What is the 21st Century Cures Act?

The 21st Century Cures Act’s Final Rule has created a bit of anxious buzz from the medical community since its passing on December 23rd, 2016 and finally its enactment on April 5th, 2021. Several issues specifically related to psychiatric practice were addressed within this law, including, but not limited to, enhanced funding for the Comprehensive Addiction and Recovery Act, and the Mental Health Parity Act. The document also outlines modifications to the FDA drug approval process and “informed consent” terms for research. Most importantly to practicing psychiatrists, the act underlines specifics about patient access to electronic health information (EHI). (1).

The concept that the Cures act spells out is not new. Complete access to healthcare records was codified by HIPAA since 1996, but it has been misinterpreted and misused. Despite the HIPAAs' purpose to improve access to records and improve their "portability," the confusion about requirements for signed consents has led to information blocking and delays. In 2009, HITECH came into law to reinforce patient access to PHI through EMR systems, yet due to continued HIPAA misinterpretation this was partly successful. Finally, the 2016 passing of the Cures Act legislation aimed to make access easier and virtually unrestricted, it basically served as a platform to clearly re-explain some aspects of HIPAA. To increase interoperability across EHR platforms, the Cures Act also explicitly tasks vendors to enable the development of computer and smartphone applications that give patients full and portable access to their health care information. It also prohibits them from “choking” EMRs and blocking access to records in the case of customer non-payment. The Act tasks users of EMRs (ex: physicians) to make records immediately available via patient portals or any other means, preferably electronic.

In response to the Cures Act, many physicians have expressed concern in regards to allowing full access to patient notes, despite this already having been the case since 1996. Critics of information transparency have argued that releasing information can, under certain circumstances, be psychically harmful to the patient. Research however, has shown that access to notes can be beneficial to the patient (3) and overall improve patient care and safety.

The Cures Act does not replace the requirement to release medical records in pursuant to HIPAA or your state regulations. HIPAA describes what PHI is, and when and what PHI can be disclosed; the Final Rule requires disclosure of EHI unless an exception applies or the disclosure is prohibited by law.

How does this apply to your private practice?

Continued on page 24
WPS Committees
2021 - 2022

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With skyrocketing medication costs and little political will to confront them, the battle raged between two immense profit-driven industries: pharmaceutical and insurance. The insurance companies rolled out high copays, and the pharma companies fought back with discount cards. So, the insurance companies responded with the most lethal, cynical weapon they could think of. And instead of aiming it at their powerful adversary, they chose a defenseless proxy: the doctors caught in the middle. The weapon, of course, is prior authorization. And while we’re besieged right now, read on to see that help is on the way.

It seems to be a common experience that a patient will learn that their medication is on hold and be told by a pharmacist or their pharmacy benefit manager that the solution is simple: the doctor just has to contact insurance to get authorization. They don’t say that prior authorization can be time consuming and complicated, and that there’s no guarantee the request will be approved. The forms can be inscrutably worded and redundant. Criteria at times are inconsistent with good clinical practice or even, at times, with current FDA indications (e.g. requiring trials of three different atypical neuroleptics before approving a branded agent for bipolar depression). Documentation requirements like chart notes, and actual dates of previous med trials are excessive and often unobtainable. While we’re invited to submit a free-form narrative or rational for a medication choice, most often, the decision is made by a pharmacist who applies rigid, often flawed criteria. Denials can be appealed, but this requires an even greater investment of time. The turnaround is lengthy, so often the process ceases to be clinically relevant. To add to the burden, insurance companies require prior authorization for generic medication, repeated authorization of medications taken for years, and even for dose changes of the same medication.

Of course, the patient is unaware of all this. All they know is that they’re not getting the medication they pinned their hopes on — and probably saw featured in idyllic commercials. That, and that some failure of the doctor is responsible. I think that psychiatry is especially hurt by the prior authorization process. With severely ill patients, the therapeutic alliance is often fragile and subject to disruption because of frustration about getting medication. As is suggested by a study of Medicaid patients in Maine many patients whose medications are denied due to prior authorization, stop taking treatment altogether. Further, psychiatrists are more likely to prescribe medications off label, which likely would result in insurance denial, though such interventions would represent appropriate clinical care. Indeed, in an APA-sponsored survey of psychiatrists, most respondents thought that prior authorization negatively impacts patient care. 59.9% admitted changing the diagnosis or fabricating previous medication trials to circumvent treatment-impeding authorization criteria.

Despite serious doubts about the ultimate value of prior authorization, it’s not going anywhere. As a first step to reigning in the excesses, members of WPS and the Maryland Psychiatric Society — along with the APA Department of Government Relations — collaborated on legislation to be introduced during the upcoming session. While not a cure-all, it’s a first step toward making the process more tolerable and clinically responsible. The legislation provides: 1) that a physician specializing in the condition being treatment make the actual decisions to deny; 2) that an expedited appeal be reviewed by another physician of the same specialty and that a decision be rendered within 48 hours; 3) non-controlled generic medications not be subject to review; 4) no reviews on meds taken for more than six months; 5) no reviews for dose changes of the same medication.

If passed, we who are caught in the middle of this battle between behemoths would receive significant relief from the law. So keep an eye out for it. And when the time comes, be ready to let your legislative representatives know the current system has affected your patients, and how it important it is to enact these changes.


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THE BEHIND THE SCENES STORY
OF THE COVID-19 VACCINE

NVRL, NIH
OCTOBER 19, 2021
7:30 P.M.
VIA HORIZON
VIRTUAL VENUE
DETAILS TO FOLLOW

Dr. Barney Graham, MD. PhD
Director
Governance
- This Fall the Governance Committee will focus on reviewing the Policy Guide.
- The Suburban Maryland Psychiatric Society is planning an educational program this Fall featuring Dr. Barney Graham, of NIH. Dr. Graham played a significant role in the development of the m-RNA vaccines (Pfizer and Moderna) for COVID-19. He is the husband of SMPS Past President Cynthia Turner Graham. Watch for details.
- Work is underway to move forward with the WPS Foundation, exploring ways to utilize the Foundation to fulfill its mission and work collaboratively with WPS.

