Frequently Asked Questions for Open Notes at Northern Light Health

| James Douglas, D.O., Medical Information Officer

When will Open Notes Go Live?

- Beginning **March 1, 2021** Northern Light Health patients will be able to view their provider notes, except for confidential and selected psychotherapy notes, on the patient portal

Why are we doing this?

- Since 2018, Northern Light Health has had a long-term plan to implement Open Notes, because research shows it improves patients' care and relationships to providers

Why are we doing this in 2021?

- Open Notes has also become a requirement for all health systems
- This falls under the information blocking section of the 21st Century Cures Act and full access will be federally mandated
- Under the HIPAA Privacy Rule, patients have always had the right to inspect or request their record
- While there may be exceptions to the sharing of notes, these rarely apply to most of our patients
- This is a watershed in the evolving history of managing health information

How has Open Notes worked in other places?

- Open Notes has been stress tested in some very sensitive healthcare settings
- Beth Israel/Deaconess piloted Open Notes for psychotherapy and the feedback was positive
- Providers' initial fears did not materialize, and patients appreciated the opportunity to read the notes

Won't we have a lot of anxious and upset patients?

- When Northern Light Mercy Hospital in Portland had Open Notes in their Allscripts electronic medical record (EMR), there were fewer concerns from patients than providers expected
- Transparency and easy access to notes builds trust between patients and providers
- In studies, there has been no observed increase in malpractice claims or reports to state medical boards

Will all documents ever included in Cerner be available, or only new documents after the 3/01/2021 Go-Live date?

- Only new documents created after the Go Live date will be available under Open Notes on the portal
- Patients may request any of their old records prior to that date, made available through the usual routines of their primary care provider's (PCP's) office and Health Information Management (HIM)

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Is there a list of which documents will be included in Open Notes?

- Generally, all Office Notes, Consultations, Hospital H&Ps, Progress Notes, and Discharge Summaries, and ER Notes will be available under Open Notes (This may be subject change in the future as we clarify the rules of the Cures act)
- The FAQ document has a link for a searchable listing of the currently open documents

What else will appear in the portal?

The following will go live along with Open Notes

- Radiology reports
- Pathology reports
- Microbiology reports

What is excluded from appearing in Rad/Path/Micro

- HIV results will not automatically appear in the portal lab results
- Note that any HIV results that a provider documents in a non-confidential Clinical Document (i.e. if it's dictated as part of the History of Present Illness or an Assessment) will be readable to the patient, even if the actual lab result is suppressed
- STD results, such as chlamydia or gonorrhea test results will appear in the Lab results

What documents are NOT routinely included in Open Notes?

- Here is a partial list of items excluded:
  - Confidential Notes (which is a specific note type)
  - Psychotherapy Notes
  - Autopsy Reports

What are valid reasons to make a note Confidential and exclude it from Open Notes?

- If the provider's impressions and plan are documented in a manner that would be likely to cause significant harm to the physician-patient relationship or lead to a worsening of their condition and this could not be mitigated by a careful discussion with the patient, then that would be a valid reason

How do I make a document Confidential?

- Choose the Confidential Note Type when creating your Dynamic Document (note) in Cerner

Can I change my mind and mark a document Confidential if I originally made it a routine document? How do I do that?

- Mark the document "In Error" and then the document will have to be recreated by copying and pasting the original document text into a new Confidential Note
- Note that any signed document will be visible to the patient until it is marked "In Error"

When does the document appear in the portal? Is there a way to delay the document appearing? Can the notes be delayed entering the patient portal by about one week from the date of the encounter?

- Documents appear in the portal when the Responsible Provider signs the document
- Currently Pathology results have an automatic 96-hour delay before automatically appearing
- Currently Radiology results have an automatic 72-hour delay before automatically appearing
- This is designed to give the provider or covering provider time to contact the patient about possible upsetting results. (This may be subject to change in the future as we clarify the rules of the CURES act.)

What happens if we use abbreviations in our dictated notes for the portal?

- Providers may still use officially accepted medical abbreviations, such as "COPD". Most patients will look up things they don't know.
- The following text will appear on the Open Records page on the portal:
- *Providers often use abbreviations or uncommon words in medical records. You can look these up by going to the main page of this portal and searching in the Health Library. If you can't find the word or abbreviation there, try looking it up at the National Library of Medicine's MedlinePlus: https://medlineplus.gov/ . There is also a list of common abbreviations at MedlinePlus: https://medlineplus.gov/appendixb.html . You can also send a secure message to your providers office with any questions you may have about your records.*

Will there be some training on how to author our documentation to avoid "pitfalls"?

- There is an excellent two-page summary of suggestions at this site:
- https://www.opennotes.org/wp-content/uploads/2016/02/Klein_notes-tip_toolkit.pdf

- Your clinical informaticists (CIs) and medical information officers (MIOs) can arrange training sessions and videos if there is interest

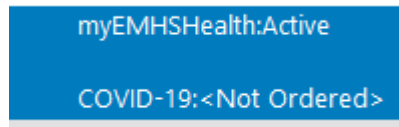# How do Open Notes work with pediatric patients?

- Open Notes will be implemented for appropriate pediatric patients age 0 -9. Parents or guardians or other authorized caregivers will have access to pediatric notes for these ages only with a signed proxy
- There are no routine Open Notes for children ages 10-17 at this time

Can teenagers have a portal account? What about emancipated minors? What is the process for giving an emancipated minor a portal account?
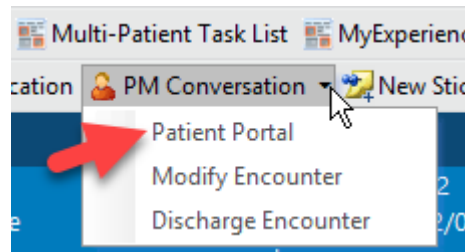
- Pediatric patients between ages 14-17 may not have portal accounts with Open Notes unless they are emancipated minors
- Portal access for this age group requires authorization by the attending physician
- See Patient Portal Access Guidelines in the FAQ document

How do I know if the patient has assigned a proxy who can access their portal?

- Any child 0-9 who has a myEMHSHealth: ACTIVE label in the banner bar has a proxy. No children 10-17 will have an ACTIVE label unless they are an emancipated minor as above

myEMHSHealth:Active

COVID-19:<Not Ordered>

- Adults accounts can be checked for a proxy by opening the PM Conversation

Multi-Patient Task List MyExperien

cation PM Conversation New Stic

Patient Portal

Modify Encounter

Discharge Encounter

How can patients find their COVID-19 test results in the portal?

- There is now a special button on the landing page of the portal for Covid-19 results

If the patient takes issue with information they see in the portal, what should we do?

- From the article footnoted on the next slide (recommended reading!) at opennotes.org:
- "When patients have access to and read their clinical notes, they can find and report mistakes. The most common errors patients reported as being serious include inaccurate descriptions of diagnosis, mistaken medical history, or inaccuracies about medications, allergies, tests, procedures, or results.[1]
- Systems can be put into place so that these errors can be acknowledged and addressed; a referral to a Health Information Management (HIM) committee is rarely needed. Patients reporting errors that are subsequently corrected trust their clinician even more." [2]
- *Disagreements needing HIM assistance should be sent to: ROILeadReview@emhs.org.

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Additional resources

- 1. Frequency and Types of Patient-Reported Errors in Electronic Health Record Ambulatory Care Notes https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2766834
- 2. More information: https://www.opennotes.org/effects-of-opennotes-faqs/

Questions?

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