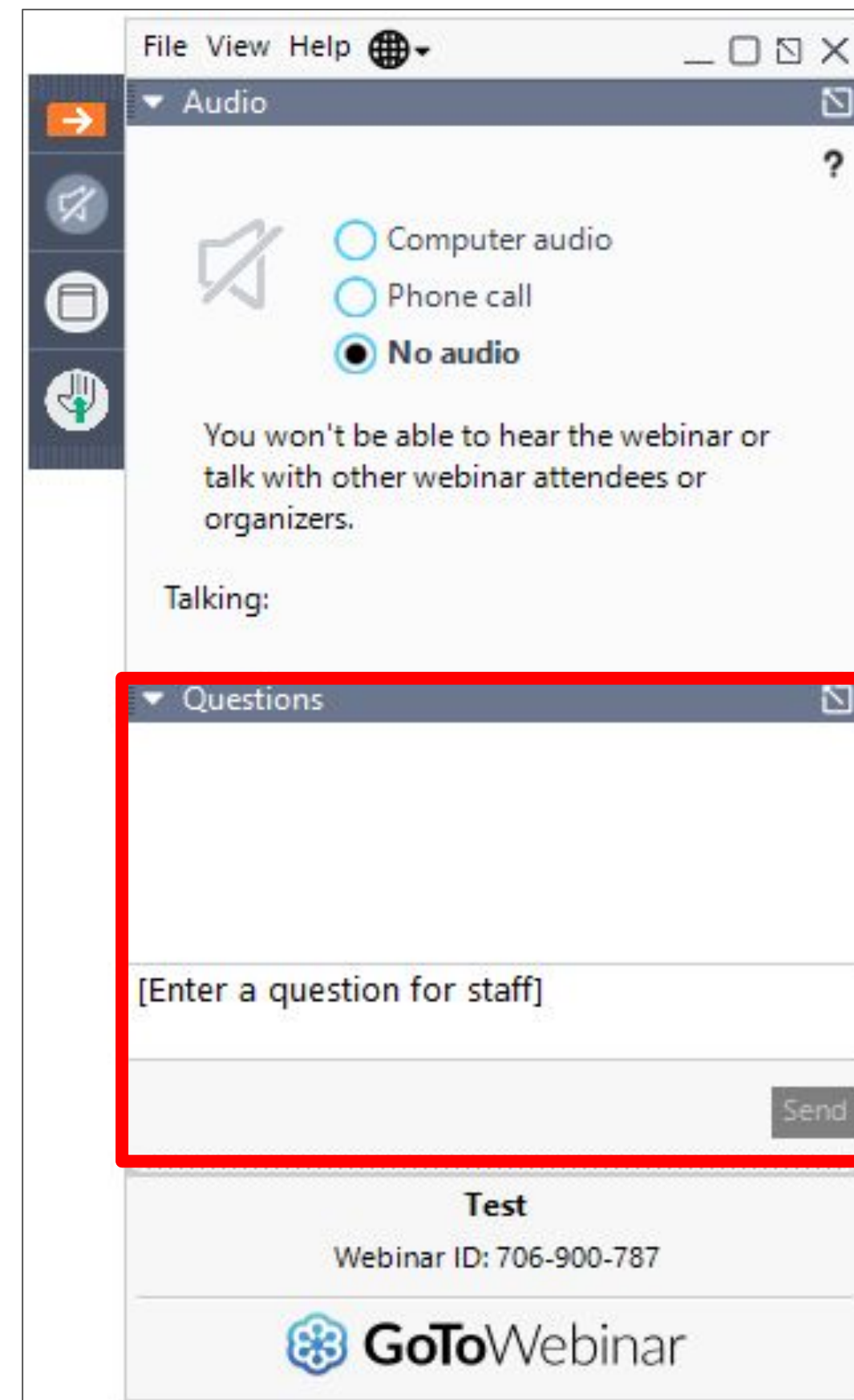**21st Century Cures Act & OP:**
Addressing Questions for Your Practice

Sue Kressly, MD, FAAP
Medical Director, OP

Welcome to 21st Century Cures Act & OP: Addressing Questions for Your Practice

- Attendees will be muted. If you have a question, enter it into the **Questions** box.

