Implications for Dental Records from 21st Century CURES Act

by C.Scott Litch Chief Operating Officer and General Counsel

At some point, you may have read about the 21st Century CURES Act and wondered whether you need to worry about it. This column will attempt to clarify and calm any concerns. The 21st Century CURES Act was passed by Congress in 2016, as an effort to foster innovation and problem solving in health care and attempt to remove barriers to information exchange. It encourages electronic information exchange between providers, payers, consumers and others for the sake of improving care, reducing costs and empowering consumers.[1] There were two subsequent regulations implementing the CURES Act, to prohibit information blocking practices and identify interoperability standards for the digital exchange of health information.[2] This column will focus on the provision that gives patients the right to immediate electronic access to their health records, including physicians' notes. The CURES Act went into effect on Nov. 1, 2020.

So what does this mean for dentistry? There is probably little immediate impact in private practice, but more of an impact for those practicing in hospitals, academic health centers, or community clinics with integrated medical/dental patient charts. The earliest impact for the broader community will be for private practitioners who use an integrated health record such as EPIC for documentation of their hospital general anesthesia cases. Over time, there will likely be more impact on private dental practices as electronic exchange of data increases.

For those impacted, patients will be able to read chart notes almost immediately after the visit without a separate records release request. In a hospital, there is the infrastructure to have patients access the electronic record through a patient portal. Most dental offices currently do not have this capability. Of course, the dental office can print out the record and let the patient/family member read it if requested.

Regardless of practice setting, it is good common sense/risk management advice to properly and accurately document patient/family discussions and information conveyed, but to do so in non-offensive and non-inflammatory ways. For example, the American Academy of Family Physicians recommends that although the CURES Act does not require physicians to change their note-writing style, some small modifications can be helpful when documenting potentially sensitive topics such as mental health, obesity, substance use disorder, sexual history, or spousal abuse. Their tips for patient-friendly notes are:

1. **Be transparent.** Your communication with the patient in the office should reflect what you put in the note. There should be no surprises.
2. **Minimize jargon and abbreviations.** If there are medical terms that patients might easily misinterpret, briefly define or simplify them, such as "short of breath," rather than SOB or dyspneic.
3. **Highlight the patient's strengths and achievements in addition to the patient's problems.** This can be particularly helpful for patients with mental health issues because it gives them a more balanced perspective of their illness as they tackle difficult behavioral changes.

4. Describe behaviors rather than labeling the patient or making judgments. For example, consider these alternatives:

- "Patient could not recall" instead of "Poor historian,"
- "Patient is not doing X" instead of "Non-compliant,"
- "Patient prefers not to" or "Patient declines" instead of "Patient refuses."[3]

The American Medical Association **(AMA)** has provided a summary of what information blocking means, since this is now prohibited under the CURES Act. Physicians can experience information blocking when trying to access patient records from other providers, connecting their EHR systems to local health information exchanges, migrating from one EHR to another, and linking their EHRs with a clinical data registry. Patients can experience information blocking when trying to access their medical records or when sending their records to another provider.[4]

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This column presents a general informational overview of legal issues. It is intended as general guidance rather than legal advice. It is not a substitute for consultation with your own attorney concerning specific circumstances in your dental practice. Mr. Litch does not provide legal representation to individual AAPD members.

[1] *For more details see: https://www.ada.org/en/publications/ada-news/2020-archive/september/ada-standards-committee-on-dental-informatics-leads-charge-to-foster-interoperability*

[2] *https://www.federalregister.gov/documents/2020/05/01/2020-07419/21st-century-cures-act-interoperability-information-blocking-and-the-onc-health-it-certification; https://www.govinfo.gov/content/pkg/FR-2020-05-01/pdf/2020-07419.pdf*

[3] *https://www.aafp.org/journals/fpm/blogs/inpractice/entry/open_notes.html*

[4] *https://www.ama-assn.org/practice-management/digital/new-information-blocking-rules-what-doctors-should-know*