Welcome & Introductions

Liz Salmi
Senior Strategist, OpenNotes
Housekeeping

- Attendees are muted.
- During the session, **type questions into the “question” section**, and we will address them at end of prepared comments.
- Some answers may be provided during the presentation. Those answers will appear underneath your question.
- The presentation recording will be available at [opennotes.org](http://opennotes.org) and [youtube.com/myopennotes](http://youtube.com/myopennotes)
- You will receive an email with links to these presentations.
OpenNotes Grand Rounds

How to Write an Open Note

Welcome!
January 29th, 2021

Leonor Fernandez, MD    CT Lin, MD
The New Era of Transparency in Healthcare
Sharing Clinical Notes with Patients

Cait DesRoches, DrPH
Director, Open Notes
Associate Professor, HMS
What is open notes?

When patients can easily read visit notes
Open Notes Across North America

260 organizations
54 MILLION people
Empowering Patients in the U.S. Health Care System

Patients in the U.S. need better access to information about their care – information ranging from their medical records to data about the costs and quality of the care they receive.

The Cures Act aims to empower Americans with their health data, delivered conveniently to computers, cell phones, and mobile applications.

Nationwide, patient-centric health IT, once achieved, can deliver a variety of benefits to patients, including:

- Transparency into the cost and outcomes of their care
- Competitive options in getting medical care
- Modern smartphone apps to provide convenient access to their records
- An app economy that provides patients with innovation and choice

Under HIPAA, patients already have a legal right to their data electronically. The ONC Cures Act Final Rule is one step in this process by enhancing access to clinical data.
There are 4 scenarios in which a provider may block information under the “Preventing Harm Exception”.

Under each of these 4 scenarios:

• The provider must reasonably believe that blocking access to information will substantially reduce the risk of harm to the patient or another person.

• Blocking access to information should be no broader than necessary to substantially reduce the risk of harm.
OpenNotes Grand Rounds

How to Write an Open Note
My 16-Year Journey to Open Notes
A Tale of Woe

CT Lin, MD, CMIO
Professor of Medicine, University of Colorado
Dynamic tension between privacy and transparency

**HIPAA:**
- DO NOT DISCLOSE PHI
- Except for Treatment, Payment, Operations
- Minimum necessary info

**Social Media:**
- Empowering patients
- Peer to peer sharing
- Nimble innovation
- Wisdom of the crowd
Signed 5 HIPAA forms about my rights for medical privacy... then updated my Facebook status with the details of all my ailments.
The naïve CMIO

The World
In 1999

Got the job by being “chief complainer”
Shuffling medical papers and piling patient files will be a thing of the past at University Hospital/Health Sciences Center campus if C.T. Lin, MD, is right.

An assistant professor in the Division of General Internal Medicine and the Director of the General Internal Practice physician, Dr. Lin is a driving force behind the introduction of computerized medical records for University Hospital and its clinics.

According to Dr. Lin, the medical field is relatively behind in computerization to help UH “catch up.” Currently experimenting with a system purchased in February or March 1997, the hospital is expected to implement the system within the next year or two. “There is so much theoretical need,” said Dr. Lin, citing the cost-effectiveness of computers can simplify research as well – evidence on how patients are easily accessed through a monitor and keyboard by faculty with approved projects.

While he recognizes the importance of cost-efficiency, Dr. Lin also is concerned with the quality of care he thinks medical research should focus. Referring to evidence-based medicine or outcome research, he says the best outcomes – Dr. Lin noted that as an academic institution, University Hospital should continue to focus on.

In between teaching, seeing patients, managing the Division of General Internal Medicine and the development of computerized medical records, Dr. Lin spends time perfecting a practice model for specialists with primary care physicians. Effective communication is at the core of such a model for physicians to communicate better with other physicians, as well as with their patients.
Use of a Patient-Accessible Electronic Medical Record in a Practice for Congestive Heart Failure: Patient and Physician Experiences

MARK A. EARNEST, MD, PHD, STEPHEN E. ROSS, MD, LORETTA WITTEYNELG, BA, LAUREN A. MOORE, MPH, CHEN-TAN LIN, MD

Abstract: Objective: The aim of this study was to evaluate the experiences of patients and physicians in a clinical trial of an online electronic medical record (SPPARO, System Providing Patients Access to Records Online). Quantitative data were obtained from questionnaires. Qualitative data were obtained from individual interviews and focus groups.