Overview

- The information being presented in this webinar is up to date as of 3/30/2021

- This webinar will be recorded and made available after the webinar

- This is an informative webinar to discuss client questions and concerns

- Please take advantage of ongoing conversations and resources including those on the OP Help Center

Take Advantage of Resources!

21st Century Cures Act: Sample Pediatric Policies & Ex...

Watch later   Share

Pediatric Success SERIES

21st Century Cures Act: Sample Pediatric Policies and Exceptions

Sue Kressly, MD, FAAP

Watch on ▶ YouTube

Supporting Webinar Resources:

- Sample Policy for Pediatrics: Information Sharing Policy
- Presentation Slide Deck
- Live Webinar Questions and Answers

https://www.officepracticum.com/resources/engaged/
21st-century-cures-act-pediatricians-policies-1051

External Resources / Links
This is a list of external resources for the 21st Century Cures Act

American Medical Association	In anticipation of physician compliance with ONC's information blocking rule, the AMA has created a two-part educational resource: • **Part 1:** Outlines what information blocking is, key terms to know, examples of information blocking practices, and a summary of exceptions for when physicians may restrict access, exchange, and use of electronic health information. • **Part 2:** Will help physicians start down the path of compliance, including questions to consider, considerations for maintaining a compliance program, and next steps. In addition, the American Academy of Pediatrics is meeting with the ONC to discuss use cases unique to pediatrics. This information will be shared as soon as it is available.
CHIME (College of Healthcare Information Management Executives)	• Information Blocking Exceptions Companion Guide (32 pages) • High-Level Cheat Sheet on the CMS and ONC Interoperability Final Rules (5 pages) • Key ONC and CMS Interoperability and Information Blocking Timelines (2 pages) • Information Blocking Q/A with ONC (6 pages) • Information Blocking Resource Center

https://op.knowledgeowl.com/help/21st-century-cures-act-external-resources

Disclosure

- I am have no legal credentials
- The information that you are about to see is my personal interpretation of educational materials that are available in the public domain
- There are nuances about information blocking and sharing that the AAP is still seeking clarity with the Office of the National Coordinator
- Expert guidance continues to evolve

It is the responsibility of each practice to develop a practice policy on how they will share information in compliance with the 21st Century Cures Act.

Objectives

- Review the OP tools that allow you to granularly protect sensitive information
- Understand how information is shared in an electronic format
- Join the OP community in a commitment to continue learning

Share Freely, Restrict Smartly

- Share as much information as broadly as possible to empower your patients (it's their information)
- Any restrictions on information sharing should fall under one of the **Exceptions** discussed in the prior webinar
- Make sure that information not shared is done so in a way that is:
  - nondiscriminatory
  - restricts only what you need to

Passive vs Active Sharing

- Cures Act only addresses responding to requests for sharing of EHI
  - Active sharing
  - Electronic Health Information
- Intent and Spirit of the Regulation includes sharing broadly & empowering patients
- The law doesn't say the only ways to share EHI are through a CDA or API however...
  - Those are the only 2 existing HIT standards currently
- The law doesn't say you need a Portal or Direct Messaging...however
  - the only way *in OP* a parent can have free access to their CDA is through the portal
  - The only way you can currently *receive* a CDA is through Direct Messaging

CDA= Clinical Document Architecture

- Definition: The HL7 Clinical Document Architecture (CDA) is an XML-based markup standard intended to specify the encoding, structure and semantics of clinical documents for exchange.

- It takes coded data in the EHR such as:
  - Problem list items (have SNOMED or ICD codes and descriptions)
  - Medications (have NDC and Rx Norm codes and descriptions)
  - Labs have LOINC codes and descriptions

- Through computer generated functionality, it can turn those coded elements into an electronic message that can be shared and consumed by a different computer and different EHR.

Not Everything in OP is in an Electronic Form

- Not everything can be provided to a patient/representative in an "electronic format"
    - Scanned documents
    - Pictures
    - Some textual notations including the "notes" field in OP
    - Surveys
    - Risk Assessments (other than smoking status)

What does a CDA look like to a patient?

