Minnesota Interoperable Electronic Health Record (EHR) Mandate – Frequently Asked Questions

Why do we have an EHR Requirement?
The goal of the Minnesota Interoperable EHR Mandate is to accelerate the adoption and use of health information technology in order to improve health care quality, increase patient safety, reduce health care costs and improve public health. The mandate was adopted in 2007, based on recommendations from the Minnesota e-Health Advisory Committee, a legislatively-chartered committee that advises the Minnesota Department of Health (MDH) on matters related to e-Health.

The interoperable EHR mandate was adopted along with several other significant statutory changes and mandates (in 2007-2010) to support the state’s movement towards e-Health, most notably:

- A requirement to develop a statewide implementation plan to meet the Interoperable EHR Mandate (Minnesota Statutes 2007, Section 62J.495).
- The requirement to establish uniform health data standards by 2009 (Minnesota Statutes 2007, Section 62J.495).
- A revision and recodification of the Minnesota Health Records Act (Minnesota Statutes 2007, Section 144.291-298) to update consent requirements for an electronic age.
- A requirement that all health care providers and payers establish and use an e-prescribing system by January 1, 2011 (Minnesota Statutes 2008, Section 62J.497).
- Passage of Minnesota’s Health Information Exchange Oversight Law to provide a framework and program for government oversight over entities providing health information exchange in order to protect the public interest (Minnesota Statutes 2010, Sections 62J.498-4982).

How is Minnesota doing in achieving the interoperable EHR mandate?

- 97% of Minnesota clinics (2015) and 100% of Minnesota hospitals (2014) have an EHR
- 97% of local health departments have adopted a public health EHR (2014)
- 69% of nursing homes have EHRs (2011)
- Much more work is needed in regard to effective use of health information technology and achieving interoperability across the continuum of care.
- More data can be found at http://www.health.state.mn.us/e-health/assessment.html.

In 2015, the Minnesota Legislature updated the mandate to exempt individual health care providers in a solo, private practice, and those who do not accept reimbursement from a group purchaser. However, when an exempt provider does adopt an EHR, system, they must still follow the statute’s criteria on EHR requirements.

What data do we know about the benefits of EHRs?
Minnesota’s providers have seen real benefits from EHRs. For example, of more than 1,000 clinics MDH surveyed in 2014:

- 93% said that their EHR enhances patient care
- 93% said that their EHR alerted them to potential medication errors
- 79% said that their EHR helped them provide care that meets clinical guidelines for patients with chronic disease
- 91% offer the ability for patients to access their personal health information, to help them take control of their health care
Can a patient opt-out of having their information shared between providers?
Yes. Minnesota law recognizes the importance of patient choice when it comes to care delivery and information flow and allows patients to choose who their information is shared with. Minnesota has created a standard consent form that any patient can use to specify who their data can be shared with, what types of data can be shared, and for what purposes. All providers must accept this form from a patient if it is correctly filled out. The form is available on MDH’s website: http://www.health.state.mn.us/e-health/privacy/index.html.

Does the interoperable EHR mandate require that patient records or client notes to be put online?
The mandate does not require that patient information be placed online. The majority of electronic health records used by Minnesota providers are not linked to the internet. Instead, they are secure internal systems. The use of an electronic health record, as opposed to paper records, does not change the confidentiality of the information or who is allowed to see it. Providers generally use role-based security controls to limit access to a patient’s information in an EHR to only people who have a need to see it for treatment, payment or operations.

What security safeguards exist for the data?
The Health Insurance Portability and Accountability Act (HIPAA) Security rule requires specific measures to safeguard electronic protected health information to ensure its confidentiality, integrity, and security. A few examples built into EHRs to protect medical records may include:

- “Access control” tools like passwords and PIN numbers, to limit access to patient information to authorized individuals, like the patient’s doctors or nurses.
- “Encrypting” stored information. That means that health information cannot be read or understood except by someone who can “decrypt” it, using a special “key” made available only to authorized individuals.
- An “audit trail” feature, which records who accessed information, what changes were made and when.

For more information, see resources developed by the Health and Human Services Office for Civil Rights: http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/privacy-security-electronic-records.pdf.

What is MDH’s role?
In consultation with the Minnesota e-Health Advisory Committee, MDH is responsible for developing a statewide plan to meet goals for statewide adoption and use of EHRs, including uniform standards to be used for securely sharing data across systems.

Does MDH penalize providers that don’t meet the requirements of the mandate?
MDH does not issue fines or sanctions against providers that have not met the mandate’s requirements. Instead, MDH provides support to providers to help them achieve the goal of statewide interoperability. Examples of supporting resources include:

- 2008 Statewide Implementation Plan http://www.health.state.mn.us/ehealth/ehrplan.html
- Privacy and Security Resources http://www.health.state.mn.us/e-health/privacy/

For more information, contact:
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