From Vision to Action
The Minnesota e-Health Initiative

Report to the Minnesota Legislature

Minnesota Department of Health

February 2008

Office of the Commissioner
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Protecting, maintaining and improving the health of all Minnesotans

February 21, 2008

The Honorable Linda Berglin
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Minnesota Senate
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Saint Paul, MN 55155-1606

The Honorable Thomas Huntley
Chair, Health Care and Human Services
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Minnesota House of Representatives
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The Honorable John Marty
Chair, Health, Housing, and Family Security Committee
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The Honorable Paul Thissen
Chair, Health and Human Services Committee
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To the Honorable Chairs:

Minnesota Statutes, section 62J.495 requires the Minnesota Department of Health to provide the Legislature an annual report that outlines progress in implementing a statewide health information infrastructure, including a status report on the development and adoption of standards for interoperability. This report on the Minnesota e-Health Initiative outlines the activities and progress that the Initiative is making toward the goals for health information technology. Some of the most significant advances for 2007 include:

- Nearly all hospitals and two thirds of primary care clinics have implemented, or are in the process of implementing, electronic health records.
- New mandates enacted in 2007 provide important impetus in ensuring all providers have interconnected electronic health records by 2015.
- 28 community collaboratives have been funded to either plan or to implement interconnected electronic health records using state funding appropriated in 2006 and 2007.

The Minnesota e-Health Initiative is ensuring that these and many other activities occurring in the public-private sectors across the state are occurring in a coordinated and focused way. The Initiative's 26-member advisory committee, along with dozens of other consumers and industry representatives, are:

- Developing a statewide plan to ensure that all providers and care delivery settings have effectively implemented interconnected electronic health records by 2015.
- Selecting health data standards for the exchange of medication histories, prescriptions, laboratory test results, and other types of clinical data.
- Identifying ways to ensure that the adoption of health information technology leads to improvements in quality and in population health.
- Identifying which public health information systems are most critical to modernize as part of meeting the 2015 mandate and for protecting and improving the public's health.

Sincerely,

Scott Leitz
Assistant Commissioner
Minnesota Department of Health

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Upon request, this material will be made available in an alternative format such as large print, Braille, or cassette tape.

Printed on recycled paper.

"Comprehensive reform this year should move Minnesota toward an interoperable electronic health record system."

Governor Tim Pawlenty
State of the State Address
January 17, 2007

62J.495 HEALTH INFORMATION TECHNOLOGY AND INFRASTRUCTURE
Subdivision 1. **Implementation.** By January 1, 2015, all hospitals and health care providers must have in place an interoperable electronic health records system within their hospital system or clinical practice setting. The commissioner of health, in consultation with the Health Information Technology and Infrastructure Advisory Committee, shall develop a statewide plan to meet this goal, including uniform standards to be used for the interoperable system for sharing and synchronizing patient data across systems. The standards must be compatible with federal efforts. The uniform standards must be developed by January 1, 2009, with a status report on the development of these standards submitted to the legislature by January 15, 2008.

Table of Contents

From Vision to Action
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February 2008

Executive Summary

Significant progress has been made on implementing the health information technology mandates enacted during the 2007 Legislative Session. These advances are the result of broad public-private sector engagement through the Minnesota e-Health Initiative. This collaboration reflects the health care community's strong commitment to pursue e-Health goals in a coordinated, systematic, thoughtful and focused way.

This report to the 2008 Minnesota Legislature summarizes progress in advancing the adoption and effective use of health information technology in Minnesota in 2007. It also provides a status report on the development and adoption of uniform standards for interoperable electronic health records. Much of the activity and progress over the last year has been focused on the statutory changes and mandates that were enacted in 2007, including:

- A requirement that all health care providers have an interoperable electronic health record system by 2015.
- The development of a statewide plan to meet the 2015 mandate.
- The adoption of uniform health data standards by 2009, which is critical for exchanging and synchronizing patient data across disparate electronic health record systems.
- Developing a standardized consent form for disclosing health records.
- Updating and strengthening privacy protections to better reflect needs in an electronic information age.
- Ensuring that public and private information systems can exchange data to achieve better population health outcomes and to respond rapidly to threats to a community's health.

The primary mechanism for the community to gather and coordinate their work on these activities is the Minnesota e-Health Initiative, with its 26-member public-private advisory committee and dozens of other volunteers representing consumers, the health care delivery community, purchasers, public health and government.

Major progress being made by the Minnesota e-Health Initiative and the Minnesota Department of Health include:

- Developing a statewide implementation plan on health information technology so that health organizations know how the 2015 electronic health record mandate impacts them and what actions they must take today to work toward the mandate.

- Assessing the status of various care delivery settings in terms of electronic health record adoption and use, in order to better assess barriers and identify solutions by delivery setting.
- Identifying health data standards needed for the exchange of high-value health information through interoperable electronic health records.
- Developing a standardized patient consent form for disclosing health records.
- Identifying priority areas for data exchange between clinical medicine and public health that will improve population health and quality/performance measurement and reporting.
- Identifying which state and local public health information systems are in most need of being upgraded to be interoperable with electronic health records by 2015.
- Supporting the work of the Minnesota Health Information Exchange as the organization launches and undertakes efforts to ensure providers have access to patients' complete medication histories.
- Identifying and/or developing educational resources, tools, templates and best practice documents, making them available through the e-Health Initiative's web site.

Continuing to achieve rapid progress in e-health priorities will require ongoing legislative support in these areas:

- Continuing to support and integrate requirements for the effective use of health information technology into health care transformation and reform.
- Supporting key elements of the health information technology implementation plan, such as a broad and inclusive definition of providers and electronic health record technologies, so that the mandate has far reaching impact on improving the quality, continuity and safety of health care.
- Emphasizing strong privacy protections as the healthcare industry moves into electronic exchange of information.

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Introduction

Significant progress has been made on implementing the health information technology mandates enacted during the 2007 Legislative Session. These advances are the result of broad public-private sector engagement through the Minnesota e-Health Initiative. This collaboration reflects the health care community's strong commitment to pursue e-Health goals in a coordinated, systematic, thoughtful and focused way.

The adoption and effective use of health information technology can play a significant role in transforming the health care system and in supporting healthier communities. Electronic health records are rapidly evolving and becoming more standardized to better meet the needs of clinicians and consumers. Tools such as computer-assisted physician order entry for e-prescribing and clinical decision support systems are bringing the power of information technology to the practice of medicine and public health, improving both quality and safety.