Finance
- The August 31st balance sheet shows an equity of $332,254.77 vs. $277,137.58 last year, an increase 19.9%.
- The IRS 990 form for 2020 is almost complete and it will be circulated for board review prior to filing.

Membership
- The total membership is 807, an increase of 6 members over the August total of 801 members.
- Members who rejoin APA because of non-payment have until September 30 to reinstate without having to join.

Communications
- Work is underway on the fall edition of Capital Psychiatry.
- WPS is looking at a redesign of the newsletter to improve readability.

Programs
- WPS and MPS are collaborating with APA on the introduction of Maryland legislation related to Prior Authorization.
- The Advocacy Committee is moving ahead with its new structure to focus on legislation, public affairs, and community outreach.

Events
- On September 25, the WPS CME Committee held a very successful Fall Symposium on innovation, featuring extraordinary speakers, many of them from Europe.
- Details will soon be announced for the October CME event and the October Critical Conversation.
- Julia Hartenstein is moving into the role of CME Staff Liaison and will handle APA CME processing.
WPS Fall Symposium Synopsis
Anne Marie Dietrich, M.D.
WPS CME Committee

Psychiatrists work hard to stay on top of the latest information, but following the myriad topics in psychiatry can be daunting. The WPS Fall Symposium on Saturday, 9/25/21, for which the overarching theme was

“WHAT’S NEW? TREATMENT INNOVATIONS FOR TODAY AND TOMORROW”

accomplished that task! The CME committee, with Dr. Matthew Rudorfer guiding the entire process, presented a virtual multinational symposium with eminent psychiatrists presenting over a 5,000-mile range, across 7 time zones. The program occurred with no major problems, thanks to the outstanding staff at NWG (Pat Troy, Deb Forsten, Julia Hartenstein, and Bobbi Sorensen) who made it look easy!

Check out treatment updates in:

- Psychedelics
- Schizophrenia
- CAP
- Perinatal Mood disorder
- Bipolar
- Depression
David J. Nutt, MD, is the Edmond J. Safra chair in Neuropsychopharmacology at Imperial College London, and director of the Neuropsychopharmacology Unit in the Division of Brain Sciences. He is also the chairman of Drug Science, a non-profit which he founded in 2010 to provide independent, evidence-based information on medications. Dr. Nutt’s informative talk started by naming the different psychedelics (“mind manifesting”) which have been used for millennia by human beings: the peyote cactus (mescaline), magic mushrooms (psilocybin), morning glory, amanita muscaris, and ayahuasca. After Albert Hoffman discovered LSD in 1938, psychiatry had some early uses for it as a psychomimetic, in self-experimentation, for psychedelic psychotherapy (a high dose in one single session), and psycholytic psychotherapy (low doses over multiple sessions). There was great clinical interest in LSD in the 1950’s and 1960’s with overwhelmingly positive results. Psychedelic research stopped largely due to the US government’s ban (1967), which was then followed by the UN ban (1971).

Psychedelics are all serotonergic agonists, with potency determined by affinity. Serotonin receptors are most dense in the cortex. Research on psilocybin has shown that it attenuates medial Prefrontal Cortex (mPFC) activity, leading to an uncoupling of the fronto-parietal connectivity (also known as the Default Mode Network or DMN). The DMN is the cortical network which orchestrates our lives, and has been pruned to be very efficient with minimal connections. By switching off this “control center”, psilocybin increases the connectivity of neurons to one another. Psychedelics appear to act on the pyramidal cells in the cortex, interrupting the rhythmic firing of neurons and resulting in hyperconnectivity. This effect seems to allow for seeing new solutions to old problems. Interestingly, meditation, particularly transcendental meditation, can also change the DMN. However, this takes many years of practice, which is not practical for most of our suffering patients.
What’s New in the Treatment of Schizophrenia

**Christoph Correll, MD**, a Professor of Psychiatry at the Donald and Barbara Zucker School of Medicine at Hofstra/Northwell, and also, professor and chair of the Department of Child and Adolescent Psychiatry at Charite Hospital in Berlin, Germany. Dr. Correll first discussed the three recently approved agents for schizophrenia: Olanzapine-Samidorphan, the VMAT-2 inhibitors, Deutetrabenazine and Valbenazine, and Lumateperone.

**Lumateperone** primarily acts on the serotonin and dopamine receptors to reduce positive symptoms of psychosis, stabilize affective symptoms, reduce motor effects, and possibly improve cognitive issues. Additionally, lumateperone binds to D1 receptors leading to activation of AMPA receptors and possible improvement in depressive symptoms. Metabolically, one 6 week study showed an improvement in fasting glucose, triglycerides, and cholesterol. The VMAT-2 inhibitors, **deutetrabenazine and valbenazine**, are FDA-approved for tardive dyskinesia (TD) in adults. They have dose-dependent responses when treating TD. **Olanzapine-Samidorphan** primarily blocks dopamine, serotonin, and mu opioid receptors to both treat psychosis and ameliorate weight gain (and possibly metabolic abnormalities).

Novel agents being studied include: Ulotaront, Xanomeline, and Pimavanserin. **Ulotaront**, an antipsychotic, is a trace amine-associated receptor 1 agonist (TAAR1) with serotonin 1A receptor agonist activity and no D2 receptor blockade. TAAR1 is a free-floating intracellular receptor which is found in the hypothalamus and GI system. In studies, Ulotaront has not been found to cause EPS, akathisia, weight gain, or metabolic abnormalities. **Xanomeline**, a muscarinic acetyl-choline receptor agonist, has been studied to address cognitive and negative symptoms of schizophrenia. Because it has significant GI side effects, trospium chloride has been added and found to decrease these side effects. Finally, **Pimavanserin**, already FDA-approved for hallucinations and delusions associated with Parkinson’s psychosis, is being studied as a treatment for the negative symptoms of schizophrenia because it is an antagonist and inverse agonist at serotonin 2A receptors, and has no post-synaptic dopamine blockade.