Methods: Questionnaire items were based on issues identified by patients and physicians in previous studies. Individual interviews and focus groups were performed using a semistructured format developed through an iterative process.

Results: Of the eight physicians who participated in the trial, seven completed questionnaires and interviews. Of the patients in the practice, 107 enrolled in the study, and 54 were assigned randomly to the intervention group. Of the 41 using SPPARO during the trial period, in questionnaires and interviews, patients were significantly more likely to feel that physicians were anticipating benefits of SPPARO and less likely to anticipate problems. Attitudes of subjects did not change from controls after the intervention period. In posttrial focus groups, SPPARO users described its practical benefits. Comprehending medical jargon was a minor obstacle. Physicians anticipated that implementing SPPARO would increase their workload and disrupt their clinic interactions. In posttrial interviews, physicians and staff found no change in their workload and no adverse consequences. All of the physicians ultimately supported the concept of giving patients online access to their clinical notes and test results.

Inclusion: SPPARO was useful for a number of patients. Physicians initially voiced a number of concerns about implementing SPPARO, but their experience with it was far more positive.

Online Release of Doctor Notes

Patients will act on errors in transcripts.
Patients will be more anxious.
This is a crazy idea; the phone will ring off the hook.

The only reason I will participate is that you are doing a rigorous study.

Patients can already request their paper chart. Why not?
Dear Dr. [Name]

I had the pleasure of seeing your patient, [Patient Name], today in the Heart Failure Clinic at the University of Colorado Hospital. As you know, she is an 85-year-old female with a history of cardiomyopathy. This is currently her four-month follow-up and she was last seen on 07/15/2003. Her last evaluation of pumping function was done on 04/08/2003. At that time, her left ventricle was of normal size. Her left ventricular ejection fraction of approximately 53.8%. She had some diastolic dysfunction, moderate mitral regurgitation which was better from her previous echo done on 04/08/2003, and mild tricuspid regurgitation, which is considerably better from her previous echocardiogram. She also had right ventricular systolic elevation pressure, which was consistent

Adriamycin-induced
Trust
Empowered
Felt understood
Adherence to treatment
SPPARO Summary

- **NO**: patient overuse or misunderstanding

- **NO CHANGE**:  
  - health utilization (visits, calls)  
  - Physician documentation

- **IMPROVED**:  
  - Patients felt more empowered  
  - Patients felt more in control  
  - Patients felt more trust in their doctors  
  - Patients described many uses for their records (travel, clarification, learning, error checking)
This is my mission!

Infuse transparency and collaboration into healthcare.

How hard could it be?
What just happened?
It was going so well!
Open Notes: Try Again

What happened in the intervening 16 years:

• CT Lin learns about ‘organizational change’
• Medical Leaders support ‘information transparency’
• 2011: National Open Notes study successful
The 80 - 20 Rule

The success of a project is 80% social skills, 20% technology

--Reed Gardner, LDS Hospital
Principles of Organizational Change

- Increase urgency
- Build the guiding team
- Get the vision right
- Communicate for buy-in
- Empower action
- Create short-term wins
- Don't let up
- Make change stick
Open Notes: Try Again

2015: Asked for volunteers: 7 primary care clinics. - After 6 months, ZERO concerns

Publicize the **positive stories** and lack of problems with road show across all regions