This report to the 2008 Minnesota Legislature summarizes progress in advancing the adoption and effective use of health information technology across Minnesota in 2007. Much of this progress was focused on the legislative changes and mandates that came out of the 2007 session:

- A requirement that all health care providers have an interoperable electronic health record system by 2015.
- The development of a statewide plan to meet the 2015 mandate.
- The adoption of uniform health data standards by 2009, which is critical for exchanging and synchronizing patient data across electronic health record systems.
- Developing a standardized, uniform form for patient consent to disclose health records.
- Updating and strengthening privacy protections to better reflect needs in an electronic information age.
- Ensuring public and private information systems can exchange data to achieve better population health outcomes and to respond rapidly to threats to a community's health.

The primary mechanism for the community to gather and coordinating their work on these mandates is the Minnesota e-Health Initiative, with its 26-member public-private advisory committee and dozens of other volunteers representing consumers, the health care delivery community, purchasers, public health and government. The Initiative is guided by a vision 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." See Attachment A for a roster of Advisory Committee and workgroup members.

Major progress being made by the Minnesota e-Health Initiative and the Minnesota Department of Health includes:

- Developing a statewide implementation plan so that health organizations know how the 2015 electronic health record mandate affects them and what actions they must take today to work toward the mandate.
- Assessing the status of various care delivery settings in terms of electronic health record adoption and use in order to better assess barriers and identify solutions by delivery setting.
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The Role of Health Information Technology in Health Care Reform and Health Care Transformation

National and state policymakers around the country are focusing on how to achieve better health outcomes for the population while controlling the unsustainable growth in health care costs. An important tool for achieving a comprehensive solution to these complex problems is the adoption and effective use of health information technology.

The health care industry is the last major industry to embrace information technology as tools to both improve efficiency and achieve better outcomes. While today's diagnostic and treatment technologies border on the miraculous, patient information has until recently still been maintained in paper charts and transmitted by fax and postal mail. But health information technology is about much more than simply capturing and documenting information. Effective use of the growing array of information technologies in health care enables clinicians to:

- Ensure a newly prescribed medication does not conflict with existing medications.
- Avoid duplicate tests because the previous results can be transmitted electronically to where the patient is being seen today.

- Readily access clinical guidelines and other evidence-based information most relevant to the patient's current condition.
- Avoid medication and other errors due to illegible or misinterpreted handwriting.
- Improve continuity of care by being able to exchange information with their patients' other providers.
- Receive reminders about preventive services that the patient is due to receive.
- Receive alerts when a prescribed action may be contraindicated.
- Improve clinical workflow processes to achieve greater efficiencies while also improving outcomes.

Health information technology can reduce administrative and clinical costs for a hospital or practice in areas such as:

- Directly dictating to an electronic health record versus paying for transcription services.
- No longer having to pull, manage and store paper records.
- Experiencing enhanced revenue capture and fewer claim denials.
- Having fewer pharmacy call-backs.
- Sometimes even benefiting from lower malpractice premiums.

The value of health information technology extends beyond that which can be easily measured in financial terms, although it can have tremendous value in increased patient satisfaction and in recruiting and retaining staff. These can include:

- Improving quality and safety.
- Enabling the patient to access their health information online, including links to tailored prevention and other information resources.
- Enabling an on-call physician to access a patient's record from home when receiving a call at night.
- Synchronizing information as a patient moves between a clinic, hospital and long-term care facility.
- Easily graphing and displaying a person's key biometric data, such as cholesterol or blood pressure levels, over time.

Progress on Achieving the Mandates Enacted in 2007

Statewide Plan to Achieve the 2015 Electronic Health Record Mandate

As a result of statutory actions enacted in 2007, all healthcare providers are required to have "an interoperable electronic health records system" by the year 2015 (Minnesota Statutes, section 62J.495).

The Legislature also tasked the Commissioner of Health with developing a statewide plan for achieving the mandate. A workgroup was formed under the auspices of the MN e-Health Initiative to create that roadmap for achieving the mandate.

Progress in the Statewide Plan to Meet the 2015 Electronic Health Record Mandate

- Convening experts from a wide array of health and care delivery settings to develop a statewide health information technology implementation plan.
- Developing an electronic health record "Adoption Continuum" and assessing progress along the continuum by provider types/care delivery settings (see Figure 1).
- Identifying barriers for each step along the adoption continuum, and recommending specific actions that providers and other organizations must take now to address those barriers.
- Focusing on challenges unique to various provider settings.
- Identifying which health information technologies are priorities for statewide adoption as part of interoperable electronic health record systems.

The workgroup developed an electronic health record adoption continuum that includes seven stages within three broader groupings: Adopt (Assess, Plan, Select), Utilize (Implement, Effective Use), and Exchange (Readiness, Interoperability) (see Figure 1).

Figure 1. The Electronic Health Record Adoption Continuum

Creating the adoption continuum also made it possible to graphically show where different provider types/care delivery settings currently are on the continuum; that is, how far each setting has to go (based on current estimates) to reach the end-goal of interoperability by 2015 (see Attachment B). The provider types covered by the mandate are those defined in Minnesota Statutes 62J.03, subdivision 8.

The types of health information technologies that are currently the focus of the statewide plan for implementing "interoperable electronic health records system" include:

- Interoperable electronic health records, including tools for e-prescribing, managing lab results, providing timely clinical decision support, and enabling secure health information exchange.
- Personal health records.
- Tools for aggregate analysis of clinical data needed to generate population health reports.

The first version of the statewide implementation plan will be released at the June 26 Minnesota e-Health Summit (www.health.state.mn.us/ehealth). This version will provide concrete and prescriptive recommendations for moving providers—regardless of their current status—toward achieving an interoperable electronic health record. It is aimed at providers, professional and trade associations, quality measurement/improvement organizations, and others. It provides targeted and actionable recommendations to ensure all provider care setting take effective and coordinated action toward achieving the mandate.

Example actions that providers can take are:

- *"Make sure that your electronic health record is nationally certified so that it incorporates all necessary functions and the latest standards.*
- *Work with others in your community/service area to coordinate and identify priorities for health information exchange based on population health or other needs. Greater value will accrue to all partners if this is done in a coordinated way across the community. When calculating a Return on Investment/Value on Investment, base it on Total Cost of Ownership so that you understand at the outset what investments will be needed over time, as well as where cost-savings will likely accrue to pay for those investments.*
- *If there are not suitable electronic health record products available in the marketplace today for your specialty, work with your national trade association(s) to push for standards and/or electronic health record certification criteria. Collaboratively define the business requirements and unique information needs of your sector. This will provide both an objective basis for your organization to evaluate products, and communicate your sector's needs to electronic health record/health information technology vendors.*
- *National privacy and security standards are rapidly emerging that will provide greater legal protection for those who adhere to them. Make sure that your electronic health record is certified nationally so that it incorporates the latest privacy standards.*
- *Work with others on defining uniform practices for implementing standards, such as collaboratively developing implementation guides.*