Dr. Correll concluded his talk with a request that we participate in the COH-FIT study (Collaboration Outcomes Study on Health and Functioning during Infection Times). It is a large international survey project, involving 200 investigators in more than 35 countries, to identify the effects of Covid-19 on physical and mental wellbeing. This is the link to the survey: [https://www.coh-fit.com/](https://www.coh-fit.com/)
What’s New in the Treatment of Child and Adolescent Disorders

CAP Treatment News
Dr. Benedetto Vitiello

- **ASD**
  - SSRIs show no promise
  - Maybe clomipramine
  - Bumetanide (loop diuretic) failed

- **ADHD**
  - MPH for 3-6 yo
  - Risperidone and Valproate - effective adjuvants but only after maximization of MPH
  - holidays, caloric supplementation, and increased monitoring all led to increased weight!
  - Viloxazine (SNRI) – poor antidepressant but maybe ADHD?

**Benedetto Vitiello, MD**, formerly of the NIMH, where he was Chief of the Child and Adolescent Treatment and Preventive Interventions Research Branch, is currently a Professor of Child and Adolescent Neuropsychiatry at the University of Turin, in the Dept of Science for Public Health and Adolescence. Dr. Vitiello discussed recent studies which examined different pharmacotherapy interventions for ADHD and Autism Spectrum Disorder (ASD).

Methylphenidate (MPH) is used off-label to treat the hyperactivity of children between the ages of 3-6 years old. One study looked at the long-term safety and tolerability of MPH in the treatment of these preschoolers, the researchers determined that IR formulation seemed to be a bit better tolerated than the ER formulation. Another study looked at stepped treatment for children with ADHD and Aggression. The primary conclusion was that the stimulant dosage should be optimized before adding either risperidone or valproate (both of which were found to be helpful). When using stimulants, parents and physicians worry about growth suppression in children. Drug holidays, caloric supplementation, and increased monitoring all led to increased weight, but did not improve the height curve for children. A new medication approved in April 2021 (Viloxazine, SNRI), which had originally been marketed as an antidepressant in the UK, may be an option for ADHD treatment.

In ASD, the SSRI’s do not appear to work on the core repetitive and restrictive behaviors, although clomipramine may be a bit more helpful than the others. A study looking at Bumetanide (a loop diuretic acting on Cl- ions) as a possible medication to enhance the GABAergic system and improve core symptoms of autism did not show any evidence of clear superiority over placebo.
What’s New in the Treatment of Perinatal Mood Disorders

Riah Patterson, MD, an Assistant Professor of Psychiatry at UNC Chapel Hill and the Medical Director for the Perinatal Psychiatry Inpatient Unit, noted in the answers to the quiz that “80% of women will have at least one pregnancy, 50% of pregnancies are unplanned, and Peripartum Depression is the most common complication of childbirth………….95%-97% of women with perinatal depression are not successfully treated”. Peripartum psychiatry actually began in the 1850’s with French psychiatrist Louis-Victor Marce who wrote in a monograph that “where subjects are predisposed to mental illness through either hereditary antecedents, previous illnesses, or through an excessive nervous susceptibility, pregnancy, delivery and lactation can have disastrous repercussions”. The first mother-baby unit (MBU) was established in 1979 in France, and the first peripartum intensive unit (PPIU) was established in 2011 at UNC.

On the PPIU, Dr. Patterson administers brexanolone, an “IV formulation of the endogenous neurosteroid allopregnanolone” (a breakdown product of progesterone). Approved in the U.S. in 2019 as the first and to date the only drug with an FDA indication of postpartum depression, brexanolone, administered as a 60-hour infusion, must be used in a Risk Evaluation and Mitigation Strategy (REMS)-approved healthcare setting. Allopregnanolone is a “positive allosteric modulator of GABA-A receptor, with mechanisms of action in multiple areas, including GABAergic dysfunction, HPA Axis, dysfunction, neurosteroid deficits, and altered network communication. In one recently published study, Dr. Patterson found that 15/16 cases had “a clinically meaningful reduction in HAM-D scores”, with 9/16 “reaching remission” after the 60-hour infusion. Dr. Patterson has not found a patient’s depression to be more resistant as the postpartum extends.
Keming Gao, MD, PhD., Director of the Mood Disorders Program and Bipolar Disorder Research Center at Case Western Reserve University School of Medicine, Dr. Gao started by reviewing the current FDA approved medications and non-pharmacological treatments for Bipolar Depression and Bipolar Mania. He noted that of the currently approved medications, only quetiapine has shown efficacy across the bipolar mood spectrum (manic, mixed, or depressive) as monotherapy to delay relapse or recurrence, but that lithium was a close second in efficacy. Dr. Gao emphasized that most patients do not have only Bipolar Disorder, with more than 90% experiencing at least one comorbid condition during their lifetime. In one study (JAMA, 2021), Dr. Gao looked at a Network Meta-analyses of adjunctive psychotherapy for Bipolar Disorder. He found that CBT, psychoeducation, and family therapy were the most effective in aiding a patient’s recovery.

Dr. Gao discussed some relatively new treatments for Bipolar Depression include Ketamine, TMS, and Midday Light Therapy. He did note that ECT is effective for acute mania, and that VNS is not covered by Medicare. With ketamine, Dr. Gao noted that most people respond after the third infusion, but that 30-40% of patients will need a 4th, 5th, or 6th infusion before a determination of success or failure (Phillips, et al, 2019). TMS studies suggest that high frequency Left unilateral is more effective than bilateral or Right lateral. Midday Light Therapy is best administered between 12 pm - 2:30 pm, for 30-60 minutes. Possible future treatments for Bipolar Disorder include transcranial Direct Current Stimulation (tDCS uses low levels of electrical current to stimulate the brain), RDoC-based research targeting anhedonia, and further investigation of the unique neuroprotective effects of lithium.
What’s New in the Treatment of Depression

Was a timely presentation by Pilar Cristancho, MD, an Associate Professor of Psychiatry and the Director of Interventional Psychiatry at Washington University School of Medicine. Dr. Cristancho started by noting that 30% of people who are diagnosed with Major Depressive Disorder (MDD) will have Treatment Resistant Depression (TRD). TRD is generally agreed to be defined as a failure of at least two antidepressant treatments and is associated with higher rates of suicide attempts, and increased medical comorbidities and disability. Dr. Cristancho noted that “disruption at a specific site or node within the functional circuit (network), linking different brain regions, results in depressive symptoms”. Neuroimaging findings from PET and fMRI have found abnormalities in the prefrontal and cingulate cortices, limbic and paralimbic structures, and in subcortical structures. Importantly, “aberrant connectivity [has been found] within the Affective Network, Reward Network, Default Mode Network, and Cognitive Network”.

