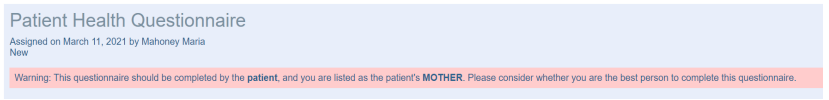
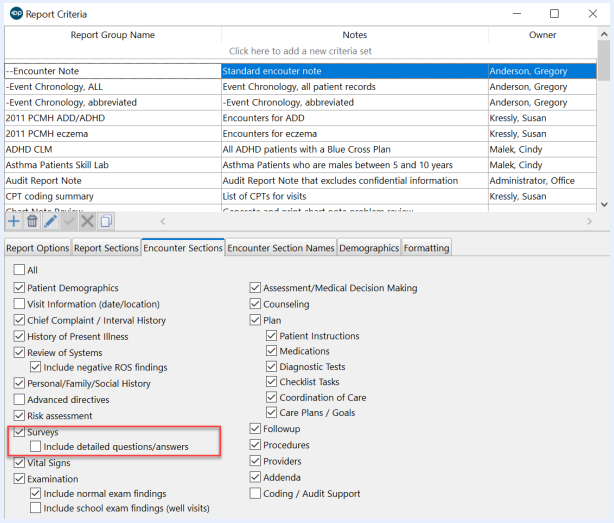
21st Century Cures Act & OP: Addressing Questions for Your Practice

Question Asked	Answer Given	
I would like the portal to show only patient exit note	OP is working on automatically triggering the patient exit note as the encounter note once finalized. In order to remain in compliance with 21st Century Cures practices should make an effort to review the contents of your practice-configured patient exit note and make sure you are comfortable with what is included. This is not currently in production but you will receive notification when it is.You may also want to state in your policy that your intent is to provide patient exit notes, but in addition the patient encounter note can also be made available upon request. Stay tuned for details.	
Are you answering the questions we submitted ahead of the presentation or do I need to ask them again?	Please ask again. We created the webinar based on questions. Sorry if we missed yours	
If the patient wants records faxed - does the time limit for HIPAA apply or does CURES trump	HIPAA supersede CURES.	
So before a patient is 14 we can share mental health with parents between 14-18 we cannot then once they are 18 - the portal becomes theirs. Are we supposed to have to shut stuff off between 14-18 or ??? (I know that this age may be different in different states). Is this something that they just haven't thought about?	Mental Health is part of 21st century cures act and mental health information should also be shared with the patient/representative with the exception of Psychotherapy notes, or if the content fits one of the other exceptions. Look what your local laws, remember to restrict as little as possible. Surveys do not go to portal. If they are included in your note, may make a difference for sharing information with patients (encounter note or patient exit note depending on survey results being included. Remember the "patient dept" in OP is non-discriminatory and doesn't separate the patient from other caregivers with portal access. Whomever has log in to portal has the same view of the information but this does not include surveys.	If you have the Report Criteria set not to include Survey Details as noted in the screenshot below, the the answers will not show in the note. 
If we turn notes on in the portal now - is it the entire note or nothing?	Notes are not currently going as of now. If you have disabled them at the Practice Administrative portal level now, it has no implications. In order to be compliant with 21st Century Cures Act at some point you will want to enable them. Discussions about what should go (encounter note vs patient exit note) in discussion, but most likely will be patient exit note and will be up to practices to make sure their contents of the patient exit note is configured to support their practice Information Sharing Policy. We are investigating the possibility of looking for key potentially sensitive words in your patient notes before sharing.	
I know you are looking to mass end date old meds. Is there a plan for end dates to be able to added to EPCS meds for the future if we forget to add one? (Or is OP looking at some kind of button so we can do "clean ups" ourselves	Yes and Yes. We don't want you to have to go find each end date for all meds. In a future release OP will do the math for you when you uncheck the "chronic flag" on any medications and populate that field (or choose today if not possible). As far as remediating medications that are already on the portal, this will be future work but we also have to make sure that bulk changes don't have negative impacts on real time data movement.	