Transition Of Care Ambulatory for MANATEE TESTPATIENT

Clinical Document

OPEN IN NEW WINDOW

Summary for MANATEE TESTPATIENT

Patient	MANATEE TESTPATIENT		
Date of birth	February 12, 2021	Sex	Female
Race	White	Ethnicity	Hispanic or Latino
Detailed Race	Afghanistani	Detailed Ethnicity	Spanish Basque
Contact info	Home: 900 MAIN STREET Sanibel, FL 33957 Tel (Work Place): (215) 343-5520 Tel (Primary Home): (123) 456-7890 Tel (Mobile): (267) 261-4441	Patient IDs	18717292 2.16.840.1.113883.3.6585.1.1
Preferred Language	hy		
Document Id	A4BCBD2B-C015-4AE6-AB6D-10D78845674F		
Document Created	March 22, 2021, 14:57:19		
Care provision	from March 22, 2021, 14:26:00 to March 22, 2021, 14:26:00		
Performer (primary care physician)	Susan Kressly		
Contact info	Work Place: Kressly Pediatrics, PC 1432 Easton Road, Suite 4E Warrington, PA 18976 Tel (Work Place): 2153435520		
Author	InteliChart Portal		
Contact info	Work Place: 1061 Red Ventures Dr. Fort Mill, SC 29707 Tel (Work Place): (866) 957-8890		

			allergy	SnomedCt)				
Neosporin Neo To Go	1049127	RxNorm	Drug allergy	Rash (-SnomedCt)	Mild	Active	3/3/2021	
cefaclor	309042	RxNorm	Drug allergy	Respiratory distress (-SnomedCt)	Severe	Active	3/4/2021	
neosporin		RxNorm	Drug allergy	(-SnomedCt)		Active	3/18/2021	

PROBLEMS

Problem Name	Code	Code System	Reported Date	End Date	Status
Frank breech presentation	18559007	SnomedCt	2/25/2021		Active
		SnomedCt	2/13/2021		Active
		SnomedCt	2/14/2021		Active
Heart murmur	88610006	SnomedCt	2/26/2021		Active
Transitory tachypnea of newborn	7550008	SnomedCt	2/12/2021	2/15/2021	Resolved
Congenital hip dysplasia	52781008	SnomedCt	2/26/2021		Resolved
Failure to thrive	54840006	SnomedCt	3/3/2021		Active
		SnomedCt	3/3/2021		Active
Child in foster care	160871009	SnomedCt	3/4/2021		Active

MEDICATIONS

Medication	Code	Code System	Start Date	Stop Date	Route	Directions	Status	Fill Instuctions
cholecalciferol (vitamin D3) 10 mcg 1 mL	251154	RxNorm	3/1/2021	4/30/2021	ORAL	Take 1 mL by mouth once a day for 60 days	Active	Generic substitution allowed
albuterol sulfate 2.5 mg /3 mL (0.0 1 vial	630208	RxNorm	3/1/2021	5/30/2021		Inhale 1 vial every 4 hours for 30 days as needed	Active	Generic substitution allowed
montelukast 4	351246	RxNorm	2/1/2021	2/28/2021	ORAL	Take 1 unit by	Inactive	Generic

What Does A CDA Look Like to a Computer?

```
3   function FillPatient(RT)
4       local function FillGuardian(G)
5           cda.code.add{target=G, element='code', system=cda.codeset.cat["HL7 Role Class"],
6               value=cda.codeset.personalRelationshipRole.Parent, lookup=cda.codeset.personalRelationshipRole.reverse}
7           cda.demographic.address.add{target=G, use=cda.codeset.address.Home,
8               street='1357 Amber Drive', city='Beaverton', state='OR', zip='97867', country='US'}
9           cda.demographic.phone.add{target=G, phone='(816)276-6909', use=cda.codeset.address.Home}
10          local GP = addElement(G, 'guardianPerson')
11          cda.demographic.name.add{target=GP, given='Ralph', family='Jones'}
12
13          return G
14      end
15
16      local function FillBirthPlace(B)
17          local P = addElement(B, 'place')
18          cda.demographic.address.add{target=P, city='Beaverton', state='OR', zip='97867', country='US'}
19
20          return B
21      end
22
23      local function FillLanguageCommunication(L)
24          cda.code.simple.add{target=L, element='languageCode', value=cda.codeset.language['English - US']}
25          cda.code.add{target=L, element='modeCode', system=cda.codeset.cat["LanguageAbilityMode"],
26              value=cda.codeset.proficiencyLevel["Good"], lookup=cda.codeset.proficiencyLevel.reverse}
27          cda.value.add{target=L, element='preferenceInd', datatype='BL', value='true'}
28          return L
29      end
30
31      local function FillProviderOrganization(O)
32          cda.id.add{target=O, id_type=cda.codeset.cat["National Provider Identifier"]}
33          cda.demographic.name.simple.add{target=O, name='Community Health and Hospitals'}
34          cda.demographic.phone.add{target=O, phone='(555)555-5000', use=cda.codeset.address.Work}
35          cda.demographic.address.add{target=O, use=cda.codeset.address.Work,
36              street='1001 Village Avenue', city='Beaverton', state='OR', zip='99123', country='US'}
37
38          return O
39      end
```