Dr. Cristancho discussed 3 types of interventional treatments: electroconvulsive therapy (ECT), transcranial magnetic stimulation (TMS), and Esketamine. ECT and TMS induce neuronal depolarization via electrical currents, beginning with magnetic stimulation in the case of TMS, which then affect downstream neural systems, by normalizing areas of hyperconnectivity and stimulating neurotrophic factors. Esketamine (the more potent S-enantiomer of ketamine with a greater NMDA receptor affinity), delivered intranasally under the supervision of a REMS-approved healthcare provider, is thought to impact the “neurotransmission of glutamate via NMDA receptor’s affinity….and also by blocking AMPA receptors and/or activation opioid receptors”. Dr. Cristancho noted that all 3 of these interventional treatments have established efficacy in TRD. Therefore, other clinical and pragmatic considerations should be addressed (such as cost, side effect burden, predictors of response, and patient preference) when deciding with the patient about which method to use.
CHESTER PIERCE HUMAN RIGHTS AWARD ENDOWMENT CAMPAIGN

Abbreviated historical narrative and relevant antecedents

Eliot SOREL MD

- Dr. Chester Pierce, founding president, Black Psychiatrists of America submits 9 demands to APA Board of Trustees for eradicating racism in psychiatry and psychiatric research (1969)
- Dr. Pierce, Judge Richard Goldstone, Atty. Mojanku Gumbi, and Dr. Eliot Sorel collaborate on Microaggressions Symposium, World Congress of Social Psychiatry (Germany, 1994)
- Race and Excellence published, based on interviews with Drs. Pierce and Ezra Griffith (1998)
- Dr. Pierce organized the African Diaspora Meeting, MGH, Boston, Dr. Sorel invited advisor (2002)
- Drs. David Henderson and Sorel meet at Harvard University to rekindle the above stated project (2013)
- APA Global Mental Health and Psychiatry Caucus (GMHPC) established by Dr. Sorel and 24 APA members founders (2013), launched at APA annual meeting (Canada 2014)
- Drs. Henderson and Sorel invited to participate in the WBG/WHO High Level Meeting (2016)
- Drs. Henderson, Sorel, Fricchione, and Bonginkosi Chiliza organize 2nd African Diaspora Meeting, where Dr. Sorel proposes Chester Pierce Human Rights Award (CPHRA) designation to Drs. Altha Stewart, APA President and Saul Levin, APA CEO, Medical Director (South Africa, 2016)
- Africa Global Mental Health Institute (GMHI) launched (South Africa 2017)
- APA International Psychiatry Council supports designation of APA/HRA as Chester Pierce Award in 2017 and to consider possible endowment, proposed by Drs. Samuel Okpaku and Sorel
- APA/CIP addresses/endorses endowment through APA members’ contributions and other donors (2018)
- APA GMHP Caucus Chairs renew call for CPHRA endowment, via members’ contributions (2019)
- Planning meeting to engage APA Foundation set for 2020, Foundation ED resigns, meeting cancelled
- APA Pres. Dr. Jeffrey Geller receptive to GMHPC proposal, via Drs. Khurshid Khurshid and Okpaku
- APA Pres. Geller and APA CEO Levin agree to resume APA/CPHRA process (January 2021)
- CPHRA Endowment Campaign working group established: Drs. Henderson, Turner-Graham, Sam Okpaku, Griffith, Levin, Sorel, coordinated by Kit Hall, APA Foundation Chief Development Officer
- Campaign launched (April 2021)
- Former Congressman Patrick J. Kennedy accepts Dr. Sorel’s invitation to join the campaign and makes generous contribution to the endowment in July 2021
- Drs. Sorel and Turner-Graham publish APA blog updating CPHRA and (former) Congressman Kennedy enthusiastic participation, and appeal to colleagues to join the campaign
- By mid-August, 2021 campaign reaches a remarkable milestone of over $80,000.00 in pledges
NEWS AND NOTES - SEPTEMBER 2021

- Rawle Andrews, Jr., Esq., has been named executive director of the American Psychiatric Association Foundation (APAF) effective September 27, 2021. Andrews most recently served as a Vice President at AARP, where he worked for 15 years. You can read more about Rawle Andrews and the APAF here.

- APA released a statement in response to the deteriorating situation following the U.S. military withdrawal in Afghanistan. The statement highlights the need to provide critical mental health support and treatment to those who served in the conflict and refugees fleeing for their lives. It also lists resources for any affected by trauma related to the 20-year war. You can read the full statement and view the collected resources here.

- SMI Adviser, a clinical support system for serious mental illness (SMI) administered by the APA and funded by SAMHSA, won three Gold Awards in the 2021 dotCOMM Awards. SMI Adviser won Gold awards for its My Mental Health Crisis Plan app, its Third National Conference on Advancing Early Psychosis Care in the U.S., and its guide on How to Talk About the COVID-19 Vaccine with Individuals Who Have Serious Mental Illness. You can read more about SMI Adviser and the dotCOMM Awards here.

- APA released guidance on coping with stress and mental health when considering a return to the workplace, featuring a new resource from the American Psychiatric Association Foundation’s Center for Workplace Mental Health. Returning to the Workplace Supporting Employees Through the Transition is a guide designed to help employers understand employees’ stresses and concerns and provide support to those returning to the workplace. You can read more about the guide and other tips on returning to work here.

Key Dates and Observances - SEPTEMBER 2021

APA Communications staff maintains a calendar of key dates, observances and events at APA and in the world of mental health in general. The calendar is kept up to date a few months in advance. You can view the calendar and keep track of important mental health dates and observances here.