Some tests have multiple LOINC codes - OP can't handle them now. Is the best practice to leave these blank?	Most panels also have a LOINC code. It is free to create and look up a code on loinc.org or contact skressly@officepracticum for assistance.	
So the issue is that we don't need to restrict mental health before age 14 but we DO need to restrict once they turn 14. The patient can get it after age 18. This isn't surveys - these are notes about depression or anxiety	I believe that regulations releasing mental health information is not standardized by age across all states. In addition, this is different than releasing to outside entities. This is information that is being released to the patient or their representatives. 21st Century Cures Act applies to mental health notes as well; the only exclusion is formal psychotherapy notes. If you have specific concerns, I would discuss with your state Medical Society.	

Time limit to produce HIPAA records is 30 days and the time limit for CURES is 10 business days	HIPAA states that you have 30 days to give a patient access to their PHI (whether it is electronic or not): https://www.hhs.gov/answers/hipaa/index.html. 21st Century Cures does NOT mandate 10 days for producing information. It says that you only have 10 days to claim an Infeasibility exception.	
I unchecked Problems Page in the Intelichart Patient interface. Is this now visible?	If you have problems accessible to your patients in your practice portal configuration, they are visible.	
My own health plan (Kaiser) blocked access to my child's record once she turned 13 yo. Can this not be a global application for our 13 yo patients? eg if some charts are shared and some are not, a parent may ask why one note was shared and one was not if we blocked for privacy issues under Risk Taking Behavior	Starting April 5th (the applicability date) this is no longer allowed. You should contact the healthcare entity and ask them to allow you access to your minor child's information except what is allowed to be restricted by the 21st Century Cures act. They must share what they can, but are still allowed to protect privacy according to jurisdictional and HIPAA laws or must claim an exception.	
Do we need to share OP well visit and Encounter notes?	Currently the visit notes themselves are not going, but we are working on a solution that will share a note upon finalization (likely the patient exit note for both). The note contents that can be mapped in a CDA are currently being sent to the portal. Encounter notes are part of the USCDI mandatory data set. You should want to empower the patients to share the notes wherever safe to do so and not covered by an exception.	
If labs are scanned into the chart under documents will the patient have access to that info via the portal/	No, that scanned result would need to be individually sent to the Portal under Document Management. https://op.knowledgeowl.com/help/what-documents-can-be-sent-to-the-patient-portal-faq	
By what date are we required to have a patient portal up and running, if we do not have one now	There is no mandate to have a portal at all, just to share. And there is no enforcement penalties posed. In my opinion, I think it would be best practice to be well on your way by the end of 2021. This will be continuous work to share more as you are able.	
Do we have to update our medical releases to include an email or direct message option for the patient to choose?	There is no mandate on what choices you give parents to get information. The 21st Century Cures Act just mandates that IF they request it electronically (CDA or API) you have a way to comply and if the information is not in an electronic format, that you work on a mutually agreeable different solution regarding how you are able to share the content.	
Are CDA's received from specialist to our practice in OP, also available to the patient on the portal?	The shared CDA that came from the specialist is not visible to the parent in InteliChart portal. However, it is likely visible to the parent in the specialist's portal by downloading the CDA from that institution's portal solution.	
Some labs I created from scratch and gave my own LOINC codes - will these still go through?	OP has put together a list of the LOINC codes for a practice to update their In House diagnostic tests. Follow the instruction below to perform the updates https://op.knowledgeowl.com/help/diagnostic-tests-loinc-codes https://op.knowledgeowl.com/help/in-house-loinc-codes	
What does validation of who can access the portal look like? Is this a signed document similar to a HIPAA release form?	Currently if a parent is entered as a contact within OP, the staff can generate a PIN for that contact to access the Portal. The child can also add Proxy for someone to access the Portal. The authentication process is part of your information inside OP matching what is on the portal and affirming they should have access by granting a PIN. There does not have to be any signed consent but your practice should make sure they are authenticating appropriate access and maintaining accurate people in the patient's contacts.	
