

## Frequently Asked Questions for Open Notes at Northern Light Health

### 1. 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

### 2. 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<sup>2</sup>.

### 3. 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 21<sup>st</sup> 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.

### 4. 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.

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

When Northern Light Mercy Hospital in Portland had Open Notes in 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.

### 6. 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 be made available through the usual routines of their primary care provider's (PCP's) office and Health Information Management (HIM).

### 7. 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 to later change as we clarify the rules of the Cures act.)** [Click Here for a searchable listing of the currently open documents.](#)

**8. What else will appear in the portal.**

Radiology reports, Pathology reports, and Microbiology reports will become live along with Open Notes.

**9. 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

**10. 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

**11. 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.

**12. How do I make a document Confidential?**

Choose the **Confidential Note Type** when creating your Dynamic Document in Cerner.

**13. 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."

**14. 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.

Preliminary documents are not visible until signed. In an unusual circumstance, the provider may save the document unsigned on their desktop, but this will delay billing and the document may not

be readily visible to other providers, and my hinder patient care, so this is not recommended. The whole purpose of Open Notes is to promote communication and patient adherence to treatment. If providers need to delay a note appearing on the portal, they should discuss this with the patient.

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 later change as we clarify the rules of the CURES act.)**

#### **15. 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.

#### **16. 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](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.

#### **17. 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.

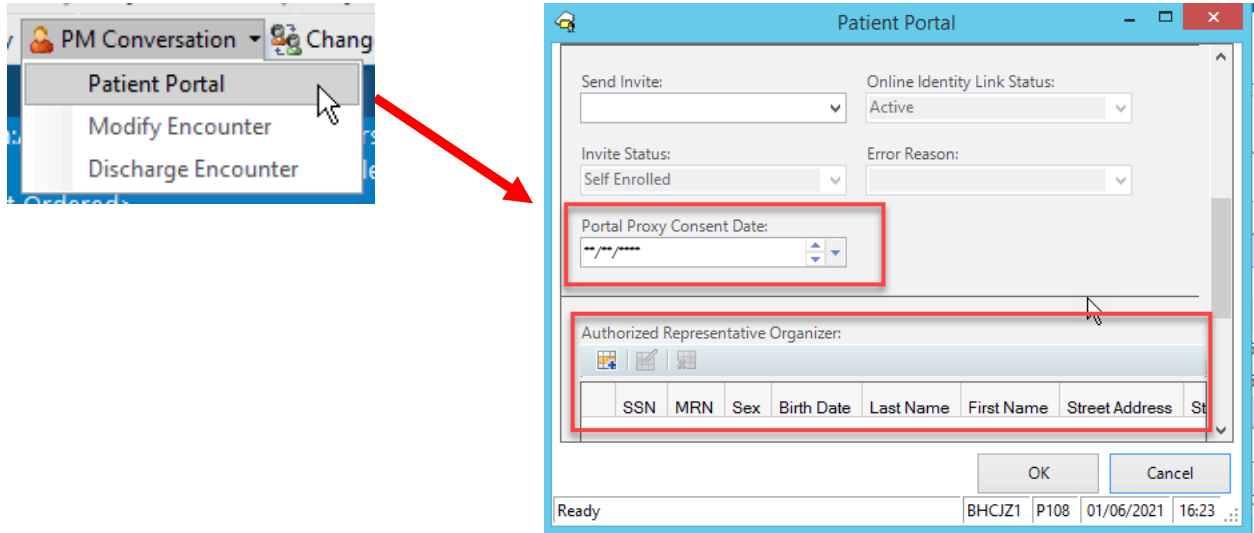
**18. Can teenagers have a portal account? What about emancipated minors? What is the process for giving an emancipated minor a portal account?**

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.