The Mental Health Services Conference | Registration Now Open! October 14 - 15, 2021 | Virtual
The Mental Health Services Conference (MHSC) will be held virtually this October 14 to 15 on the theme “Sociopolitical Determinants: Practice, Policy and Implementation.” The purpose of the MHSC will be to highlight educational programs and innovations in clinical services designed to ensure equal access to high-quality mental health care for all populations regardless of race/ethnicity, age, religion, nationality, sexual orientation, gender identity, socioeconomic status, or geographical background. Hear more on the conference from Scientific Program Committee Chair Sarah Vinson, M.D.: https://www.youtube.com/watch?v=IbFrydLm&t=2s
More information: https://www.psychiatry.org/psychiatrists/meetings/the-mental-health-services-conference

September Course of the Month – Computational Psychiatry and Future Perspectives
With the development of computational methods, the contribution of algorithms is promising to the diagnosis process of psychiatric disorders. The course focuses on adaptive learning, providing a quantitative basis for measuring and predicting subjective states, and providing neurobiologically inspired models that can be used to inform mechanistic interpretations of large-scale data.

Click here to access the Course of the Month and sign up for updates about this free member benefit.
2022 Annual Meeting Submissions
APA is now accepting abstract submissions for its 2022 Annual Meeting, to be held May 21-25, 2022. The theme of the meeting is “Social Determinants of Mental Health.” Submissions must be made electronically through APA’s online abstract submission system to be considered. The site will close on Thursday, September 9, at 5 p.m. ET. http://apapsych.org/2022-am-submission

Enroll in Summer Courses Through September
APA is offering 10 interactive, collaborative courses this summer with reading, pre-recorded videos and quizzes, live group activities, case vignette discussions, and individual project assignments. Attendees can earn up to 4 AMA PRA Category 1 Credits™ accredited activities during each two-week course, with the last two sessions starting Sept. 13 (Disasters and Mental Health) and Sept. 20 (Imminent Suicide Risk Assessment in High-Risk Individuals). https://www.psychiatry.org/psychiatrists/meetings/annual-meeting/learning-opportunities/courses

Striving for Excellence Series: Addressing Mental Health Disparities Among African Americans/Blacks Through Patient Care
Morehouse School of Medicine & APA have launched the Striving for Excellence educational series, each learning activity will focus on a different subject that will bring awareness to disparities in African American/Black mental health care. The information provided in the series will help to increase behavioral health systems’ capacity to provide outreach, engage, retain and effectively care for African American/Black care seekers. 12 Live Webinars + Two Self-Paced Learning Modules, a total of 14 AMA PRA Category 1 Credits™ Available for Physicians. https://www.psychiatry.org/psychiatrists/cultural-competency/striving-for-excellence-series

Other Items for your Newsletter:

Call for Nominations: Chester M. Pierce Human Rights Award
As the Chester M. Pierce Human Rights Award Endowment Campaign enters its final month, APA seeks nominations for the 2022 Chester M. Pierce Human Rights Award. This award recognizes the extraordinary efforts of individuals and organizations to promote the human rights of populations with mental health needs by bringing attention to their work. Letters of nomination and supporting materials may be submitted to Omar Davis (odavis@psych.org) by Friday, October 8, 2021.

Call for Nominations: Research Awards & Bruno Lima Award in Disaster Psychiatry
Each year, the APA honors individuals for outstanding research and significant contributions to the field and practice of psychiatry that improve the lives of people with mental illness. These honors include the Alexander Granick Award, the Kempf Fund Award, the Blanche Itleson Award, the Mrazek Award, the mentoring award, and the Nasrallah Family Award. Learn more about these exciting opportunities and the Bruno Lima Award in Disaster Psychiatry on the APA Award Page. Nominations should be sent to Laura Thompson at lthompson@psych.org in PDF format with the award name as the subject.

2020 Impact Report is Now Available
The American Psychiatric Association Foundation’s 2020 Impact Report is now ready to download and view. In a year that started with so many challenges but ended with so much hope, we are grateful for the Foundation’s generous donors, corporate and foundation partners who made our work possible! https://apafdn.org/news-events/news/our-2020-impact-report-is-now-available

Roadmap to Psychiatric Residency Guide (New Edition)
View the newly updated guide for medical students. Not only are psychiatrists uniquely trained to consider the patient from a “whole person” perspective, but the field also includes a wide range of practice settings and diverse opportunities for sub-specialization.

What Is APA Doing in the Nation’s Capital for Your Patients and Practice?
AMA PRA Category 1 Credits™ are available for Physicians.

New Publication: Mental Health Professionals Guide to their Role in the Criminal Justice System
Mental Health Professionals Guide to their Role in the Criminal Justice System is a new pocket guide from the American Psychiatric Association Foundation’s Justice Team. The guide is intended as a resource for all mental health professionals on how they can better support individuals with mental illness who become entangled in the criminal justice system. The book is available for purchase now on the APA Publishing website.

CLASSIFIEDS
Office Space Available
K STREET OFFICE TO RENT:
Available part time (shared/furnished) or full time (unshared/unfurnished) beginning Oct 1 at Farragut Square. Large windowed office overlooking K Street in beautifully appointed suite with two psychiatrists. Shared waiting room and utility room with file cabinet space, sink, refrigerator, free wifi. If full-time, parking in garage is possible for an additional fee. One block from Red and Blue lines; two blocks to Yellow line. Full time $1825 per month; or $365 per day. Please call Leslie Goransson, MD at 202-296-4531 for more information.

OFFICE IN TYSONS CORNER NEAR TYSONS GALLERIA AVAILABLE FOR LEASE OR SUB-LEASE
Spacious office on the first floor of the building as part of a 3-office suite. It includes:

- A comfortable beautifully decorated shared waiting room for patients. A copy room/receptionist room. Safe, secure, and spacious office space that stays locked in a building with top-level security. The building has a cafeteria and other healthcare offices for easy referrals. Easy free parking for you and your patients in a parking garage. Please contact toyegbile@yahoo.com or madhubhatiamd@gmail.com for more details.