Examples of actions others can take include:

- *Professional and trade associations must make every effort to use existing and new venues such as conferences, meetings, newsletters and web sites to exchange lessons learned and best practices on electronic health record and health information technology adoption.*

- *Professional and trade associations should develop policy statements/issue briefs on key aspects of health information technology, such as its role in improving quality, reducing overall costs, and increasing patient safety. A core set of messages should flow from these statements that can be incorporated into articles, slides and other communications.*
- *Trade and professional associations must take the lead in creating the venue for collaboratively defining functional and other electronic health record requirements for settings for which current electronic health record products do not meet their needs.*
- *Trade and/or professional associations for medical specialties should create ongoing or ad hoc workgroups to develop or identify standards for their specialty areas that will help advance development of appropriate electronic health record products for those specialties.*
- *Software vendors must seek to better understand the unique business and informational needs of these settings, encouraging collaborative approaches to defining those across the industry.*
- *Academic institutions should continue to use electronic health records as integral tools in their training programs to both develop competencies and drive demand.*
- *MDH should work with others knowledgeable in electronic health record planning and implementation to establish a clearinghouse of information on planning needs and lessons learned. The information needs to be based on real life experience and separate facts from myths.*

Acting on the recommendations above will require a growing cadre of health care and public health staff trained in health informatics to guide effective implementation and use of health information technology. (Health informatics is the emerging field that overlaps information technology/computer sciences and the practice of healthcare delivery, using proven methods for ensuring that technology improves the quality, safety and cost-effectiveness of care.)

Health Data Standards

Progress in Setting Standards

- Convening health care experts to establish priorities and develop recommendations for standards, based on those that are most advanced and capable of being implemented in the near future.
- Approving recommendations and sets of standards for use in Minnesota that are consistent with national recommendations.
- Contributing statewide collaborative and coordinated input to national standards-setting efforts.
- Developing informational and educational resources for providers.

The 2007 Minnesota Legislature tasked the Commissioner of Health with establishing health data standards by January 2009. Standards are critical to achieving

interoperability across disparate electronic health record systems, since many of these systems currently use proprietary methods of recording information (and many health care organizations customize them even further).

Considerable progress was made since the 2007 session. A standards workgroup of healthcare industry experts was convened under the e-Health Initiative to identify health data standards for Minnesota in a way that could both contribute to and leverage the monumental and historic work going on nationally. By the time of this report, the workgroup made the following recommendations—subsequently approved by the e-Health Advisory Committee:

- Recommendation: All Minnesota health care organizations should use health information technology products that are certified by the Certification Commission for Healthcare Information Technology (CCHIT) or a comparable national certification process.
  Establishing this standard early will help ensure that there will be a critical baseline of functionality and information exchange capabilities in the electronic health records used in Minnesota.
- Recommendation: All Minnesota health care organizations should use the standards as proposed by the Health Information Technology Standards Panel (HITSP) in accordance with the defined business use cases, such as e-prescribing.
  This ensures Minnesota will be consistent with nationally-adopted standards, which will facilitate inter-state exchange.
- Recommendation: Adopting and implementing standards within Minnesota should be done through an ongoing public-private collaborative process.
  A broad-based consensus approach is needed to achieve universal adoption.
- Recommendation: All Minnesota health care organizations should use the following five standards for transactions related to e-prescribing and medication management.
  (a) For eligibility and benefits inquiries and responses between prescribers and Plan sponsors:
  Accredited Standards Committee (ASC) X12N 270/271 4010A
  (b) For eligibility and benefits inquiries and responses between dispensers and Plan sponsors*:*
  NCPDP Telecommunication Standard Specification, Version 5.1
  (c) For transactions between prescribers and dispensers:
  NCPDP SCRIPT 8.1
  (d) Exchange of Medication History:
  NCPDP SCRIPT 8.1
  (e) Formulary & Benefit Information*:*
  NCPDP Formulary and Benefits Standards 1.0.
  Establishes uniform standards in a very high value area of exchange.
- Recommendation: All Minnesota health care organizations should prepare for implementation of the following four standards and should implement them when

they are approved as part of CCHIT (Certification Commission for Healthcare Information Technology) or a comparable national certification process.

(a) Ability to send, store, and receive coded medication information:
Federal Medication Terminologies (FMT): NDC, RxNorm, UNII, SNOMED CT and HITSP C32 v.2.0.

(b) Send text or coded allergy information with new electronic prescriptions to Pharmacy (directly), PBM (directly), or via intermediary network (e.g. SureScripts, RxHub):
NCPDP SCRIPT 8.1 (NEWRX) using the free text field of the message drug segment (DRU 090).

(c) Receive medication fulfillment history:
NCPDP SCRIPT 8.1 (RXFILL)

(d) Send electronic prescription to pharmacy including structured and coded SIG instructions:
NCPDP SCRIPT 10.5

Establishes uniform standards in a very high value area of exchange.

The two national bodies noted early, which serve as the basis for much of the standards activities in Minnesota, are:

- Certification Commission for Health Information Technology (CCHIT): Certifies electronic health record software products for functionality and the ability to exchange information (www.cchit.org).
- Health Information Technology Standards Panel (HITSP): Harmonizes the actual data standards to be used for capturing and exchanging information (www.ansi.org/hitsp/).

The Standards Workgroup provided many hours in reviewing and providing formal comment on national standard setting efforts. Workgroup members provided hundreds of specific comments to CCHIT on newly proposed functional requirements for electronic health records. For three separate review and comment periods, the workgroup identified subject matter experts across the state from the various fields for which the functional requirements were being proposed—ambulatory care, in-patient, Emergency Departments, child health, cardiology and others. Detailed feedback was solicited to refine the requirements or to suggest new ones, which was then consolidated into a single statewide response. Minnesota was the only state to submit such a coordinated, combined and statewide response to CCHIT.

In terms of standards needed for information exchange, the focus is on those areas that have the highest value for improving clinical care and population health. The goal is to leverage national efforts wherever possible, and to influence and accelerate national efforts when they are of importance to Minnesota. When an area is identified for which no national standard is being developed, that need is communicated to the appropriate national body, encouraging their prompt consideration for developing a standard.

Establishing standards for transmitting health information (or more accurately narrowing the current list of over 2,100 standards to something that can be more readily adopted

universally) is a surprisingly complex undertaking. For instance, just for e-prescribing and medication management, there are 48 different required standards, of which nine relate directly to e-prescribing (see Table 1), the remainder serving as "foundation" standards required for most exchanges, such as privacy, security and messaging.