<b>PATIENT PORTAL ACCESS GUIDELINES</b>				
<b>0-9 yrs</b>	<b>PROXY CONSENT FORM NOT REQUIRED</b>	Verify person requesting proxy access has authority to do so, <u>prior to</u> generation of invitation.		Sign up parent/guardian as proxy from Authorized Representative Organizer. <b>***Note: If signed proxy consent form not on file when patient turns 10 yrs, proxy access automatically severed.</b>
<b>10-13 yrs</b>	<b>PROXY CONSENT FORM REQUIRED</b>	Verify with chart documentation patient has not consented to own care and person requesting has authority to do so, <u>prior to</u> generation of invitation.		<b>** Parent/Guardian must sign portal proxy permission form <u>BEFORE</u> portal access can be granted. Sign up parent/guardian as proxy under Authorized Representative Organizer, enter date proxy consent form signed within Portal conversation.</b>
<b>14-17 yrs</b>	<b>NO ROUTINE PATIENT OR PARENTAL ACCESS</b>	<b>PROVIDER APPROVAL REQUIRED FOR CHILD'S ACCESS</b>	Provider must document approval in chart <u>PRIOR TO</u> signing <u>child</u> up for portal.	<u>Child must have</u> their own email address. <u>Child not allowed to</u> use parent/guardian email address.
<b>14-17 yrs Special Needs Patient</b>	<b>PROXY CONSENT FORM REQUIRED</b>	<b>PROVIDER APPROVAL REQUIRED FOR PARENT/GUARDIAN ACCESS</b> Provider must document in chart portal access is granted due to special needs of patient, both parents/guardians must be in agreement for portal access.		<b>** Parent/Guardian must sign portal proxy permission form <u>BEFORE</u> portal access can be granted.</b> Sign parent up under Authorized Representative Organizer.
<b>18+</b>		<b>PATIENT IS NOW AN ADULT WITH NO SPECIAL NEEDS</b>		Provider permission not needed for portal access . Do not use Authorized Representative Organizer for portal access given directly to patient. Patient can sign proxy consent form, <u>in person</u> , allowing a 3rd party access to their portal.
<b>18+ Special Needs Patient</b>	<b>PROXY CONSENT FORM REQUIRED</b>	Verify guardianship documents within chart to verify person requesting has authority to do so <u>prior to</u> generation of invitation.		<b>**Legal guardian must sign portal proxy consent form <u>BEFORE</u> access can be granted.</b> Sign up legal guardian as proxy up under Authorized Representative Organizer.
<b>** Parent/Guardian must sign proxy consent form, <u>in person</u>, giving themselves permission to access portal account on behalf of a minor, <u>prior to</u> generation of any invitation.</b>				
<b>***Tips/Tricks: Documenting name(s) of those Proxied to a patient's portal account and date Proxy Consent form signed within comments section of the PIAF, helps ensure forms are updated annually, minimizing risk of proxy losing access to portal account due to proxy consent form expiring.</b>				

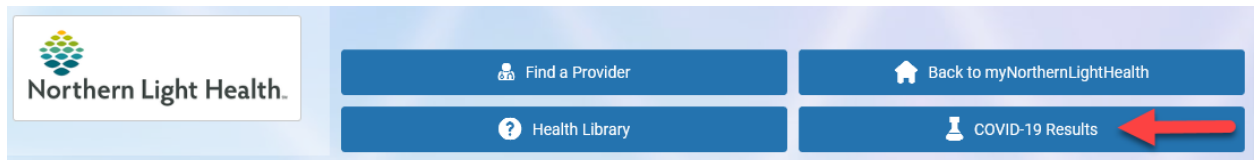
**19. How do I know if the patient has assigned a proxy who can access their portal?**

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



**20. 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.



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

We anticipate a similar, but more streamlined version of the current HIM revision in process today.

- Patient submits a formal request for medical record change to the office. Ideally, this would be through the **Patient Portal**, which would be automatically included into the patient’s medical record.
- The responsible Provider reviews the submission, and if the suggested correction is accurate, would edit the record accordingly. Patient would be notified through the portal of the correction.
- If the provider disagrees with the suggested correction, the request would be escalated to HIM, for review via the current formalized correction process.

From the article in the endnotes below (recommended reading!) at [opennotes.org](http://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.<sup>[1]</sup> 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.”<sup>[2]</sup>

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<sup>[1]</sup> Frequency and Types of Patient-Reported Errors in Electronic Health Record Ambulatory Care Notes <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2766834>

<sup>[2]</sup> More information: <https://www.opennotes.org/effects-of-opennotes-faqs/>