WPS MEMBER MARKS THE 20TH ANNIVERSARY OF 9/11
In a recent, far ranging interview with MDEdge/Psychiatry, WPS member Col (ret) Eliseth Cameron Ritchie MD, MPH, discusses the evolution of trauma psychiatry in the twenty years since the attacks of 9/11/2001. Stationed in Virginia in 2001, Dr. Ritchie provided immediate care to survivors and their families. In her interview she discusses how trauma focused interventions have changed radically since then. Early response shifted from Critical Incident Stress Debriefing to ensuring safety, respecting the boundaries of survivors, and serving families as well as immediate victims. Dr. Ritchie also describes how medically structured interventions have been adapted to the military culture of stoicism. She describes unique medical interventions like cervical ganglion injections along with the incorporation of walk-around therapy, the training of support animals, and physical activity into more typical protocols. Her views on the need to address traumas such as moral injury and on acknowledging the limitations of exposure based therapies reflect the unique breadth and length of her experience in the field. The full interview may be found at https://www.mdedge.com/psychiatry/article/246427/ptsd/how-engage-soldiers-veterans-psychiatric-treatment?channel=39313.
Following the Food and Drug Administration’s (FDA) recent action that authorized a booster dose of the Pfizer COVID-19 vaccine for certain high-risk populations and a recommendation from the Centers for Disease Control and Prevention (CDC), the Centers for Medicare & Medicaid Services (CMS) will continue to provide coverage for this critical protection from the virus, including booster doses, without cost sharing.

Beneficiaries with Medicare pay nothing for COVID-19 vaccines or their administration, and there is no applicable copayment, coinsurance or deductible. In addition, thanks to the American Rescue Plan Act of 2021 (ARP), nearly all Medicaid and CHIP beneficiaries must receive coverage of COVID-19 vaccines and their administration, without cost-sharing. COVID-19 vaccines and their administration, including boosters, will also be covered without cost-sharing for eligible consumers of most issuers of health insurance in the commercial market. People can visit vaccines.gov (English) or vacunas.gov (Spanish) to search for vaccines nearby.

“The Biden-Harris Administration has made the safe and effective COVID-19 vaccines accessible and free to people across the country. CMS is ensuring that cost is not a barrier to access, including for boosters,” said CMS Administrator Chiquita Brooks-LaSure. “CMS will pay Medicare vaccine providers who administer approved COVID-19 boosters, enabling people to access these vaccines at no cost.”

CMS continues to explore ways to ensure maximum access to COVID-19 vaccinations. More information regarding the CDC COVID-19 Vaccination Program Provider Requirements and how the COVID-19 vaccine is provided through that program at no cost to recipients is available at https://www.cdc.gov/vaccines/covid-19/vaccination-provider-support.html and through the CMS COVID-19 Provider Toolkit.
On October 12, 2021, Glorinda Segay, D.B.H., will be the next guest speaker for the National Institute of Mental Health (NIMH) Director’s Innovation Speaker Series. Dr. Segay is the Director of the Division of Behavioral Health (DBH) at the Indian Health Service (IHS) and an enrolled member of the Navajo Nation in the Southwest.

The Navajo Reservation is rich in cultural ways, language, and practices. However, the unique elements that become integral to someone who is born and raised on the Navajo Reservation may not always work in a new environment and can result in trauma. To adapt after dislocation, resilience is needed—but it can be challenging without the ways and wisdom of the elders. During her talk, Dr. Segay will share her journey, her work at the IHS, and what the agency does to promote mental health among Native Americans.

**Background**

NIMH established the Director’s Innovation Speaker Series to encourage broad, interdisciplinary thinking in the development of scientific initiatives and programs, and to press for theoretical leaps in science over the continuation of incremental thought. Innovation speakers are encouraged to describe their work from the perspective of breaking through existing boundaries and developing successful new ideas, as well as working outside their primary area of expertise in ways that have pushed their fields forward. We encourage discussions of the meaning of innovation, creativity, breakthroughs, and paradigm-shifting.

**Registration**

[Registration](#) for this free online event is required.

More Information: NIMH will provide sign language interpreters. Individuals with disabilities who need reasonable accommodations should contact the Federal Relay at 1-800-877-8339. Submit general questions to the [NIMH Director’s Innovation Speaker Series email](mailto:).
Our September “Fact vs. Fiction” risk management resource may be of interest to your members this month, and you are welcome to include it in your member communications.

If a patient is non-adherent to your treatment plan (e.g., does not take medications as prescribed, does not keep regular appointments, fails to obtain necessary labs, etc.) and this then results in care that does not meet the standard of care, you should still continue to treat them to the extent they will allow. Even if you are not meeting the standard of care, it is better than the patient not receiving treatment.

What do you think - fact or fiction?

**ANSWER:** Fiction!

If the patient will not agree to the treatment plan and will not let you provide treatment that meets the standard of care, that generally is not a treatment relationship you can stay in. Sub-standard care, in terms of liability, is not better than no treatment.

Before terminating the treatment relationship, you may want to consider the cause(s) of non-adherence; for more information, see our [article](#).
World Patient Safety Day 2021 is September 17th, and this year’s topic is safe maternal and newborn care. In our efforts to support mental health and all those served by and working in the field of psychiatry, we are pleased to feature Donna Vanderpool, MBA, JD, PRMS Director of Risk Management, as our blogger this month. In her article, Donna shares strategies that doctors can implement to provide good clinical care in honor of World Patient Day this September.

PRMS Psych-cess: November 4

Please save-the-date for our next PRMS Psych-cess: Forensic Psychiatry on Thursday, November 4, 2021. PRMS Psych-cess is a virtual event for residents, fellows, and early career psychiatrists, led by experts in the field to set attendees up for success. Stay tuned for more details and the registration link!
The top four issues to address when seeing patients in-person are:

1. Masks
2. Vaccinations
3. Consent to be seen
4. Ventilation

NOTE: These are very fluid issues; the requirements, particularly related to masks and vaccines, are frequently changing.

