for understanding what health information is likely to be disclosed and to who the information is to be disclosed. Because the general consent covers any health information that a provider deems relevant to their current treatment of the patient, it is less likely that the patient know or remember what information may be released.

#### **Other Issues Related to Interpretation #1**

- The Patient Consent Subgroup had an additional discussion questioning the percentage of people that would sign the general consent. In general, most people currently sign the general consent, although it may be under either Interpretation #1 or Interpretation #2 – depending on the provider. Some Patient Consent Subgroup members believe that fewer people would sign the general consent if they were more empowered through education and better understood their ability to exercise more control over their health information.

**Patient Consent Issue #8 – Interpretation #2:** This interpretation holds that the general consent only permits the provider to disclose health records to other providers being advised or consulted in relation to the releasing provider's current treatment of the patient (e.g., for continuity of care or referrals).

This second interpretation reads subdivision 3a, (c)(1) as though the statute were written as:

**(1) the release of health records to a provider who is being advised or consulted with in connection with the releasing provider's current treatment of the patient;**

#### **Advantages of Interpretation #2**

- This interpretation provides patients more detailed control over "when" and "how" their health information is disclosed.
- This interpretation provides the patient with a better opportunity of understanding what health information is likely to be disclosed and to who the information is to be disclosed. Because the general consent covers only health information related to the releasing provider's current treatment of the patient, it is more likely that the patient understands what information is related to that current treatment.
- This interpretation would put less pressure on patients to remember all of the times that they have signed the general consent.
- Some Patient Consent Subgroup members believed that this interpretation would mean that additional statutory language for specific consents related to sensitive health conditions is less necessary/likely.
- This interpretation is consistent with some health care providers' current implementation of Minnesota's patient consent requirements.

**Disadvantages of Interpretation #2**

- This interpretation requires organizations to document and track more specific consents to disclose health information, because the general consent has a narrower scope.
- For organizations currently following Interpretation #1, this interpretation would require increased effort and cost to obtain and document patients' consent.
- This interpretation is less consistent with providers' ability to exchange health information in border states.
- This interpretation increases the importance of the definitions of the terms "Medical Emergency and "Related Health Care Entity." The exceptions to needing patient consent that use the terms "Medical Emergency and "Related Health Care Entity" would be needed more often because the general consent has a narrower scope.

**Other Issues Related to Interpretation #2**

- Some Patient Consent Subgroup members believe that Interpretation #2 may become easier to implement over time as electronic health record systems and data standards advance and support more sophisticated exchanges.
- As the exchange of health information moves from paper media to electronic media, there will be increased ability to track who has accessed patients' health data, when it was accessed and why. These increased tracking abilities may impact patients' feelings about how and when they want to provide consent.

**Patient Consent Issue #9:**

***Minnesota law does not provide a mechanism or framework for a provider to rely on another provider's representation of having obtained patient consent to disclose health records.*** One mechanism that could help facilitate the automated, real-time electronic exchange patients' health information while maintaining patient consent would be a mechanism/framework that allows patients to provide consent through the requesting provider at the point of service. That is, the patient consent requirements would allow the disclosing provider to automatically and electronically exchange patients' health information to the requesting/treating provider based on the requesting provider's representation of having obtained the patient's consent.

To address this issue, Minnesota law would need to provide a framework and mechanism to transfer/share responsibilities and liability for patient consent between the disclosing and requesting providers. For example, Minnesota law could permit health records to be exchanged when a requesting provider obtains the patient's consent and then communicates to the disclosing provider that it has appropriate patient consent for the information being requested. There may be multiple mechanisms to transfer the responsibilities and liability between the disclosing and requesting provider, but options should minimally address:

1. When a provider disclosing health records may rely on a requesting provider's representation of having obtained patient consent for the requested health records;
2. The responsibilities of a provider requesting health records when a request for health records is based on the representation of having obtained appropriate patient consent;
3. The liability of a disclosing provider for having released records based on a requesting provider's misrepresentations of having obtained patient consent; and

4. The liability of a requesting provider for misrepresenting that the provider had obtained patient consent when requesting health records.

The Patient Consent Subgroup considered the following two options as methods of addressing this issue:

**Patient Consent Issue #9 - Option #1: Leave the liability-related portions of Minnesota's patient consent requirements unchanged.** This option would simply leave Minnesota Statutes § 144.335 Subdivision 3a, (e) as:

(e) A person who negligently or intentionally releases a health record in violation of this subdivision, or who forges a signature on a consent form, or who obtains under false pretenses the consent form or health records of another person, or who, without the person's consent, alters a consent form, is liable to the patient for compensatory damages caused by an unauthorized release, plus costs and reasonable attorney's fees.

#### **Advantages of Option #1**

- o This option maintains the status quo, which some Patient Consent Subgroup members believe places liability on both the requesting and disclosing provider.

#### **Disadvantages of Option #1**

- o This option does not clearly address a disclosing provider's ability to rely on a requesting provider's representation of having obtained patient consent to release health records.
- o Many health care organizations believe that this places the liability for inappropriate disclosures on the disclosing provider, and therefore makes it nearly impossible to rely on another provider's representation of having obtained patient consent to disclose health records.
- o Providers who are operating under this language today do not rely on other provider's representation of having obtained patient consent to disclose health records. Hence, it is difficult to see how this option would facilitate the automated, real-time electronic exchange patients' health information.