Table 1. Standards for e-Prescribing*

e-Prescribing Activity	Relevant Standard
Eligibility inquiries and responses between prescribers and plan sponsors	Accredited Standards Committee (ASC) X12N 270/271
For eligibility and benefits inquiries and responses between dispensers and plan sponsors	NCPDP Telecommunication Standard Specification, Version 5.1
For transactions between prescribers and dispensers	NCPDP Script 8.1
Exchange of Medication History	NCPDP Script 8.1
Formulary & Benefit Information	NCPDP formulary and benefits standards 1.0
Ability to send, store, and receive coded medication information	Federal Medication Terminologies (FMT): NDC, RxNorm, UNII. SNOMED-CT health information technology SP C32 v.2.0
Send text or coded allergy information with new electronic prescriptions to Pharmacy (directly), PBM (directly), or via intermediary network (e.g. SureScripts, RxHub)	NCPDP Script 8.1 (NEWRX)
Receive medication fulfillment history	NCPDP Script 8.12 (RXFILL)
Send electronic prescription to pharmacy, including structured and coded dispensing instructions.	NCPDP Script 11.1

- More detailed information is available at www.health.state.mn.us/ehealth/standards/

Minnesota was the only state to submit coordinated, combined, statewide input on minimum electronic health record functional standards to the national Certification Commission for Health Information Technology (CCHIT).

To support providers in understanding and effectively adopting this complex array of health data standards, MDH has developed an extensive series of web pages that provide background and educational information, report on progress of the Minnesota Standards Workgroup, and report on and summarize the extensive work being conducted nationally. Standards also play a pivotal role in the health information technology implementation

plan being developed around the 2015 interoperable electronic health record mandate, as well as in the e-Health communications plan.

e-Health Grants

The 2007 Minnesota Legislature re-authorized spending to support the adoption of interoperable electronic health records in rural settings and in inner-city community clinics. $7 million was made available in grants over the biennium for community collaboratives to undertake planning and implementation projects. These grants required a dollar of local match for every three dollars of state funds. Another $6.3 million was made available in no-interest loans, repayment needing to begin within two years of loan origination and completed within six years.

Progress in the electronic health record grant and loan programs

- $3.5 million in grants awarded to 16 community e-health collaboratives.
- Eligibility criteria and application instructions developed for the no-interest loans program.
- Initial round of preliminary loan requests reviewed.
- Leveraged federal and other funds to augment legislative appropriations.

The grants were awarded to 16 community collaboratives to increase the adoption and effective use of interoperable electronic health records—seven planning projects for up to $50,000 each and nine implementation grants of up to $750,000 each. See Attachment C for the complete list and description of grant-funded activities.

Availability of the no-interest loans is ongoing and on a first-come, first-served basis. As of January 2008, three preliminary approvals were given.

$1.5 million was appropriated for FY07 which subsequently funded six community collaboratives for assessment/ planning projects and five for implementation projects. Of the six assessment/planning grants awarded in 2007, three received implementation grants in 2008, demonstrating that this funding resulted in substantial advancement for some organizations.

The best electronic health record implementations
don't just automate existing paper processes
but take the time to completely re-design
how business is done.

Critical lessons learned from that initial appropriation of e-Health grants projects helped inform both the current round of grants and loans as well as the e-Health Initiative overall:

- Implementing health information technology is very complex and almost always takes longer than anticipated, especially when it involves working across disparate organizations in a community collaborative.
- Collaboration is essential among health information "trading partners" within a community, and should be initiated early in the planning process.
- Thorough and systematic planning is critical, and must engage all the staff that will be impacted by the electronic health record early in the process.
- Using existing tools, tips and templates saves time and resources.
- Contracting with a trusted consultant familiar with electronic health record planning and implementation is indispensable in saving time and avoiding costly mistakes.
- Having to fund health information technology adoption in addition to other capital expenditures is a major financial strain for rural and small health organizations.
- Adequately preparing and engaging the workforce is a critical success factor.
- The best implementations are those that don't just automate existing paper processes but take the time to completely re-design how business is done.

Privacy and Confidentiality

Progress in Privacy and Confidentiality

- Developed a standard consent form to release health records.
- Secured federal funding to participate in a national collaborative on inter-state exchange of health records.
- Re-convened a work group of privacy and security experts under the auspices of the e-Health Initiative and the Minnesota Privacy and Security Project.

The 2007 Minnesota Legislature completed a historic revision of the Minnesota Health Records Act, Minnesota Statutes, sections 144.291 through 144.298. The statutory privacy protections that had evolved over the past two decades contained several limitations as health care moved into an electronic information age. The meanings of key terms were ambiguous, resulting in health care organizations being unsure when and how consent was required. The Legislature also needed to define what constituted an emergency, so that a provider could access a patient's health information without the patient's consent if that information was essential to provide effective and safe emergency care. The issue of how consent could be relayed electronically also needed to be addressed, and what privacy protections should apply a record locator service. (A record locator service or RLS is a sort of electronic Rolodex that points a provider to other health care organizations that have relevant health records on a patient.)

The statutory revisions to the Health Records Act also included a new requirement for the Commissioner of Health to develop a standardized consent form that patients could use to authorize release of their health records for specific purposes as determined by them. A broadly representative workgroup of attorneys, chief privacy officers, citizen advocates and others was convened in order to identify the relevant state and federal legal requirements for consent, determine which were most important to include in this form, and to craft language and design a form that would be easy to understand and to complete. The form and instructions are included as Attachment D.

In 2008 the workgroup will continue to perform two major functions:

- Develop standard language for a consent form template for treatment that also addresses the requirements for opting out of a record locator service.
- Working collaboratively with other states in a federally-funded project to identify barriers to interstate data exchange.

Population Health and Public Health Information Systems

Progress in Population Health

- Developed a common framework for quality improvement and population health, including:
  - Adapting and modifying national principles to guide the uses of clinical data to improve population health outcomes.
  - Defining the roles and responsibilities of all stakeholders in *population health* (the broad, shared responsibility of all to improve health outcomes and achieve better value in our healthcare system) and *public health* (the governmental responsibility to protect, maintain and promote the health of all).
  - Developing a model for how health information technology supports improvements in quality and population health.
- Identified priority areas for exchange between clinical care and public health that will improve population health and quality/performance measurement and reporting.

The Minnesota e-Health Initiative is placing a special emphasis on ensuring that the adoption of health information technology leads to improvements in population health. A major driver for the adoption of health information technology is the poor health outcomes experienced in our country despite spending nearly one out of every six dollars on health care. Population health goals are often the same ones used to measure quality in health care, such as diabetes and hypertension control, breast cancer screening, immunizations, medical errors, and healthcare-acquired infections.

