

Sharing Notes

Frequently Asked Questions

Q: What is Shared Notes?

A: Shared Notes is the Yale New Haven Health version of OpenNotes. OpenNotes is a national movement encouraging clinicians to offer patients, parents and their care partners' ready access to the health care notes doctors, nurses and other clinicians write after a clinical appointment or discussion. Opening notes helps patients or parents to read material that, through the federal Health Insurance Portability and Accountability Act (HIPAA), is already theirs to receive and review, if they so desire. To learn more please visit www.Opennotes.org

Q: As a provider, why would I use Shared Notes?

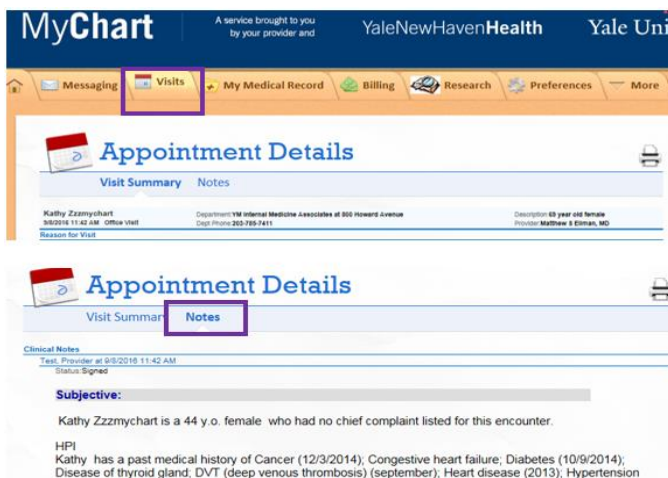
A: There are many reasons why Shared Notes can improve patient care.

- Enhance patient engagement and empowerment
- Patients feel more in control of their care and like it
- Supports culture of transparency and sharing information
- Recognizes patient ownership of their own medical record and facilitates that access.
- Builds trust between patient and provider
- Enhances patient safety – allows the patient to catch errors
- Reminds and reinforces the visit messages
- Aligns with our vision of patient centered care

Q: What notes are shared in this way and who can see them?

A: Initially only Outpatient Progress Notes will be shared.

Notes Visible	Notes not visible
<ul style="list-style-type: none"> • Progress notes • Patients with MyChart Access only • From the full MyChart Website 	<ul style="list-style-type: none"> • Note for patients 13 to 17 years old. • Notes created prior to your sites go live date • From within the MyChart Ap



Notes can be viewed by clicking on Visits Tab, choose visit summaries, select the specific visit and then Notes.

Q: How will patients learn about Shared Notes?

A : While it is certainly preferred that the clinician would tell the patient that they will have access to the note via MyChart, the patient will get in basket notification from within MyChart explaining their note access.

Q: What happens if I amend a note?

A: Only the amended note will appear for the patient to see. The status at the top of the note will change from 'Signed' to 'Addendum'.

Q: Will a patient see a note that is written by a student, resident or fellow?

A: The note will not be shared with the patient until a fellow or attending have assumed and signed the note.

Q: How does a patient request a change to their notes?

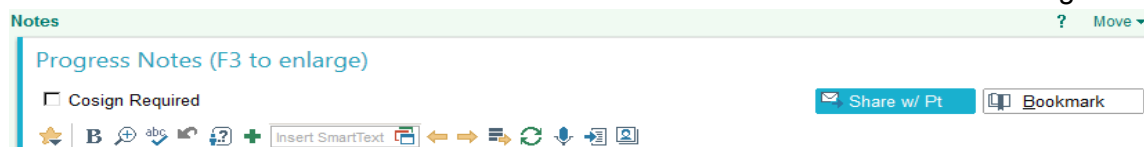
A: The patient can call Health Information Management at (203) 688-2224 for help with making any corrections.

Q: Is this going to slow me down?

A: Studies at sites already sharing notes have shown through provider surveys that sharing notes did not slow the provider down. They also showed that provider email volume did not increase and conversations with patients about their notes happen infrequently.

Q: What if there is a note I don't want to share?

A: As you participate the button in your note 'Share w/ Pt' will be automatically set to share, you can unclick while in the note. When discussing sensitive topics with a patient, for example, it is a good idea to ask them if they want the ability to view their note online. If they do not, you can check the box to hide the note right in the room. Also, if the patient contacts you and ask you to hide a note after the fact, you can edit the encounter and unclick 'Share w. Pt' box. This will remove it from online viewing.



Q: Can I unclick 'Share w. Pt' after the encounter is closed?

A: Yes you can. If you close the note the patient will immediately get a MyChart In Basket notification that a note is there and it will be viewable. If you go back in and 'un-share' the note, the patient will no longer see it in MyChart but the in basket notification will remain.

Q: Do I need to change the way I document my notes?

A: You may need to make some minor changes. Here are some tips from others who have shared notes.

Do	Don't
<ul style="list-style-type: none"> • Explain to patients what they may expect to see in notes • Expect patients to read, download and share your notes-write accordingly • Use situational wording to focus discussion on the problem at hand • Incorporate lab or study results • Include educational materials • Soften certain language: <ul style="list-style-type: none"> ○ Obesity = BMI too high ○ Heart Failure = heart not pumping correctly ○ Poor historian = patient could not recall ○ Patient denies = patient did not report ○ Noncompliant or Non-adherent = patient chooses not to... 	<ul style="list-style-type: none"> • Oversimplify notes • Omit sensitive issues such as obesity, substance abuse, mental health, suspicions of life threatening illness, etc. • Use pejoratives e.g. fat, angry, resistant • Include jargon or abbreviations such as SOB (easily misinterpreted) or BID (not easily understood)

Q: What if there is information in the notes that a patient does not understand? How can a patient get assistance?

A: Patient can follow the usual channels to understand how to engage with their care, such as sending an email or making a phone call. Medical assistants or nurses will help patients to understand next steps, just as they currently do. In departments that have implemented Message Pools, staff can answer any interpretation questions that arrive via your MyChart In-Basket. There is also a link to medical abbreviations and topics from within MyChart to help answer the common questions.