**NOTE: Project staff are continuing to work on the exact language of the following Option based on the comments of the Patient Consent Subgroup at the December 20, 2006 meeting.**

**Patient Consent Issue #9 - Option #2: Divide liability among the parties involved based on a balancing test.** This option would facilitate electronic health information exchange by allowing a provider requesting health records to obtain the necessary consent from the patient and communicate the fact of the consent to the disclosing provider. The also allows the disclosing provider to rely on the representation of the requester that consent had been obtained from the patient. This option has several parts which all work together.

#### **Add a definition to Minnesota Statutes, section 144.335, subdivision 1:**

"Request" means a patient consent or a written communication of a patient's permission to release health information.

#### **Amend Minnesota Statutes, section 144.335, subdivision 3a:**



Subd. 3a. Patient consent to release of records; liability. (a) A provider, or a person who receives health records from a provider, may not release a patient's health records to a person without

(i) a signed and dated consent from the patient or the patient's legally authorized representative authorizing the release, ;

(ii) unless the release is specifically authorized by specific authorization in law; or

(iii) a representation from a provider that they hold a request.

Except as provided in paragraph (c) or (d), a consent is valid for one year or for a lesser period specified in the consent or for a different period provided by law.

Add to Minnesota Statutes, section 144.335:

Subdivision 3e. In adjudicating a dispute involving the disclosure of patient health records, a court will use the following in determining how liability will be allocated.

(a) By issuing a request for health records, a person warrants to the disclosing provider that:

(i) the request contains no information known to the person to be false;

(ii) the request accurately states the patient's desire to have health records disclosed or that there is specific authorization in law; and

(iii) the request does not exceed any limits imposed by the patient in the consent.

(b) By complying with a request, a provider warrants that:

(i) the provider has complied with the requirements of this subdivision regarding disclosure of health records;

(ii) the request contained no information known to the provider to be false; and

(iii) the provider has complied with the limits set by the patient in the consent as stated in the request.

(c) No person or provider may disclaim or contractually limit the application of this subdivision, nor obtain indemnity for its effects, if the disclaimer, limitation, or indemnity restricts liability for misrepresentation as against persons reasonably relying on the request or disclosure.

(d) A court of this state presumes that:

(i) A request made by a person that complies with the provisions of this subdivision is valid and represents the wishes of the patient.

(ii) The information listed in a request is accurate.

(iii) The recipient of a request has no knowledge or notice that the person making the request:

(A) breached a duty to the patient; or

(B) does not rightfully have a request.

(iv) The signature on the request is not forged.

(v) The request was not obtained under false pretenses.

(vi) The request was altered without the patient's permission.

(e) A court of this state shall give effect to liability allocations between the parties provided by contract that do not allocate liability to the detriment of the patient and to the extent the allocation is not inconsistent with the requirements of this chapter.

(f) A patient is eligible to receive compensatory damages plus costs and reasonable attorney's fees if the provisions of this section are violated.

#### Advantages of Option #2:

- This option provides a framework and mechanism to transfer/share responsibilities and liability for patient consent between the disclosing and requesting providers.
- This option maintains all of the patient protections against inappropriate disclosures that currently exist in Minnesota Statutes § 144.335, Subdivision 3a (e).
- This option facilitates patients' ability to consent to a provider accessing their health records at the point of care, which ensure that a larger set of health records are available to the treating provider.
- This option only permits health care providers to request the release of health records based on their representation. This minimizes the opportunity for inappropriate disclosures for non-treatment purposes.
- Technology could be used in a health information exchange to capture the data needed to document providers' representations that patient consent was given. Within a health information exchange, the ability to document providers' representations facilitates the ability to verify compliance.
- The language in subdivision 3e(b)(ii) would be an incentive for providers in an electronic environment to quickly and accurately record revocations and other statements of limitation so that the system could identify potential problems with the disclosure of patients' health information.
- This option would be conducive to the development of a standard patient consent form that would offer all participants a "safe harbor" to assist in managing the risk of inappropriate disclosures.

#### Disadvantages of Option #2:

- Patients' ability to limit the disclosure of health records to treating providers can have a negative impact on the care that the patient receives. Incomplete disclosure also may expose health providers to malpractice claims. However, these facts are also true today. This disadvantage highlights that may suffer consequences for choosing not to consent to the release of health records. However, this concern could be addressed by a statement in the consent that partial release of records will affect care.
- This amendment that acknowledges the ability to rely on a representation is limited to providers and so to treatment situations. There are some situations where a health plan has information that would be helpful in providing care (i.e. filled prescriptions). Broadening this provision to include health plans/payers/group purchasers was discussed.

If "person" is substituted for "provider," then the HIPAA provisions would have effect and so would prevent requests by third parties such as attorneys. Adding "for treatment, payment or health care operations" may be too broad and raise privacy concerns.

- By maintaining existing language stating that consents must be written and signed, the oral communication that does occur among providers is not addressed. Participants were unsure whether this practice of sharing information about patients by providers could be completely eliminated.

**Other Issues Related to Option #2:**

- There was some discussion about the need for a public conversation about consent, what it means and how patients achieve choice in the process. More clarity on the consent form is one option as is education to help patients understand that they don't have to sign the consent on order to see the provider.
- Currently, some patients use the ability to limit the disclosure of health records for "inappropriate" purposes. For example, patients who are seeking drugs will not authorize complete disclosures to assist them in obtaining drugs. Others ask that their records be changed to show a longer history of a particular condition to make them eligible for some kinds of care (e.g. through the Veteran's Administration). There was concern that enabling electronic health information exchange will exacerbate this situation.
- On a related note, it was recognized that there is no current statutory authority for providers or health plans to provide information to the appropriate authorities about certain behaviors like those of drug-seekers.