How doctors can adjust to new reality—opening notes to patients

MAR 2, 2021

Andis Robeznieks
Senior News Writer

The federal government’s new rule on “Interoperability and Information Blocking” requires doctors to give patients access to their notes and takes effect April 5. Some experts, however, said the goal for physicians should be to go beyond mere compliance with the rule and to use this as an opportunity to help patients take greater involvement in their health.

The information-blocking rule was originally set to begin Nov. 2, 2020, but the Department of Health and Human Services (HHS) pushed the date back in response to advocacy by the AMA and other physician, hospital and health IT organizations that were seeking to give their members more time to adjust during the COVID-19 pandemic.

According to OpenNotes, a Beth Israel Deaconess Medical Center-based organization that describes itself as an “international movement promoting and studying transparent communication in health care,” more than 55 million patients already have access to their notes—including 10.4 million who gained access last year.

“We want transparency to become part of the culture of medicine—it’s good for patients,” said Catherine DesRoches, DrPH, executive director of OpenNotes. “The health care system increasingly wants patients to take ownership of their care, and we see that through insurance plan designs and rhetoric about patient-centered care. But patients can't do that unless they have the information they need.”

Research has shown that when patients have access to the information in their record, they become more engaged in their care. That, in turn, enables patients to better understand what they need to do next regarding follow-up care and being safe, said DesRoches, an associate professor of medicine at Harvard Medical School.

She is also the co-author of an AMA STEPS Forward™ module, “Adopting OpenNotes: Partnering with Patients.” The module, which is being updated, outlines key steps to get started and best
Don’t be an information blocker

“Information blocking” is defined as any activity designed to interfere with access, exchange, or use of electronic health information. The new federal rule defines the failure to share these eight types of notes with patients as a form of information blocking:

- Consultation notes.
- Discharge summary notes.
- History and physical.
- Imaging narratives.
- Laboratory report narratives.
- Pathology report narratives.
- Procedure notes.
- Progress notes.

There are a few exceptions to the rule. Psychotherapy notes and “information compiled in reasonable anticipation of, or use in a civil, criminal or administrative action or proceeding,” are exempted. Other exceptions include concerns with patient privacy or harm.

“Rather than focus exclusively on how to comply with the letter of the mandate, physician practices and health care organizations can think about the patient benefits and then pursue a plan that weaves transparency right into the culture of what they're doing,” DesRoches said. “Then it just becomes the norm and that's good for patients and, ultimately, I believe it's also good for clinicians.”

Advice on going open

For practices getting started on their open notes journey, DesRoches said major health IT vendors have options built into patient portals for sharing notes. She added, however, that physicians may want to add wayfinding tools to their site to help patients navigate where the option appears on the menu and where they must click.

“There's no coding work that needs to be done,” she said. “It's relatively simple from a technology perspective.”

One of the tips on getting started included in the STEPS Forward™ module is to develop an in-house
FAQ document to address clinician and staff concerns and detail the rollout.

“Clinicians tend to worry about their workflow and that this may create extra work because patients will be upset or confused and will be calling and emailing more,” DesRoches said. Experience has shown that this doesn’t happen. It’s good to explain that and include links to research backing that up.

The FAQ should also address what to do when a patient identifies an error in the record and have a process in place to make the correction.

Lastly, DesRoches recommends including information about what the research has found regarding patient benefits from note sharing.

“When patients read their notes, they feel more in control,” DesRoches explained. “They do a better job with follow-up, with taking their medications and they help keep their records accurate.”