21st Century Cures Act

Introduction and FAQs for Child and Adolescent Psychiatrists

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Introduction

The Office of the National Coordinator for Health Information Technology (ONC)'s *21st Century Cures Act*, signed into law by President Obama, promotes and funds the acceleration of research into preventing and curing serious illnesses; accelerates drug and medical device development; attempts to address the opioid abuse crisis; and aims to improve mental health service delivery. The final rule for the 21st Century Cures Act was published on May 1, 2020.

While the bill is largely known to help fund efforts such as precision medicine, it contains some provisions to improve healthcare IT and improve patient access to their own electronic health information.

The final rule includes a provision stating that patients can electronically access all electronic health information (EHI), structured and/or unstructured, at no cost. Section 4004 of the regulation authorizes the U.S. Secretary of Health & Human Services to identify any blocking of information to patients while still allowing reasonable exceptions. The consequences of being an "information blocker" can be severe. Many child and adolescent psychiatrists in private practice may be in violation of some aspects of the 21st Century Cures Act and will need to determine if they meet any of the available exceptions.

CAP Specific Considerations

The 21st Century Cures Act represents a critical shift in thinking about patient care and documentation. This act clarifies that the patient is the true owner of their health information, wherever it happens to be stored. They are entitled to access this record - we are simply the holder of this medical record for the patient. Aside from psychotherapy process notes, all information typed into an EHR system is typically discoverable and can be obtained through legal measures, including items blocked from patient portals or items marked as sensitive and "unshared." Therefore, it is imperative to practice with the understanding that if you do not want someone to read information in the chart, do not type it. There are significant benefits to having transparency in documentation for a patient-provider relationship. It could help with care coordination and transitions between providers and works to de-stigmatize mental health treatment for all.

CAP specific Questions

Q: What exceptions to the 21st Century Cures Act would CAPs most frequently consider for their practices/patients?

A: Important to note for all exceptions that the clinician is still required to respond to the request in a timely manner, and to document the exception they are citing to not release the information.

Q: When can I use the Risk of Harm Exception? What constitutes 'harm'?

A: Substantial risk of harm such as developing suicidal or homicidal ideations from reading the contents

of the note. If access to the note may cause a risk that another to harm the patient (a parent reading about a patient's information) that may also be covered under this exception, or Privacy. Emotional distress alone is likely not sufficient.

Q: When can I use the Privacy Exception?

A: Examples for which the Privacy Exception may be used include:

- Patient/guardian-specific requests - The patient or guardian may request that the clinician not share the information with any others. This request can be used as justification to not release information without being considered information blocking.

- For compliance with other state and federal laws that protect patients, such as substance use treatment records, sexual health treatment, and mental health treatment. Each state has its own laws governing patient privacy and release of these types of patient records - it is vital to review your own state's statutes.

Q: When can I use the Psychotherapy Notes Exception?

A: The psychotherapy notes exception refers to what most psychiatrists would recognize as process notes. This refers to a record of sessions that the mental health clinician does NOT intend to use for billing or communication purposes, and are not intended to be maintained as part of the patient's medical record. In general, if the note is what a CAP is using to seek insurance reimbursement, it is NOT covered by this exception. Session notes that are used to synthesize and interpret a patient's biopsychosocial formulation but no other purpose likely ARE covered by this exception and can be withheld from the patient without being considered information blocking.

Q: When can I use the Infeasibility Exception?

A: This will be a commonly used exception, at least initially, if an EMR system is unable to unambiguously segment off information that should be shared with information that should not be shared. For example, if confidential information that an adolescent has shared about their sexual or substance use history is intermingled in narrative with other information, and it is not feasible to separate this information out, then the note can be withheld without being considered information blocking under this exception. The CAP would still be obliged to respond in writing to the request in a timely manner (within 10 days), stating that the request cannot be fulfilled due to infeasibility

Q: What if I don't have or use an EMR?

A: Regulation amongst providers without EMRs is somewhat unclear, but the initial feedback from ONC seems to indicate that the Infeasibility Exception would apply. The CAP would still be obliged to respond in writing to the request in a timely manner (within 10 days), stating that the request cannot be fulfilled due to infeasibility.

Q: What is the penalty if I don't/can't comply?

A: In order for a provider to be an "information blocker", they must knowingly intend to block the data from the patient. A provider will not be held liable due to limitations in their technology and would not be penalized at this time. This may change in the future. See AMA's Summary for additional details.

Q: Are there any age specific considerations to be aware of for child and adolescent patients?

A: The following points should be considered in this matter:

- The law does not restrict a parent from having access to an unemancipated adolescent minor's records. State laws regarding a minor's ability to access their own records still apply. State laws define ages of minors.

- If feasible, consider setting up a multi-tiered access to a teen's records, where parents have access to some basic information, and a teen has additional access to their treatment record.

- Teens may not be used to accessing their own health information and may not understand the long-term ramifications of disclosing this information to others. You may need to educate adolescents about the importance of keeping their information private. Also remind teens not to share access or passwords with anyone else.

Q: Can we restrict access to a treatment note that contains sensitive information such as reports of child abuse, or observations from a third party individual?

A: This would fit under the Privacy Exception if the patient specifically requests the information remain private. It may also count toward the Preventing Harm exception if there is a risk that by sharing this information with another person, there could be physical retribution in response. Providers should be thoughtful about how to navigate their EHR to keep specific information private if possible.

Q: What if a parent provides information that they do not want the child to know about, such as family history?

A: This would fit under the Privacy Exception. However, it is important to distinguish accessible information through one's patient portal from the legal medical record in one's EHR system. Aside from psychotherapy process notes, all information typed into an EHR system is typically discoverable and part of the legal medical record, including items blocked from patient portals or items marked as sensitive and "unshared". Therefore, it is imperative to practice with the understanding that if you do not want someone to read information in the chart, do not type it. This is the patient's record and they are entitled to access this record - we are the holder of this medical record for the patient.

Q: In general, how do we handle making sure that a patient's privacy is protected, especially as it relates to gender and sexuality spectrum?

A: Please refer to information described above regarding HIPAA Privacy Rules at 45 C.F.R. and specific state statutes regarding rules for minors. Please be mindful of where the data is stored. For example, if a patient has a preferred name, but is not comfortable sharing that name with family members who have access to the patient's chart, then it would be important to think of where or how that information is stored.

Q: Should this change how I write a note or other charting decisions?

A: The following items should be considered when writing notes:

- Assume EVERYTHING you write in a chart can potentially be viewed by the patient. This may include communications to other individuals initiated through the EHR. For example, a consulting provider

may have access to your progress notes and other PHI of the patient. Be mindful of your wording in the chart; avoid speculation about motives behind an action and medical jargon. Use thoughtful descriptive language or quotations to substantiate your medical assessment and to offer a fuller picture. Consider your notes as an extension of conversation, mirroring how you speak with the patient in session. Avoid casting dispersions on culturally sanctioned practices. Keep critical billing/coding information in your notes.

- Requiring a patient or family to provide a signed written consent (often referred to as a "HIPAA form") before sending medical records to another medical provider continues to be unnecessary in many cases. With the 21st Century Cures Act, such a policy might be considered information blocking if it causes undue delays in patient's care. Physicians and organizations should carefully review their policies on sharing and transmitting data to other medical providers to ensure that it is in accordance with current laws.

- If for some reason you do need to restrict a patient's access to their data, you should clearly identify your reasoning with respect to the Exceptions where information blocking is permissible.

For any questions or comments, please reach out to AACAP's Clinical Practice Department at clinical@aacap.org.