Communicate the vision of transparency

CMO's and PFCC support Open Notes unanimously
<table>
<thead>
<tr>
<th>Consider Changing</th>
<th>Alternative Suggestion</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Morbidly obese”</td>
<td>“Has BMI&gt;30” or “overweight per medical criteria.” Note: obesity if important, should be included. Patients often react positively to thoughtful discussion pointing to relation to other conditions.</td>
</tr>
<tr>
<td>“Patient refuses to take pills”</td>
<td>“Patient has had difficulty adhering to therapy”</td>
</tr>
<tr>
<td>“Patient continues with severe depression and thoughts of suicide”</td>
<td>If psychologic conditions are discussed openly with patient, no reason to redact from medical documentation</td>
</tr>
<tr>
<td>“14-year old has a positive pregnancy test”</td>
<td>Parent proxy access to minor patient chart is discontinued at birthday age 14 (both Open Notes and test results). Also clinician can uncheck “Share with patient”</td>
</tr>
</tbody>
</table>
**Available Online**


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**How to Write an Open Note**

**Executive Summary:**

Open Notes are what we call progress notes that are available to patients. Most patients want to see their documentation as it is currently written, including specific medical language, as they most often share them with other providers. **NEVER** consider alternate wording in some situations.

**Consider Changing** | **Alternative Suggestion**
--- | ---
Mild anxiety, depression, patient’s report | Patient states they have no mental health diagnosis.
Patient refuses to take the pill... | Patient states they have no mental health diagnosis.
Painful injection, patient’s report | Patient states they have no mental health diagnosis.
Patient refuses to take the pill... | Patient states they have no mental health diagnosis.

**Examples:**

- **Concise description of abdominal pain:** The patient reports intermittent, dull discomfort in the lower abdomen.
- **Concise description of abdominal pain:** The patient reports intermittent, dull discomfort in the lower abdomen.

**Behavioral health terminology:**

- Shows symptoms of major depression or one has had thoughts of suicide.
- Patient is paranoid, but refuses to acknowledge this.
- Patient with mental illness
- Patient with risk of self-harm

**Adolescent care:**

- 14-year-old patient has a positive pregnancy test

**Legal and other proceedings:**

- Results of FEES (forensic nurse exam)
- Patient states he is not the father...

**Empathy, teamwork, support:**

- Tell patients of any new medical facts or changes in medical plans.
- Manage disagreement
- Be empathetic, supportive
- Emphasize teamwork

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When we think about our patients in a kind of language that WE know patently offensive to the uninitiated, who is to say that our own attitudes toward our patients are not affected by that language? —Cassandra Cook, PhD, New York

Our notes {should reflect} what we listened, we observed, we thought, and we cared, which {is context} is what each human being hopes for when putting their life in the hands of their physicians.—Heather E. Centers, MD, via 7/25/15

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**Version:** October 23, 2020, ET Un
People Using the EHR

- **Clinicians, Nurses, Staff using EHR**
- **Patients using EHR**

Source: Epic, October 2019, count of unique users collected from 12 organizations
Transparency? Get over it.

EHR → Past

MyChart → Now

Endless debate: Risky to share?

Open Results
OpenNotes

Next

23andMe
Instagram
travelocity
OpenTable
E*TRADE
Thank you!
How Can We Write Better Notes?

Leonor Fernandez, MD
Assistant Professor, Harvard Medical School
Director, Patient Engagement, Healthcare Associates
Beth Israel Deaconess Medical Center
Disclosures

- No financial disclosures.
Writing Better Notes

**Presenters**

- **Jared Klein, MD, MPH**
  7 Tips for Writing Better Notes

- **Jeremy Warner, MD, MS**
  Writing Better Notes in Oncology

- **Leonor Fernandez, MD**
  Words Matter: Insights from a Survey

- **Steve Dobscha, MD**
  Best Practices for Writing Mental Health Notes


Notes: Traditional Roles

• Convey information to others on care team
• Help clinicians consolidate their thinking
• Establish a reviewable record for quality and legal purposes
• Provide evidence of service for billing
Note Bloat: Content Shaped by Billing Requirements

• Convey information to other clinicians/to ourselves
• Help clinicians consolidate their thinking
• Establish a reviewable record for quality and legal purposes
• Provide evidence of service for billing