ISSUE #1: MASKS IN THE OFFICE

- Unvaccinated providers, staff, and patients in the office need to be masked.
- Masks for vaccinated providers and staff
  - States may require or recommend that all healthcare workers, including all staff in physician offices, be masked.
    - For example, Massachusetts requires masks for both vaccinated and unvaccinated individuals at all times in health care facilities, specifically including physician offices. The mask requirement applies to patients, staff, vendors, and visitors.
    - Other states, such as Virginia, recommend masks wearing by staff in healthcare facilities, pursuant to CDC guidelines. Note that private businesses may be able to impose greater requirements, such as requiring masks for all.
  - Masks for vaccinated patients
    - Some states, such as Oregon, are requiring all people to wear masks indoors, regardless of vaccine status.
- Risk Management thoughts:
  - Given the CDC's guidelines for everyone to be masked in health care facilities, those not following the guidelines, if not required to by the state, may have to explain to patients why they are deviating from CDC guidelines.
  - Some psychiatrists have found clear plastic face shields useful when seeing therapy patients in person.
- Resources:
  - The Littler law firm is tracking state masking orders, which can be accessed here.
  - State medical associations may have state-specific resources
  - The local health department

ISSUE #2: COVID VACCINATIONS

- Vaccinations for providers and staff
  - States can require all who work in healthcare to be vaccinated. For example, California requires all who work in healthcare, including doctors' offices (specifically including behavioral health) to be vaccinated.
  - Other states vary in the exact healthcare facilities that requirement applies to, such as only applying to hospitals and long-term care facilities.
  - Given the recent full approval of a COVID vaccine, more of these vaccine requirements may be enacted.
- Resources:
  - The Littler law firm is monitoring the states and their findings can be accessed here.
  - State medical associations
• Vaccinations for patients
  » Given the COVID Delta variant surge, and the possibility of breakthrough infections, psychiatrists can choose to see only patients who are vaccinated in their office if:
  » The reason for the policy is based on the obligation to keep everyone safe, including staff and patients,
  » And the offer is made to continue treatment via telepsychiatry.
For more information, see this commentary by Jacob Appel, MD, JD.

ISSUE #3: CONSENT TO BE SEEN IN-PERSON
Consider having patients sign a consent form to be seen in the office. Such a document can spell out patient responsibilities (such as not coming into the office with a fever or other symptoms), what the psychiatrist is doing to minimize risk, and a statement that the patient is assuming the risk by choosing to be seen in person.
Resource: Contact your professional liability insurance company for a template.

ISSUE #4: OFFICE VENTILATION
In addition to physical distancing, wearing masks, hand hygiene, and vaccination, ventilation improvements can be useful in mitigating the risk of COVID transmission.
Resources, including no-cost improvements, include:
• From the CDC
• From OSHA

TO DO:
• Determine state requirements for masks and vaccines
• Develop office policies and procedures
• Communicate policies to staff
• Communicate policies to patients
• Re-evaluate as requirements and recommendations change
The 31st Annual Renfrew Center Foundation VIRTUAL Conference for Professionals
Perspectives on Feminism, Eating Disorders and Beyond
Available November 12, 2021 through December 31, 2021
Up to 38 CEs/CMEs Offered

The Renfrew Center Foundation invites you to join us for our 31st Annual Conference for Professionals. Renfrew is bringing you a virtual Conference offering up to 38 CEs/CMEs/Contact Hours, showcasing 3 exciting Keynote presentations, 6 live Master Classes, 16 on demand workshops, networking activities and numerous special events which have been a part of the Renfrew Conference for the past three decades.

REGISTRATION NOW OPEN

KEYNOTE PRESENTATIONS:

**A Conversation with Gabourey Sidibe**
Gabourey Sidibe, actress and author of “This is Just My Face, Try Not to Stare”
Date: Friday, November 12, 2021
Time: 10:45am -12:00pm (EST)

**Eating Disorders: Where We’ve Been, Where We Are, Where We’re Going**
Joel Yager, MD, Professor of Psychiatry at the University of Colorado School of Medicine
Date: Friday, November 12, 2021
Time: 1:45pm -3:30pm (EST)

**Doing Race Differently: RCT, Neuroscience and the Hope for Change**
Amy Banks, MD, Harvard trained psychiatrist and a Founding Scholar of the International Center for Growth in Connection
Maureen Walker, PhD, Licensed psychologist with an independent practice in psychotherapy and anti-racism consultation
Date: Saturday, November 13, 2021
Time: 10:45am -12:30pm (EST)
Nearly 50,000 Americans die by suicide annually and the numbers are increasing—significantly.

To respond to this challenge, experts will present the latest advances in suicide-focused assessment and treatment.

This free workshop offers optional continuing education credits and is appropriate for those in the mental health, medical, nursing, social work, and counseling fields.

Upon completion, participants will be able to:
• Identify risk factors
• Assess suicide risk using different approaches
• Evaluate the latest treatments

Visit mclean.org/sw2021 to learn more and register.
How does this apply to your private practice?

Providers must be able to make eight types of patient data available to all patients:

1. Consultation notes
2. Discharge summary notes
3. History and physical
4. Imaging narratives
5. Laboratory report narratives
6. Pathology report narratives
7. Procedure notes
8. Progress notes

Exempted notes are:

A) Psychotherapy notes contents remain protected and not discoverable. However the following details have to be reported:
   ● medication prescription and monitoring,
   ● counseling session start and stop times,
   ● the modalities and frequencies of treatment furnished,
   ● results of clinical tests, and
   ● any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

B) Notes compiled in reasonable anticipation of, or use in a civil, criminal or administrative action or proceeding.

Exceptions

Providers are allowed to refuse release of records pursuant to eight exceptions (see Table 1). The most pertinent to private practices are:

1. Preventing Harm (45 CFR § 171.201): It will not be information blocking for an actor to engage in practices that are reasonable and necessary to prevent harm to a patient or another person, provided the below conditions are met:
   a. The actor must hold a reasonable belief that the practice will substantially reduce a risk of harm;
   b. The actor’s practice must be no broader than necessary;
   c. The actor’s practice must satisfy at least one condition from each of the following categories: type of risk, type of harm, and implementation basis; and
   d. The practice must satisfy the condition concerning a patient’s right to request review of an individualized determination of risk of harm.

2. Privacy (45 CFR § 171.202): It will not be information blocking if an actor does not fulfill a request to access, exchange, or use EHI in order to protect an individual’s privacy, provided certain conditions are met, such as if:
   a. Consent or authorization for release is required by a state or federal law (HIPAA does NOT require consent) the actor may choose not to provide access. Such as for use in a civil, criminal or administrative, proceedings. Or information regarding substance use disorders if the provider is a 42 CFR Part 2 entity.
   b. Content of psychotherapy notes can be withheld with the exception of information regarding:
i. medication prescription and monitoring,
ii. counseling session start and stop times,
iii. the modalities and frequencies of treatment furnished,
iv. results of clinical tests, and
v. any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

c. A provider **may choose** not to provide access, exchange, or use of an individual’s EHI if doing so fulfills the wishes of the individual, provided further conditions are met (see § 171.202 for further information).