I know that surveys are not shared to the portal but are they shared to the parent CHADIS login where they can be viewed?	Technically it is possible for a parent to look at "prior surveys" but it is not straightforward. OP is discussing potential solutions with CHADIS.	
Did it get established whether voided medications or not picked up are visible?	Currently voided prescriptions are still visible on the portal. Development will be working to address this in the coming weeks and we will notify practices when that is accomplished. There will be two phases to this development work: fixing it going forward and then OP will investigate whether we can remediate currently voided medications that remain visible. More to come.	
Will non-standard snomed or loinc codes go over? non-standard as in user defined fabricated codes (I mean we have a few "fake" snomed codes (there is a number we put in there) for purposes of creating care plans.)	InteliChart does not attempt to validate or interpret LOINC or SNOMED codes, they display what OP sends to them. However, through a CDA a receiving healthcare entity would not be able to match the information and reconcile it with any meaning.	
I have not seen pop up alerts. Is there a knowledge article available?	Adding Miscellaneous notes to enable pop up message when making an appointment https://op.knowledgeowl.com/help/adding-misc-notes Using General Notes https://op.knowledgeowl.com/help/general-note	

How do you suggest a workflow for getting portal restricted information to other providers? Other providers need to know about the marijuana use as self medication for the depression, but parents may not get this information.	It's a challenge. We are not there yet but there are several pediatric leaders involved in a national stakeholder initiative to create HIT standards to "tag" sensitive data in a way that the sender and receiver understand what to do with that information including re-sharing. In the meantime, if it is critical to the care of a patient, a phone call to another healthcare provider involved in care may be the best way to communicate the information accurately and safely.	
Will OP be able to send notes directly to the specialist that the patient is going to?	If that Specialist has a Direct Email address that has been published and shared then yes. If the office has the Direct Email address, you can send the note.	
Where can we get a copy of the sample policy? Was that provided in the previous webinar?	It is in 4th slide of this deck. Link on OP help center https://www.officepracticum.com/resources/engaged/21st-century-cures-act-pediatricians-policies-1051	
Is it ok to send a document via secure email for example using Virtru ?	Let's separate security vs electronic sharing. Using secure encryption for emailing documents (whatever their content or form) is a great way to share information and likely fits within your security profile. However, the "electronic form" is a CDA. So sharing the CDA via an encrypted email does both things. On the other hand, the parent can access a CDA directly through the portal without your involvement. https://op.knowledgeowl.com/help/op-patient-portal-parent-parent-experience-access-clinical-summary	
DO you have a sample template for practices to get the "legal" aspects of this off-the-ground. Just something that we can then add to and modify?	It is in the 4th slide and the link in OP Help Center,It was. It is in 4th slide of this deck. Link on OP help center https://www.officepracticum.com/resources/engaged/21st-century-cures-act-pediatricians-policies-1051 https://op.knowledgeowl.com/help/21st-century-cures-act-external-resources	
For the LOINC codes, we've been creating these codes and not looking up the actual codes. We do enter the CPT code. Is this going to be an issue? Should we go back and add the actual LOINC code?	There should be no impact for sharing on the portal itself as InteliChart simply sends the code and description we provide to them. However, this will not be able to be reconciled by a receiving entity who gets a CDA because the receiving entity will not be able to interpret the "made up" LOINC.	
In our state, we are to inform parent that a minor is seeking drug/alcohol/mental health therapy toward "the end" of the treatment. Ideas on how to achieve this through the portal?	I am not familiar with state regulations and what constitutes informing the parent. It may not be necessary to accomplish this as an "electronic" action. I would check with your state requirements and feel free to send the requirements directly to me to help problem solve.	