The Burden of Clicks

Illustration by Ben Wiseman
Atlas of the Labrador Brain

- Love and Loyalty
- Thinking About Food
- Actually Eating Food
- Chase... Retrieve... Repeat.
- Chewing On and Carrying Stuff
- A Whiff is Worth a 1000 Woofs
- Soaking Up Sunbeams
- Rainy Day Doldrums
- Get Wet, Splash & Dash
- Snuggling and Snoozing
- Slurps, Licks, and Kisses
- Marking Behavior
If I don’t finish this note now I will have to do it when I get home after the kids go to sleep.

I don’t remember everything that we talked about.

Did I list all the relevant diagnostic codes and conditions?

Population Health checklist--did I close gaps?

Smart phrase 1, smart phrase 4, Import half of my last note.
## Billing/Auditing Requirements Shape What We Document And How

### DOCUMENTATION GUIDELINES FOR ESTABLISHED PATIENT VISITS

<table>
<thead>
<tr>
<th>Code</th>
<th>Total Time</th>
<th>Level of MDM</th>
<th>Element 1: Number and Complexity or Problem(s) Addressed</th>
<th>Element 2: Amount and/or Compliency of Data Reviewed and Analyzed</th>
<th>Element 3: Need of Complications and/or Mortality or Morbidity</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>19-25 min</td>
<td>Straightforward</td>
<td>1 self-limited or minor problems</td>
<td>Minimal or none</td>
<td>Minimal risk of mortality from additional diagnostic testing or treatment</td>
</tr>
<tr>
<td>99215</td>
<td>10-15 min</td>
<td></td>
<td>1 well-limited or minor problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99212</td>
<td>30-44 min</td>
<td>Low</td>
<td>1 stable chronic illness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99213</td>
<td>20-28 min</td>
<td></td>
<td>1 acute uncomplicated dysentery or diarrhea</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99214</td>
<td>45-59 min</td>
<td>Moderate</td>
<td>1 patient requires additional diagnostic testing or treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99216</td>
<td>60-74 min</td>
<td>High</td>
<td>1 severe illness necessitating hospitalization</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Exemptions

1. More than half of the total must involve counseling or coordination of care.
2. **MEDICAL DECISION MAKING**
   - N/A
   - System of complaint
   - 2-4 systems
   - 5-7 systems
   - 8+ systems

### TIME

- 5 minutes
- 10 minutes
- 15 minutes
- 25 minutes
- 40 minutes

### Notes

- Two of the three key components - history, exam and medical decision making - are required.

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Table from: [https://www.aafp.org/fpm/2003/1000/fpm20031000p31-rt1.pdf](https://www.aafp.org/fpm/2003/1000/fpm20031000p31-rt1.pdf)

New Roles and New Opportunities for Notes

• Reinforce patient understanding
• Increase patients’ sense of control over health
• Enable patients to help identify important errors
• Enhance the relationship between clinician and patient
• Improve the ability of clinicians to consider the patient perspective?
New Roles and New Opportunities for Notes

• SOAP note: Subjective, Objective, Assessment and Plan
• APSO note: Assessment and Plan, Subjective, Objective

Could EMR be designed in ways that make notes more helpful?
Sustainable (Re)Design
Dramatic Rise of Telehealth During Covid-19 Pandemic

Number of Visits per Day in Transition to Telehealth at One Primary Care Practice

- Office visits
- Telehealth visits

Source: The authors

NEJM Catalyst (catalyst.nejm.org) © Massachusetts Medical Society
Access to Telehealth

Older patients, Black, and Latinx patients, and patients with low income have Less Access to Telehealth

Digital Equity Requires Action

- Build intentionally: design for marginalized populations
- Design a systematic offer for portal, notes, and video visits to every patient - avoid bias
- Support patients so they can access/register/use portal
- Track and Identify Disparities in Access/Use and Experience

How to Write Better Notes

1. Engage Patients Intentionally and Systematically

• Make sure your clinic/health system supports the ability of all patients to utilize portal

• Tell patients yourself that you invite them to read the notes and give you feedback

• “Let me know if you think there may be a mistake in your note”

• Angle the Computer Towards the Patient/Dictate in front of Patient
How to Write Better Notes

2. Listen and Note Key Concerns Respectfully

- Patients want to know that you listened and heard them
- Use the correct pronoun identified by patient
- Include patient perspective respectfully, especially if you see things differently
3. Be clear. Less is usually more.