Not Everything in the Patient's Chart Is Currently Shared

- The USCDIv1 Elements are all that are currently required to be shared
- What's NOT automatically shared from OP *currently*
  - Internal Messages without "web portal user"
  - Items with privacy higher than "Any Staff Member"
  - Patient exit notes (in note format)
  - Patient encounter notes (in note format)
  - Details of Social history
  - Past Medical History (including *birth history details)*
  - Family history
  - Scanned items unless "shared to portal"
  - Smoking status: **Not** currently shared to portal

Portal View is NOT Just "Current" Information

- The portal view does not just reflect current problems, medications, etc.
- It is purposefully designed to comply to HIT standards which gives the patient and their healthcare team the history to inform care decisions
- Consider a patient seeing a specialist for seizures, it would be important to see all of the past medications that the patient was tried on not just what they are on today
- Start/End dates matter to delineate current vs past to the patient view

Protecting Sensitive Information
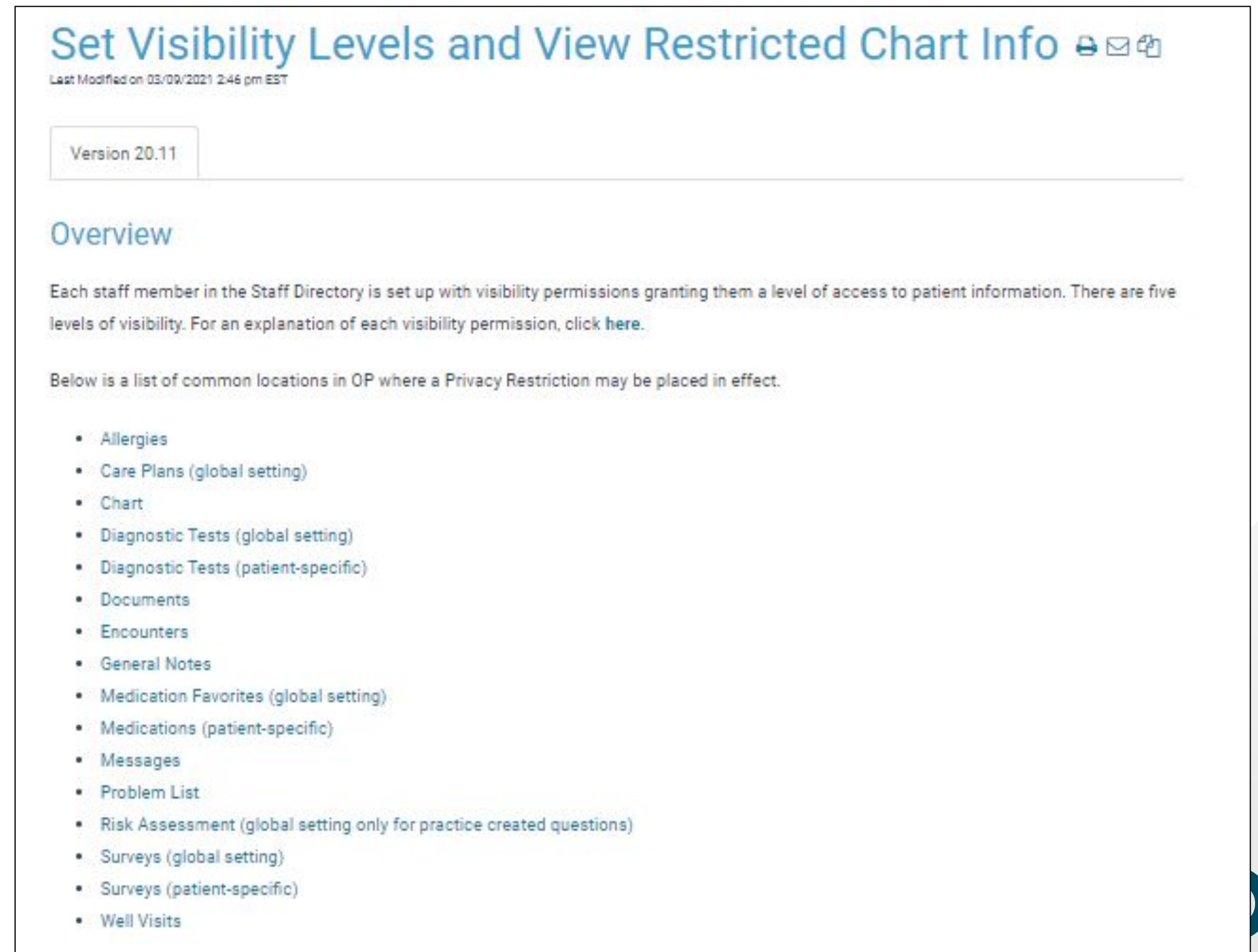
What Sensitive Information Should be Protected?

