MARY A. RACKHAM INSTITUTE
UNIVERSITY OF MICHIGAN

New Electronic Health Information Access Rules and Exceptions

What is the 'Information Blocking' Rule?

Information blocking refers to a practice by health care providers or health care systems that interferes with the access, exchange, or use of electronic health information (EHI) by the patient. The Cures Act, passed in 2016, established the expectation that health care providers and systems would engage in "reasonable and necessary activities that do not constitute information blocking." In 2020, the Cures Act Final Rule was enacted and made clear the requirements and exceptions for releasing EHI to patients.

An example of information blocking could be a patient having unreasonable difficulty accessing their medical records because a clinic's policy is to send paper copies of electronic medical records — such as progress notes — within 30 to 60 days after they are requested by the patient (allowing time for printing and mailing of the records to the patient), *but* the clinic's electronic medical record system is capable of providing much quicker patient access to these medical records via an electronic delivery system. For instance, the progress notes that are sent to a secure patient portal within a specified time period after each visit. This scenario could be considered unreasonable because the clinic has the technical capability to provide timely electronic access to at least some of its records, but it isn't doing so when it mails paper copies of electronic records.

Note: For more on Information Blocking and mental health care specifically, see this FAQ from American Psychological Association.

What are the Exceptions to Information Blocking?

There are eight exceptions that fall into one of two categories. Exceptions that:

- Allow health care providers/systems to **not** fulfill requests to access, exchange, or use EHI.
- Involve **procedures** for fulfilling requests to access, exchange, or use EHI.

Category 1

Exceptions that allow health care providers/systems to not fulfill requests to access, exchange, or use EHI.

1. **Preventing Harm Exception**
   Applies when denying access to EHI will substantially reduce the risk of harm to a client or another person (ex: release may endanger physical safety or EHI is inaccurate). This is at the discretion of the clinician and/or supervisor but is done so only after significant consideration of the circumstances and a determination of potential harm is made.

2. **Privacy Exception**
   Applies when denying access to EHI request is consistent with HIPAA-patient-access limitations. For example, in divorce/custody situations, the requesting parent must be determined to have legal rights to the information before it would be shared with that parent.

a. If a client has requested that their EHI not be shared or only portions of it be shared, MARI will follow those.

3. **Security Exception**
   Applies when there is a need to protect the security of EHI — as long as it is directly related to safeguarding confidentiality, integrity, and availability of EHI, it is tailored to specific security risks, and it is implemented in a consistent and non-discriminatory manner.

4. **Infeasibility Exception**
   Applies when legitimate logistical challenges exist related to providing EHI access. For example, the provider/system does not have and may not be able to obtain the necessary technology, legal rights, or other means to provide EHI access. The exception applies:
   a. If the provider/system's electronic health record vender (in MARI's case, ClinicTracker) has not yet provided a means for direct patient access to records.
   b. With family or couples therapy where multiple client information is part of the EHI *and* cannot be unambiguously separated, and/or where part of the EHI may create concerns about potential harm to a patient.
   c. For testing and evaluation cases, if the test questions cannot be separated from the test answers. There are often licensing, copyright and other prohibitive rules related to providing access to testing materials and maintaining the integrity of such testing measures.
   d. In an event beyond the control of the provider/system (e.g. natural or man-made disaster, public health emergency, internet service interruption, act of regulatory authority).

5. **Health IT Performance Exception**
   Applies when the health technology system (in this case, ClinicTracker and the MARI patient portal) has to be made temporarily unavailable or altered to benefit the overall performance of the software, provided it does not last longer than necessary, it is implemented in a consistent and non-discriminatory manner, and meets other requirements.

Category 2

Exceptions that involve *procedures* for fulfilling requests to access, exchange, or use EHI.

6. **Content and Manner Exception**
   Applies when there is a need to limit the content of EHI to be accessed, exchanged, or used, if the provider/system establishes the content that must be provided to the request (content) or establishes the manner in which the request is fulfilled (manner).

7. **Fees Exception**
   If the cost of accessing the EHI or in collecting the requested records will require significant time or resources, the provider — MARI — is able to charge fees related to accessing, exchanging, or using EHI, although these fees need to be based on objective and verifiable criteria that are uniformly applied (e.g. same fee to all patients) *and* need to be reasonably related to costs of providing this access.

8. **Licensing Exception**
   Applies when a provider/system needs to protect the value of their innovations and charge reasonable royalties in order to earn returns on investments made for those innovations.

How do I Access My Records at MARI Now?

MARI has been working on strategies to reasonably increase client access to their electronic medical records in line with the Cures Act within the context of the available resources in our electronic medical record, ClinicTracker (CT). We have changed how we create clinical notes and how they will be available to clients. For example, this new rule means that clients will automatically have access to appointment summary notes shortly following a session.

The notes will be available in their patient portal account under a new tab in their account. Notes will only be released once the clinician has reviewed and signed them and they have been reviewed and signed by an additional supervisor if needed (depending on the providing clinician). Additional clinical records will eventually be available in this same manner.

Additional clinical documentation (e.g. Collaborative Treatment Plans, Full Evaluation Reports, Termination Reports) are planned to be automatically available over time as our internal resources and EHI technical system functions allow. Those additional types of records are still available upon request, following the release requirements and exceptions as identified above.

To request records, please send a message through the patient portal, selecting Registration and Intake as the recipient and adding “Records Request” as the subject line.

Best Practices for Clients and Clinicians - Keep the Conversation Open!

Talk with your clinician, when possible, before you access records and follow up with them for more details, to answer questions, etc.

To be clear, this is *not* a requirement! But we highly encourage clients to let their clinician know they are interested in reviewing the clinical notes and documentation. In the past, a client would have to submit a written request for records. With instantaneous access, any client might access the viewable clinical notes in their portal account at any time without giving their clinician notice. However, we highly encourage clients to talk with their clinician(s) before accessing their EHI in order to understand the content. That said, it is your healthy information and you have every right to access it.

Please keep in mind:

- Clients should go to their clinician with any questions or concerns about what is written in the EHI because records are written and used as technical clinical information.
- Note also that records must include many elements to establish medical necessity, and meet state, payor, or other recordkeeping requirements. Regarding medical necessity, **it is important for clients to understand that insurers or government payors may refuse to cover their care if you do not accurately report the extent of their diagnosis, symptoms, problems, and lack of progress.**
- **Please do not rely on apps or unvetted internet resources** to translate medical/mental health terms into plain English. You can’t be certain that any app will accurately translate psychological terms, so it is better for you to just read the actual record and ask the clinician to explain anything you don’t understand or would like more details about.

- Please remember that we are trying our best to shift to documentation that is more understandable and accessible to patients, but it is a process. Let us know when you have questions or concerns and keep the lines of communication open.