- Avoid excessive repetition of data and old notes
- Do not import Social History if you did not elicit it or review it
- When possible, use language that mirrors how you speak with patients
- Consider whether sensitive details are necessary
How to Write Better Notes

4. Use Supportive and Empathic Language

• Think of how it your words will sound to the patient
• Avoid judgmental and stigmatizing terms
• Include patient’s efforts, strengths, and resources
• Document goals and progress
How Patients Feel Reading Notes

Did you feel offended/Did you ever feel judged by something you read in a note?

29,656 Survey Respondents

- YES: 10.9%
- Offended: 7.9%
- Judged: 7.4%
- Both: 4.4%
Vocabulary in Medical Notes
Do we need to evolve?
Thematic Analysis
Why did patients feel judged or offended?

- Mistake/Inaccuracy 23%
- Not Heard/Misquoted 15%
- Labeling Descriptions 13%
- Medical Idioms 12%
- Obesity 10%
- Stigma 8%
- Condescension 5%

Preliminary Results, Fernandez L et al, 2019
Thematic Analysis Lessons
What might we do differently?

• Obesity: Document the patient’s BMI. (NOT Morbidly Obese)

• Diabetes: Document as a condition, not as an adjective (NOT diabetic)

• Adherence: Describe behavior -she typically takes her medicine twice a week (NOT noncompliant)

• Drug Use Disorders: Alcohol or Opiate use disorder, NOT alcoholic or IVDA Urine is negative or positive, not clean or dirty*.

Take Home Points for Better Notes

Patients want the note to reflect the visit, and the visit to reflect the note

- Document the patient’s perspective
- Think of the tone
- Don’t surprise the patient
- When not sure: mirror the way you speak with a patient
Thank you.

Leonor Fernandez, MD
Beth Israel Deaconess Medical Center
Harvard Medical School
<table>
<thead>
<tr>
<th>UPCOMING WEBINARS</th>
<th>PRESENTERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thursday, February 18</td>
<td>• Fabienne Bourgeois, MD (Boston Children’s)</td>
</tr>
<tr>
<td>Open Notes in Pediatrics/for Adolescents</td>
<td>• Cindy Kuelbs, MD (Rady Children’s)</td>
</tr>
<tr>
<td>Monday, March 8</td>
<td>• Everett Weiss, MD (Memorial Sloan Kettering)</td>
</tr>
<tr>
<td>Open Oncology Notes</td>
<td>• Bertram Yuh, MD (City of Hope Cancer Center)</td>
</tr>
<tr>
<td></td>
<td>• Rosie Bartel (patient advocate)</td>
</tr>
<tr>
<td>Tuesday, March 23</td>
<td>• Brian Clay, MD, UC San Diego</td>
</tr>
<tr>
<td>Open Inpatient Notes</td>
<td>• <strong>TBA</strong></td>
</tr>
<tr>
<td><strong>TBD late March</strong></td>
<td>• <strong>Collaboration with the Center to Advance Palliative Care (CAPC)</strong></td>
</tr>
<tr>
<td>Open Palliative Care Notes</td>
<td><strong>TBA</strong></td>
</tr>
<tr>
<td><strong>TBD April</strong></td>
<td><strong>Anshu Abhat, MD (LA County Department of Healthcare Services)</strong></td>
</tr>
<tr>
<td>Open Notes in the Safety Net</td>
<td><strong>TBA (Institute for Family Health Services)</strong></td>
</tr>
</tbody>
</table>
Q&A

Open Discussion