A public-private, local-state workgroup under the MN e-Health Initiative was convened to carry out two related tasks:

- Identify priority areas for information exchange between clinical care and public health that will lead to improvements in both quality/performance measurement and reporting, and in population health.
- Identify which state and local public health information systems need to be modernized in order to exchange with clinical care and to meet the 2015 electronic health record mandate.

The priority action areas for information exchange will then be used to both inform the health information technology Implementation Plan and to help set priorities for establishing health data standards.

Principles for Improving Population Health through Health Information Technology

- The use of electronic clinical data is beneficial and necessary to improve population health.
- The use of electronic population health data is beneficial and necessary to improve the health of individuals.
- Everyone who uses clinical data for population health purposes should abide by a common set of principles and policies.
- Those who use clinical data for population health purposes should be transparent about their principles, policies and practices.
- Healthcare organizations should support the use of a common set of data derived directly from electronic clinical data systems for the purpose of measuring population health.
- Population health functional components are an essential part of electronic health records.
- Financial or other incentives will be necessary to accelerate the use of clinical data for population health purposes.

Adpated from *eHealth Initiative Blueprint: Building Consensus for Common Action, www.ehealthinitiative.org.*

Communications, Education and Collaboration

Because the mandates described above impact every health organization and provider across the state, communicating the mandates and what they mean for providers is a critical challenge for the Minnesota e-Health Initiative. A public-private collaborative effort was initiated to develop a communications plan. The purpose of this is to motivate and engage professional and trade associations and additional groups to inform others about what the mandates mean to providers, and what actions they can take today to either start or advance down the path to achieving the mandate's goals. Various informational and educational tools are being developed so that individuals and organizations can deliver consistent messages about the need to adopt electronic health records and other health information technology.

Progress in Communications, Education and Collaboration

- Developing a communications plan for engaging professional and trade associations in informing and motivating health care providers and organizations around both the mandates and effectively adopting and using health information technology
- Convening a collaborative effort around implementing the communications plan.

Like all technology, health information technology is only as good as the people using it. A challenge for nearly every health care organization is ensuring that their staff not only have sufficient computer skills, but also have the knowledge and skill needed to take full advantage of the technologies to improve how they do their work (the latter being what health informatics is about). The workgroup has begun to collaborate with postsecondary educational institutions to: (1) ensure that electronic health record and health informatics training is part of the curriculum for all health professionals; and (2) explore ways in which educational content for informatics can be effectively delivered to the current workforce in ways that fit into busy schedules.

Other Major Progress in e-Health

Minnesota Health Information Exchange

In September 2007, the Governor and some of Minnesota's largest health care organizations announced the creation of what may quickly become the nation's largest health information exchange. The Minnesota Health Information Exchange (MN HIE) is an electronic network that will increase patient safety and quality of care, and will decrease costs by allowing doctors, hospitals and clinics to access vital medical record information. The public-private partnership was introduced by its founders, which include health plans, providers, and state government. MN HIE grew out of the foundation created by the Minnesota e-Health Initiative, and was encouraged with the philosophical and statutory support provided by the Legislature and Governor Pawlenty.

Health Care Administrative Simplification – Rules For Standard, Electronic Health Care Transactions

Minnesota Statutes, section 62J.536, enacted in May, 2007, requires all health care providers and group purchasers to exchange the following three types of health care administrative data electronically, using a standard data format and content by 2009: eligibility inquiry and response; claims; and payment/remittance advice. Minnesota is the first state in the nation to adopt such a requirement, which is intended to help reduce health care administrative costs and improve service.

Studies have shown that exchanging common health care administrative transactions on paper, or in nonstandard formats, is more expensive than standard, electronic data exchanges and can result in problems of incomplete or incorrect information that cause delays and further expense. One recent national study estimated that the costs of processing paper health care claims at $1.58 per claim, or nearly double the cost of electronic billings, at 85 cents per claim. A 2006 report estimated that between $15.5 and

$21.8 million is spent annually in Minnesota for follow-up telephone calls between health care providers and payers to resolve questions related to eligibility and claims.

As health care transactions become standard and electronic, more of every health care dollar can then be spent on maintaining and improving health, and less on duplicative, inefficient, or unnecessary administration. In addition, common standards for the electronic exchange of health care administrative transactions are an important first step toward other goals for a more responsive, automated, efficient health care system.

The standards for the required electronic transactions are being developed as rules by the Minnesota Department of Health (MDH) and are based on the federal Medicare program, with modifications the commissioner of health finds appropriate after consulting with the Minnesota Administrative Uniformity Committee (AUC). The AUC is a broad-based, voluntary group representing Minnesota's public and private health care payers, hospitals, health care providers and state agencies. It has served since 1992 to develop agreement among payers and providers on standardized administrative processes. The AUC acts as a consulting body to various public and private entities, but does not formally report to any organization and is not a statutory committee. As the rules are developed, they will be announced at least one year in advance of their 2009 effective dates, to allow health care providers and payers time to become aware of and comply with the requirements.

Rules for the eligibility transaction were adopted in December, 2007, following extensive development and review by the AUC and opportunities for further outside reviews and public comment. This standard transaction will help health care providers quickly and accurately verify their patients' insurance coverage and the medical benefits or services for which they are eligible – a transaction occurring millions of times each year. The rules become effective January 15, 2009.

The Minnesota Department of Health is currently consulting with the AUC on the development of the remaining rules for health care claims and payment/remittance advice transactions. The rules for the standard electronic exchange of claims will be announced by July 15, 2008, and will take effect July 15, 2009. Similar rules for the payment/remittance advice transaction will be announced by December, 2008, to take effect December 15, 2009. (www.health.state.mn.us/asa)

Minnesota Telehealth Network (MTN)
MTN evolved out of a small telemedicine network originally formed in 1994 as a collaboration between the University of Minnesota and Tri-County Hospital in Wadena, and grew to serve 17 sites in northern Minnesota. In 2006, with funding from the federal Office for the Advancement of Telehealth, the MTN began an expansion of the network to add 22 hospitals and clinics in northern Minnesota and northeastern North Dakota. Available specialty services include dermatology, child and adolescent psychiatry, adult psychiatry, asthma and allergy, gastroenterology, neurology, orthopedics and wound care. The network currently facilitates nearly 1,000 specialty physician visits annually and is developing programs in tele-homecare, remote rural satellite clinic support and nursing

home triage. In addition to grant funding, MTN operations are supported by network members and patient fee reimbursements.