- That is a practice and provider decision
- Should only protect the granular part of the data which is sensitive, not "block" everything
- Must make sure that you don't have a policy that can be construed as discriminatory
- HIPAA rules take precedence over 21st Century Cures Act
- Jurisdictional laws take precedence over 21st Century Cures Act

Protecting Sensitive Data in OP

- Non-clinical information that may be sensitive should not be stored where others may have access to it or it may be inadvertently shared (use pop up alerts, general notes, to document information you don't want shared such as "mother has a PFA against father")
- Take advantage of Visibility Function in OP
  - Problem list
  - Medications
  - Allergies
  - Counseling Section
  - Entire Note

Set Visibility Levels and View Restricted Chart Info
Last Modified on 03/09/2021 2:46 pm EST

Version 20.11

Overview

Each staff member in the Staff Directory is set up with visibility permissions granting them a level of access to patient information. There are five levels of visibility. For an explanation of each visibility permission, click here.

Below is a list of common locations in OP where a Privacy Restriction may be placed in effect.

- Allergies
- Care Plans (global setting)
- Chart
- Diagnostic Tests (global setting)
- Diagnostic Tests (patient-specific)
- Documents
- Encounters
- General Notes
- Medication Favorites (global setting)
- Medications (patient-specific)
- Messages
- Problem List
- Risk Assessment (global setting only for practice created questions)
- Surveys (global setting)
- Surveys (patient-specific)
- Well Visits

Visibility Levels

There are five levels of visibility:

- **Any staff member**: A record set with this level is visible to all staff members. The record could be printed by any staff member and provided upon request. It can be accessed by the patient or parent when they are logged into their Patient Portal if this section of the chart is on the portal.
- **Clinical staff only**: A record set with this level is not immediately visible to your staff members. Only staff members who have at least the Clinical Staff Only Standard Visibility Level are able to see this part of the chart upon request. Staff members who are able to see this record are able to print it out and provide it to internal or external persons upon request. This type of record is not visible on the Patient Portal.
- **Providers only**: This level of visibility has the same functionality as Clinical Staff Only, but from Providers Only standard medical records visibility level and higher. This type of record is not visible on the Patient Portal.
- **Physicians only**: This level of visibility has the same functionality as Clinical Staff Only, but from Physicians only standard medical records visibility level and higher. This type of record is not visible on the Patient Portal.
- **Author only**: This is the highest level of visibility and is the most restrictive. If a record is marked as Author Only, only the staff member that created the record is able to retrieve it. This staff member is the only one able to print this record. This type of record is not visible on the Patient Portal.