It looks Problem List items that do not have a SNOMED code assigned will not really display in a CDA. True?	Any problem list item that doesn't have a SNOMED or ICD with code/description will not be displayed on the portal nor be able to be shared on a CDA nor interpreted by a receiving entity.	
You previously stated about needing an "end date" for medications rather than just removing the "chronic" checkbox. When would you need to put an end date? If a prescription is given for 30 days, doesn't OP automatically give an end date of 30 days?	Many prescriptions in OP automatically calculate an end date which is past along to the portal and displays as a past medication. When you have the chronic flag checked in OP and then remove it, often it leaves the medication without an end date and it displays as current on the portal. OP is doing 2 things: introducing a change in OP so when you uncheck the chronic flag we will calculate and insert an end date if possible, or insert the date of the action for you. This is not currently in production and we will notify you when it is as part of the release notes. In addition, we are exploring ways to remediate the prescriptions which are already in that state for you in bulk (to reduce your need to do it one by one).	
Does the law say that you have to receive a CDA?	There is no law that mandates you receive a CDA. At some point, theoretically someone could report you for "potential" Information Blocking if they are attempting to share important electronic data/EHI with you and you refuse to implement the capability to receive that information.	
We do not have a lab interface with our local hospital or LabCorp because we were told our practice is too small, not enough volume. Can we use the 2st Century Cures Act to force these labs to set up the interface with OP	Laboratories must be compliant and share data with you. However, they are allowed to charge you a "reasonable" fee to do so. I would go back and ask and contact me if you meet resistance.	
We enter medications prescribed by an outside provider under Med Reference during med reconciliation process at each visit. Do Med Reference medications show up in portal?	Yes	
Are there any guideline for the amount of time that is considered reasonable to respond to a request for records?	There are no recommendations. HIPAA does say that the maximum is 30 days no matter how you share information. However, the ONC does comment in the FAQs that your delays cannot have negative impact on the patient's ability to receive care or that may constitute Information Blocking. It is reasonable to ask the patient/representative what information they are looking for and why and respond accordingly.	
We have 2 full time care coordinators/navigators - each deals with numerous continuity of care referrals daily. What do you think of our Care Coordinators as primary contacts for requests for information?? TY Sue.	This is a reasonable solution for processing requests. Make sure that you have a "coverage" workflow for in the event the usual personnel are out of the office.	
How do we customize the pt exit note?	This help article will help you customize the exit note https://op.knowledgeowl.com/help/report-criteria	

What is the clean up sql	Once you get the slide deck. Slide 20 will give you the SQL to copy and paste to pull a list of Problem List items to clean up and change the visibility status. It is also now available on the OP Help Center: https://op.knowledgeowl.com/help/sql-visibility-clean-up-problem-list	
We have not did start and stop for medication or resolved for problem list are we ok if we do this going forward	There is no mandatory requirement to change this and OP will attempt in the future to add end dates to medications where possible (not yet currently available.) Problem lists don't require an end date (may be helpful, but not mandatory) as long as the resolved *status* is indicated if you want the problem to show as resolved, not current in the portal.	
Do we need a Consent for Release of medical records to specify what, where and what format for records to be sent? Or is this not needed as patients no longer have to sign release to send out information?	It depends if you are actively or passively sharing information. If the patient/representative is using the portal they inherently have given consent to access and use their own information. Similarly, for requests through portal messaging their log in affirms they have a right to the request. For active requests, there is no federal standard for a written request. There is also no standard that patients have to acknolwedge they received your Information Sharing policy. Make sure your policy for sharing information (apart from portal requests) validates the requester has a right to receive the information (especially if on the phone). Your practice may choose to obtain a written request when in person or via fax, or sign for any records that are picked up in the office but it is not mandatory.	
Surveys do not go to patient portal, but they do go to CHADIS?	Survey results are not visible on the patient portal. If parents used the link from a message in the InteliChart portal to find their way back to CHADIS they can theoretically review prior survey results.	