Federal Communications Commission (FCC) Rural Health Care Pilot Program
In fall 2006, the FCC announced a pilot program to expand reimbursements for telecommunications services to support statewide and regional telehealth networks. In fall 2007, the FCC authorized the Greater Minnesota Telehealth Broadband Initiative, a collaboration of six rural health care provider networks representing over 120 facilities—Minnesota Telehealth Network, SISU Medical Systems, North Region Health Alliance, Medi-sota, and Minnesota Association of Community Mental Health Programs—to apply for up to $5.4 million in reimbursements over three years. The goal of the collaboration is a strong, integrated telehealth delivery system supported by a robust public-private telecommunications infrastructure. The MDH Office of Rural Health and Primary Care will support the project along with other statewide partners, including the University of Minnesota, MNSCU, and the Minnesota Office of Enterprise Technology.

Minnesota e-Health Grant leveraged $1.6 million in federal funding for Lac qui Parle Network
In 2006, the Lac qui Parle Health Network (LqPHN), Johnson Memorial Hospital in Dawson, Appleton Area Health Services, and Madison Lutheran Home, received a $40,000 planning and readiness grant through the Minnesota e-Health Collaborative Grant Program to being strategic health information technology planning. The planning accomplished through the state grant program placed LqPHN in a position to access significant federal funding. In 2007, the federal Health Resources and Services Administration, Office of Rural Health Policy awarded the MDH Office of Rural Health and Primary Care a $1.6 million Critical Access Hospital Health Information Technology Network grant to support LqPHN's electronic health record implementation among network members across the continuum of care. Minnesota was one of 16 grant recipients from among about thirty state applicants.

> *"This funding will help us build a system for exchanging health records electronically,"* said Mark Roisen, director of the Lac qui Parle Health Network. *"With electronic health records, we'll be able to provide care more efficiently and safely to our patients."*

Summary of e-Health Priorities for 2008

The Minnesota e-Health Initiative and the Minnesota Department of Health will be working toward systematic and thoughtful progress on the following priorities:

- Disseminating the first iteration of the health information technology implementation plan so that health organizations know how the 2015 electronic health record mandate impacts them and what actions they should take today.
- Assessing the status of various care delivery settings in terms of electronic health record adoption, including assessing barriers and identifying solutions by delivery setting.
- Identifying health data standards needed for the exchange of high-value health information through interoperable electronic health records.
- Disseminating the universal patient consent form for disclosing health records.
- Developing a universal, standardized patient consent form for treatment.
- Identifying priority areas for data exchange between clinical medicine and public health that will improve population health goals.
- Identifying which state and local public health information systems are in most need of modernizing to meet the 2015 mandated.
- Supporting the work of the Minnesota Health Information Exchange as the organization undertakes its efforts.
- Developing a series of communications tools to help inform and engage providers and their associations in collaboratively achieving the state mandates.
- Identifying and/or developing educational resources, tools, templates and best practice documents and making them available through the e-Health Initiatives web site.

e-Health Priorities for the Minnesota Legislature

Continuing to achieve rapid progress in e-health priorities will require ongoing legislative support in these areas:

- Continuing to support and integrate requirements for the effective use of health information technology into health care transformation and reform.
- Supporting key elements of the health information technology implementation plan, such as a broad and inclusive definition of providers and electronic health record technologies, so that the mandate has far reaching impact on improving the quality, continuity and safety of health care.
- Emphasizing strong privacy protections as the healthcare industry moves into electronic exchange of information.

Attachments

Attachment A: Minnesota e-Health Initiative Advisory Committee membership

Attachment B: Electronic Health Record Adoption Continuum

Attachment C: Minnesota e-Health Grant Projects, 2007-2008

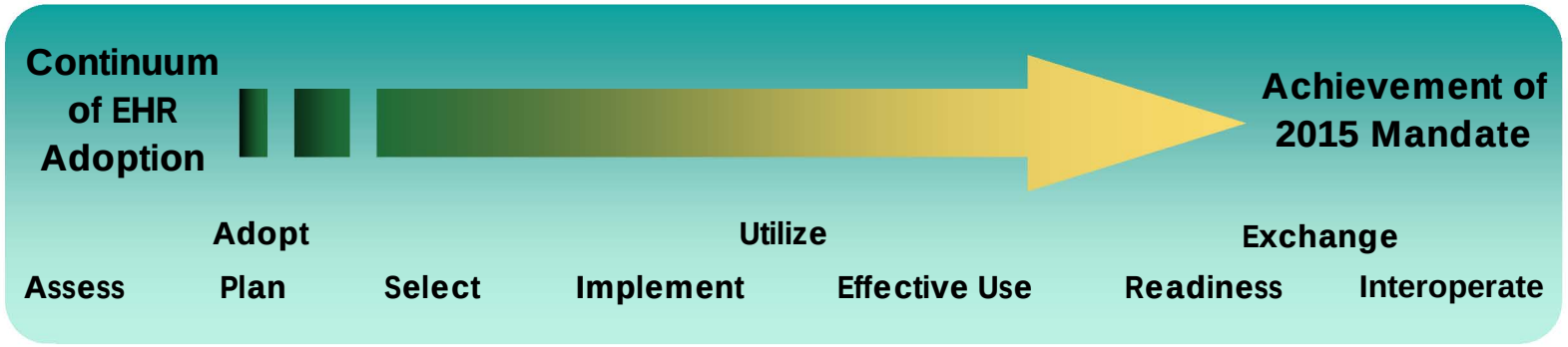
Attachment D: Standardized Consent Form for Release of Health Information

Attachment A: MN e-Health Advisory Committee Members

Mary Wellik, ***Advisory Committee Co-Chair*** Director, Olmsted County Public Health Services Representing: Local Public Health	**Jennifer Lundblad, PhD,** ***Advisory Committee Co-Chair*** President and Chief Executive Officer, Stratis Health Representing: MN Quality Improvement Organization
David Abelson, MD Vice President for Strategic Improvement Park Nicollet Health Services Representing: Institute for Clinical Systems Improvement	**Alan Abramson, PhD** Senior Vice President of IS&T and CIO HealthPartners Representing: HIPAA Collaborative
Laurie Beyer-Kropuenske, JD Director, Information Policy Analysis Division Department of Administration Representing: State Government	**RD Brown** Retired Representing: Consumers
Don Connelly, PhD, MD Professor, Health Informatics University of Minnesota Representing: Academics and Research	**Walter Cooney** Executive Director Neighborhood Health Care Network Representing: Community Clinics
Fred Dickson Vice President and CIO Blue Cross Blue Shield Minnesota Representing: Health Plans	**Raymond Gensinger, Jr., MD** Chief Medical Informatics Officer Farview Health Services Representing: MN-HIMSS
John Gross Director, Health Care Policy Minnesota Department of Commerce Representing: State Government	**Maureen Ideker** Associate Administrator, Care Management Rice Memorial Hospital Representing: Small Hospitals
Katie Jones Pharmacist Mayo Hospital Representing: Pharmacists	**Paul Kleeberg, MD** Medical Director, Clinical Decision Support HealthEast Care System Representing: Professional with Expert Knowledge
Marty LaVenture, PhD Director, Center for Health Informatics Minnesota Department of Health Representing: Minnesota Department of Health	**Bobbie McAdam** Director, e-Business Medica Representing: Health Plans
Rina McManus Director, Anoka County Community Health and Environmental Services Representing: Local Public Health	**Walter Menning** Vice Chair, Information Services Mayo Health System Representing: Academics and Research
Brian Osberg Assistant Commissioner Minnesota Department of Human Services Representing: State Government Purchasers	**Carolyn Pare** Chief Executive Officer Buyers Health Care Action Group Representing: Purchasers of Health Care
Rebecca Schierman Quality Improvement Manager Minnesota Medical Association Representing: Physicians	**Peter Schuna** Administrator/CEO Cerenity Care Center Representing: Long Term Care
Jennifer Sundby, RHIA Health Information Management Consultant The Evangelical Lutheran Good Samaritan Society Representing: Long Term Care	**Joanne Sunquist** Chief Information Officer Hennepin County Medical Center Representing: Large Hospitals
Bonnie Westra, RN, PhD Assistant Professor University of Minnesota, School of Nursing Representing: Nurses	**Tamara Winden** Supervisor, Laboratory Information Systems HealthEast Care System Representing: Laboratories