Visibility Clean-up

- Dr. Berman shared a DB Viewer SQL on the listservs to find problem list items
- Changing the status in OP will trigger an update to remove the problem from the portal
- We will also be looking at an SQL for medications
- Best practice: sanity check the information *at least* at every well visit
- A few practices had withheld sending portal information at all based on a certain "trigger date". We are working to find a way to push the older information after you have had a chance to clean up your data.

SQL Magic

```sql
select c.* from (
select  pcp, patno, fname, lname, icd_1, snomed1, words, privacy,
case when lower(words) like  '%abuse%' then 'sensitive'
when lower(words) like  '%drug expos%' then 'sensitive'
when lower(words) like  '%drug withd%' then 'sensitive'
when lower(words) like '%sexual%' then 'sensitive'
when lower(words) like '%marijuana%' then 'sensitive'
when (words) like '%THC%' then 'sensitive'
when lower(words) like '%gay%' then 'sensitive'
when lower(words) like '%compliance%' then 'sensitive'
when lower(words) like '%std%' then 'sensitive'
when (words) like '%STI%' then 'sensitive'
when lower(words) like '%chlamydia%' then 'sensitive'
when lower(words) like '%gonorrhea%' then 'sensitive'
when words like '%UDS%' then 'sensitive'
when lower(words) like '%suicid%' then 'sensitive'
when lower(words) like '%addicition%' then 'sensitive'
when lower(words) like '%etoh%' then 'sensitive'
when lower(words) like '%queer%' then 'sensitive'
when lower(words) like '%weed%' then 'sensitive'
when lower(words) like '%grass%' then 'sensitive'
when upper(words) like '%MJ%' then 'sensitive'
when lower(words) like '%assault%' then 'sensitive'
else 'ok' end as sensitivity
from (
select a.*,   trim(coalesce(icd_1_descript, '') || ' ' || coalesce(snomed1_descript,'') || coalesce( note,'') ) as words  from (
select patno, fname,lname, staffname as pcp, icd_1, icd_1_descript, snomed1, snomed1_descript, cast(left(note1,5000) as char(5000)) as note,
case when chartnotes.privacy_level = 'A' then 'public' when chartnotes.privacy_level is null then 'public' else 'private' end as privacy from chartnotes

inner join register on register.patno = chartnotes.patno
inner join staff1 on staff1.staffid = register.addr_id
 where section_subheading = 'PAST MEDICAL HISTORY'
and patno > 99
and status_pat ='ACTIVE'
and lname <> 'TESTPATIENT'
and problem_list ='Y'
order by patno
) a ) b
) c
```

Protecting Sensitive Data on the InteliChart Portal

Portal Management > Code Management: Labs

Protecting Sensitive Data on the InteliChart Portal

Portal Management > Code Management: Diagnosis

Visit Notes: What is Currently Going?

- Only CDA summary (shown in clinical documents area)
- IF want patient to see encounter note or patient exit note currently: Print to PDF and share as document
- Working toward automatic sharing of note summary
  - Should it be encounter note or patient exit note?
  - Should it be both?
  - Should it be practice choice?

Labs: A work in progress

- Currently lab results only shared in patient portal if part of an encounter
- IF important to share results timely: print to PDF and share
- Going forward: feedback wanted
  - Should we share when lab results are received or only informed/complete?
  - You can protect at InteliChart practice portal level by "delaying" results but may constitute Information Blocking

Sharing Lab Results

Have a Question?

- Type it into the **Questions** box
- Any unanswered question(s) will be communicated to the Webinar attendees via email

Resources

- OP's Homepage on 21st Century Cures: https://op.knowledgeowl.com/help/21st-century-cures-act
- Link to resource for sample Information Sharing Policy: https://www.officepracticum.com/resources/engaged/21st-century-cures-act-pediatricians-policies-1051
- ONC FAQs: https://www.healthit.gov/curesrule/resources/information-blocking-faqs
- CHIME's Resource Center: https://infoblockingcenter.org/
- Visibility Levels in OP: https://op.knowledgeowl.com/help/set-visibility-levels-and-view-restricted-chart-info
- More OP Resources to come

Thanks for Attending!