3. **Security (45 CFR § 171.203):** It will not be information blocking for an actor to interfere with the access, exchange, or use of EHI in order to protect the security of EHI.

4. **Infeasibility (45 CFR § 171.204):** It will not be information blocking if an actor does not fulfill a request to access, exchange, or use EHI due to the infeasibility of the request such as due to:
   a. Uncontrollable events
   b. Inability to unambiguously segment the requested EHI
   c. Infeasibility under the circumstances:
      i. The type of EHI and the purposes for which it may be needed;
      ii. The cost to the actor of complying with the request in the manner requested;
      iii. The financial and technical resources available to the actor;
      iv. Whether the actor’s practice is non-discriminatory and the actor provides the same access, exchange, or use of EHI to its companies or to its customers, suppliers, partners, and other persons with whom it has a business relationship;
      v. Whether the actor owns or has control over a predominant technology, platform, health information exchange, or health information network through which electronic health information is accessed or exchanged; and
      vi. The actor must provide a written response to the requestor within 10 business days of receipt of the request with the reason(s) why the request is infeasible.

5. **Health IT Performance (45 CFR § 171.205):** It will not be information blocking for an actor to take reasonable and necessary measures to make health IT temporarily unavailable or to degrade the health IT’s performance for the benefit of the overall performance of the health IT, provided certain conditions are met.
### Table 1: Exceptions to the Final Rule

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<tr>
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<th>Exceptions to the Final Rule</th>
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<tbody>
<tr>
<td>1.</td>
<td><strong>Preventing Harm</strong> <em>(45 CFR § 171.201)</em> practices that are reasonable and necessary to prevent harm to a patient or another person, provided certain conditions are met</td>
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<tr>
<td>2.</td>
<td><strong>Privacy</strong> <em>(45 CFR § 171.202)</em> State or federal privacy laws prevail over act</td>
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<td>3.</td>
<td><strong>Security</strong> <em>(45 CFR § 171.203)</em> Covers delays from all legitimate security practices by actors, but does not prescribe a maximum level of security or dictate a one-size-fits-all approach</td>
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<td>4.</td>
<td><strong>Infeasibility</strong> <em>(45 CFR § 171.204)</em> Natural disasters, excessive cost/resources to comply with request, inappropriate request for the stated purpose, control over technology. Must reply within 10 days with infeasibility explanation.</td>
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<tr>
<td>5.</td>
<td><strong>Health IT Performance</strong> <em>(45 CFR § 171.205)</em> For reasonable and necessary measures to maintain and improve health IT performance</td>
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<td>6.</td>
<td><strong>Content and Manner</strong> Content can be minimum necessary and may be provided in an alternative manner than electronic should it be technically infeasible or unagreeable to send it in the requested manner.</td>
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<tr>
<td>7.</td>
<td><strong>Fees</strong> Fees that result in a reasonable profit margin can be applied. They must be commensurate with the overhead for the technology used to store and access the EHI.</td>
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<td>8.</td>
<td><strong>Licensing</strong> Applies to vendors and it allows them to license and charge royalties for their services.</td>
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### What are the repercussions?

The penalties for medical professionals who fail to comply with the rule are still unclear; however, clinicians are expected to become subject to “appropriate disincentives” proposed by the HHS Secretary (6).
<table>
<thead>
<tr>
<th>HIPAA</th>
<th>CURES</th>
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<tr>
<td><strong>Who is responsible?</strong></td>
<td></td>
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<tr>
<td>Health care providers who electronically transmit any health</td>
<td>All healthcare providers who store healthcare information electronically</td>
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<td>information in connection with payments</td>
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<tr>
<td><strong>Who am I required to respond to?</strong></td>
<td></td>
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<tr>
<td>-Insurance companies (payment)</td>
<td>Patient request</td>
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<tr>
<td>-Other clinicians/hospitals taking care of the patients (treatment)</td>
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<td>-Healthcare operations</td>
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<td>-Patient</td>
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<td><strong>Response time allowed</strong></td>
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<td>30 days (60 days if an extension is applicable)</td>
<td>ASAP</td>
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<td><strong>How to respond?</strong></td>
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<tr>
<td>Requested format</td>
<td>Immediate access to records via: portal, secure or non-secure (if accepted by patient) email, fax etc.</td>
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<tr>
<td><strong>Do I need a signed consent form</strong></td>
<td>NO! Consent releases are not required for release towards treatment, payment, healthcare operations or to the patient</td>
</tr>
</tbody>
</table>
Information Blocking and the ONC Health IT Certification Program: Extension of Compliance Dates and Timeframes in Response to the COVID-19 Public Health Emergency Interim Final Rule

**Sources and Resources**


PRMS® ensures that psychiatrists working 20 hours per week or less receive the same unrivaled protection and service as those practicing full-time. Plus, you may be eligible to save on your malpractice insurance premium.

Part-time psychiatrists have access to our complete program, which includes a psychiatry-specific policy, a multitude of expert risk management resources and materials, and a claims team experienced in psychiatric litigation should you ever need them.

When selecting a partner to protect you and your practice, consider the program that puts psychiatrists first. Contact us today.

More than an insurance policy
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Actual terms, coverages, conditions and exclusions may vary by state. Insurance coverage provided by Fair American Insurance and Reinsurance Company (NAIC 35167). FAIRCO is an authorized carrier in California, ID number 375-7. www.fairco.com.
Dear WPS Members:
The editorial team Capital Psychiatry: Magazine of the Washington Psychiatric Society is currently seeking articles for publication in the upcoming Winter 2022 issue. Articles should be 1500-2000 words in length that are of psychiatric topical and scientific interest to our readership. We also welcome relevant literary essays in the style of The New Yorker to allow you to give free rein to your creative muse. We encourage members to submit brief abstracts of articles for the Winter 2022 issue and beyond. The deadline for the winter issue is December 15, 2021. Please email your abstracts to gpperman@gmail.com.

Thank you and let us know if you have any questions. Feel free to contact me for a copy of the Capital Psychiatry Editorial Policy.

Cordially yours,
Gerald P. Perman, MD / Editor, Capital Psychiatry