Attachment B: Electronic Health Record Adoption Continuum

Adopting Interoperable Electronic Health Records



What strategies will shorten these lines and help move them to the right?

Large Hospitals

Small Hospitals

Radiology

Pharmacies

Primary Care Clinics

Nursing Homes

Local Health Departments

Estimated range of adoption based on various surveys and other sources

Minnesota Department of Health, February 2008

Attachment C: Minnesota e-Health Grant Projects, 2007-2008

2008 Grants

The Minnesota Department of Health's Office of Rural Health and Primary Care awarded grants totaling $3.5 million to help Minnesota providers in rural and inner city areas develop electronic health record systems.

The funding comes from the Interconnected Electronic Health Record Grant Program, a part of Governor Pawlenty's e-Health Initiative. The e-Health Initiative is part of a broader set of strategies designed to improve the quality and efficiency of health care.

Minnesota law requires all Minnesota health care providers to use electronic patient health records by January 1, 2015. The Interconnected Electronic Health Record Grant Program is intended to help community collaboratives, community clinics, rural hospitals, small town physician clinics, nursing homes, and other small health care providers transition from paper records to electronic systems.

Seven community projects received planning and readiness grants between $23,000 and $50,000.

- Cedar Riverside People's Center, Minneapolis
- Community Health Information Collaborative, Duluth
- Community Memorial Hospital, Cloquet
- Lake Superior Community Health Center, Duluth
- Sleepy Eye Medical Center, Sleepy Eye
- St. Gabriel's Hospital, Little Falls
- Upper Mississippi Mental Health Center, Bemidji

Nine implementation projects, ranging from $89,000 to $650,000, were awarded to:

- Northern Minnesota Network, Isanti
- Roseau Area Hospital and Homes collaborative, Roseau
- SISU Medical Systems, Duluth
- Community-University Health Care Center, Minneapolis
- Neighborhood Health Care Network, St. Paul
- Open Cities Health Center, St. Paul
- Lakeland Mental Health Center, Fergus Falls
- Lakeview Medical Clinic collaborative, Sauk Centre
- St. Elizabeth's Hospital collaborative, Wabasha

2007 Grants

$1.3 million was authorized for grants by the 2006 Minnesota Legislature to support the adoption and use of interoperable electronic health records in rural and underserved areas. MDH awarded a total of 12 grants: seven for readiness assessment and planning

projects for organizations exploring new or expanded health information technology, and five for implementation projects

Each project consists of a community e–health collaborative of at least three health organizations that have agreed to work together to either plan for or implement electronic health records and/or health information exchange. Each of the communities listed are in rural settings, most designated as Medically Underserved and Health Professional Shortage areas.

Seven community collaboratives received planning and readiness grants between $20,000 and $50,000:

- Cass Lake IHS (Cass Lake), with Leech Lake Tribal Health; Red lake Indian Hospital; White Earth Health Center
- Lac qui Parle Health Network (Madison), with Johnson Memorial Health Services (Dawson); Appleton Area Health Services; Madison Lutheran Home
- Lakeview Medical Clinic (Sauk Centre), with other health care providers in the Sauk Center area; Main Street Drug; Coborn's Pharmacy
- Minnesota Health Care Connection (MnHCC) (Statewide), with Community Health Information Collaborative (CHIC); Itasca County Health Care Network (ICHN); Stratis Health
- Neighborhood Health Care Network (for the Community Care Network) (Metro), with Northpoint Health & Wellness Center; Westside Community Health Services; Hennepin County Community Health; Hennepin County Medical Center; UCare; Minnesota Department of Human Services
- Ortonville Area Health Services (Ortonville), with Graceville Health Center; Northside Medical Center; Carlson Drug; Liebe Drug; Countryside Public Health
- Roseau Area Hospital & Homes (Roseau), with Altru Clinic; Mattson Pharmacy

Five community collaboratives were awarded implementation grants ranging from $124,000 to $250,000:

- Community Health Information Collaborative (Northeast MN), with SMDC Health Systems; SISU Medical Systems; St. Luke’s Hospital and Clinics; the health and/or human services agencies of Carlton, Cook, Itasca, Lake and St. Louis counties; College of St. Scholastica Center for Healthcare Innovation
- Cuyuna Range District Hospital (Crosby), with Central Lakes Medical Center (Crosby); Longville Lakes Clinic
- Pine Medical Center (Sandstone), with Gateway Family Health Clinics; Mercy Hospital and Health Care Center
- Stratis Health (for a project Willmar), with Affiliated Community Medical Center; Family Practice Medical Center; Rice Memorial Hospital; Rice Care Center; Kandiyohi County Public Health; Kandiyohi County Human Services; University of Minnesota Health Informatics; Avenet Web
- Tri-County Hospital (Wadena), with Fair Oaks Lodge; Wadena Medical Clinic; Rural Radiology; Wadena County Public Health

Attachment D: Standardized Consent Form for Release of Health Information

Instructions for Minnesota Standard Consent Form to Release Health Information

Important: Please read all instructions and information before completing and signing the form.

An incomplete form may not be accepted. Please follow the directions carefully. If you have any questions about the release of your health information or this form, please contact the organization you will list in section 3.

This standard form was developed by the Minnesota Department of Health as required by the Minnesota Health Records Act of 2007. If completed properly, this form must be accepted by the health care organization(s), specific health care facility(ies), or specific professional(s) identified in section 3.

A fee may be charged for the release of the health information.

The following are instructions for each section. Please type or print as clearly and completely as possible.

1| Include your full and complete name. If you have a suffix after your last name (Sr., Jr., III), please provide it in the "last name" blank with your last name. If you used a previous name(s), please include that information. If you know your medical record or patient identification number, please include that information. All these items are used to identify your health information and to make certain that only your information is sent.

2| If there are questions about how this form was filled out, this section gives the organization that will provide the health information permission to speak to the person listed in this section. **Completing this section is optional.**

3| In this section, state who is sending your health information. **Please be as specific as possible.** If you want to limit what is sent, you can name a specific facility, for example Main Street Clinic. Or name a specific professional, for example chiropractor John Jones. Please use the specific lines. Providing location information may help make your request more clear. Please print "All my health care providers" in this section if you want health information from all of your health care providers to be released.

4| Indicate where you would like the requested health information sent. It is best to provide a complete mailing address as not everyone will fax health information. A place has been provided to indicate a deadline for providing the health information. **Providing a date is optional.**

5| Indicate what health information you want sent. If you want to limit the health information that is sent to a particular date(s) or year(s), indicate that on the line provided.

For your protection, it is recommended that you initial instead of check the requested categories of health information. This helps prevent others from changing your form.
EXAMPLE: _*jh*_ All health information

If you select **all health information**, this will include any information about you related to mental health evaluation and treatment, concerns about drug and/or alcohol use, HIV/AIDS testing and treatment, sexually transmitted diseases and genetic information.

Important: There are certain types of health information that require special consent by law.

Chemical dependency program information comes from a program or provider that specifically assesses and treats alcohol or drug addictions and receives federal funding. This type of health information is different from notes about a conversation with your physician or therapist about alcohol or drug use. To have this type of health information sent, mark or initial on the line at the bottom of page 1.

Psychotherapy notes are kept by your psychiatrist, psychologist or other mental health professional in a separate filing system in their office and not with your other health information. **For the release of psychotherapy notes, you must complete a separate form noting only that category. You must also name the professional who will release the psychotherapy notes in section 3.**

6| Health information includes both written and oral information. If you do not want to give permission for persons in section 3 to talk with persons in section 4 about your health information, you need to indicate that in this section.

7| Please indicate the reason for releasing the health information. If you indicate marketing, please contact the organization in section 4 to determine if payment or compensation is involved. If payment or compensation to the organization is involved, indicate the amount.

8| This consent will expire one year from the date of your signature, unless you indicate an earlier date or event. Examples of an event are: "60 days after I leave the hospital," or "once the health information is sent."

9| Please sign and date this form. If you are a legally authorized representative of the patient, please sign, date and indicate your relationship to the patient. You may be asked to provide documents showing that you are the patient or the patient's legally authorized representative.

MINNESOTA MDH DEPARTMENT OF HEALTH

This form was approved by the Commissioner of the Minnesota Department of Health on January 30, 2008.

JAN2008

Minnesota Standard Consent Form to Release Health Information

1 Patient information

First name_____ Middle name _____ Last name _____

Patient date of birth ___ /___ / _____ Previous name(s) _____
MM DD YYYY

Home address _____

City_____State_____ Zip code _____

Daytime phone _____E-mail address (optional)_____

Medical Record/patient ID number (optional)_____

2 Contact for information about how this form was filled out (optional) :

I give permission for the organization(s) listed in section 3 permission to talk to

First name_____Last name_____ about how this form was completed, this person can be reached at: Daytime phone _____ E-mail address (optional)_____

3 I am requesting health information be released from at least one of the following:

Organization(s) name _____

Specific health care facility or location(s) _____

Specific health care professional's name(s) _____

4 I am requesting that health information be sent to:

Organization(s) name _____

And/or person: First name _____ Last name _____

Mailing address _____

City_____ State_____ Zip code_____

Phone (optional) _____ Fax (optional) _____

Information needed by (date) ___ / ___ / _____ (optional)
MM DD YYYY

5 Information to be released

IMPORTANT: indicate only the information that you are authorizing to be released.

___ Specific dates/years of treatment _____

___ All health information *(see description in instructions for what is included)*

OR to only release specific portions of your health information, indicate the categories to be released:

___ History/Physical	___ Mental health	___ HIV/AIDS testing
___ Laboratory report	___ Discharge summary	___ Radiology report
___ Emergency room report	___ Progress notes	___ Radiology image(s)
___ Surgical report	___ Care plan	___ Photographs, video, digital or other images
___ Medications	___ Immunizations	___ Billing records

___ Other information or instructions _____

The following information requires special consent by law. Even if you indicate **all health information**, you must specifically request the following information in order for it to be released:

___ Chemical dependency program *(see definition in instructions)*

___ Psychotherapy notes *(this consent cannot be combined with any other; see instructions)*

Minnesota Standard Consent Form to Release Health Information

Patient's name _____

6 Health information includes written and oral information

By indicating any of the categories in section 5, you are giving permission for written information to be released **and** for a person in section 3 to talk to a person in section 4 about your health information.

If you do not want to give your permission for a person in section 3 to talk to a person in section 4 about your health information, indicate that here (check mark or initials) _____

7 Reason(s) for releasing information

___ Patient's request
___ Review patient's current care
___ Treatment/continued care
___ Payment
___ Insurance application
___ Legal
___ Appeal denial of Social Security Disability income or benefits
___ Marketing purposes (payment or compensation involved? ☐ NO ☐ YES, amount _____)
___ Other (please explain) _____

8

I understand that by signing this form, I am requesting that the health information specified in Section 5 be sent to the third party named in section 4 above.

I may stop this consent at any time by writing to the organization(s), facility(ies) and/or professional(s) named in section 3. If the organization, facility or professional named in section 3 has already released health information based on my consent, my request to stop will not work for that health information.

I understand that when the health information specified in section 5 is sent to the third party named in section 4 above, the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws.

I understand that if the organization named in section 4 is a health care provider they will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form.

If I choose not to sign this form and the organization named in section 4 is an insurance company, my failure to sign will not impact my treatment; I may not be able to get new or different insurance; and/or I may not be able to get insurance payment for my care.

This consent will end one year from the date the form is signed unless I indicate an earlier date or event here:

Date ___ / ___ / _____ Or specific event _____
MM DD YYYY

9

Patient's signature _____ Date ___ /___ /_____
MM DD YYYY

Or legally authorized representative's signature_____ Date ___ /___ /_____
MM DD YYYY

Representative's relationship to patient (parent, guardian, etc.)_____

This form was approved by the Commissioner of the Minnesota Department of Health on January 30, 2008.