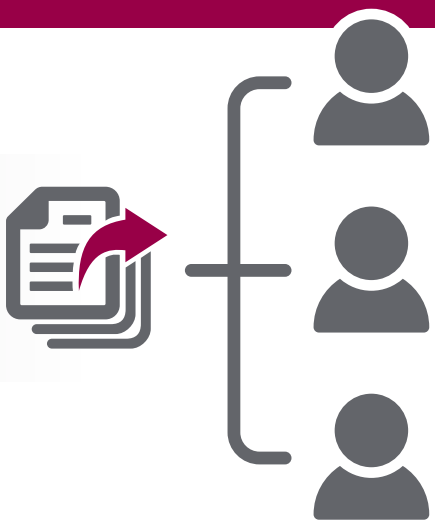
Improving Patients' Access to their Health Information

All Users and Facilities

The U.S. Department of Health and Human Services, as mandated in the 21st Century Cures Act, requires that we are specific regarding the medical records we electronically share with the patient.



How does this mandate apply to my patient documentation and to me?

This mandate applies to all encounter types—Ambulatory, Inpatient, Outpatient Surgery, Emergency Department, etc. Clinical documents as outlined by the United States Core Data for Interoperability (USCDI) include:

- History and Physical
- Consultation Notes
- Progress Notes
- Procedure Notes
- Discharge Summaries
- Imaging Reports
- Laboratory Reports
- Pathology Reports

Patients currently can see labs and radiology in real time, and with this new mandate, patients will be able to view operative notes and pathology reports as soon as they are finalized. We are already releasing much of what is mandated. On **March 30, 2021**, in accordance with our legal and compliance department decisions, we will begin releasing the balance of this information to our patient portals, Enterprise Wide.

Are there exceptions to what a patient will see?

Patients will not be able to see Psychotherapy notes. There is also an additional situation where notes will not pass to the patient portal:

- In very specific circumstances for which you have evidence that documenting information that will come into the hands of the patient or proxy could result in physical harm to the patient, document the encounter in a non-portal shared note.
    - o You may choose to document these concerns in the "Non Portal Note" or the "Child Abuse Report Form", both of which are available in Cerner and are not shared in the patient portal.

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How will sharing more medical information benefit our patients?

Patients report important clinical benefits from reading their medical information on a patient portal. Patients report that they:

- Have improved understanding of their health and medical conditions
- Recall their care plan more accurately
- Are better prepared for visits
- Feel more in control of their care
- Take better care of themselves
- Take their medications as prescribed more frequently
- Have more successful conversations and stronger relationships with their doctors

How will sharing more medical information benefit our Providers?

- Help patients to remember and understand their care plans
- Facilitate shared decision-making and better outcomes
- Improve adherence to medications
- Invite patients to spot mistakes and help prevent harm
- Enhance patients' ability to keep caregivers informed
- Answer questions through your notes
- Build trust and partnership

How can I maximize the educational potential of medical notes?

- Continue to document with full medical terminology that is required for the legal medical record as defined by the Medical Records Committee
- Briefly define medical terms when feasible
- Incorporate lab or study results into your notes to give patients the full picture
- Include educational materials or links to trusted content for your patients
- Be mindful of sensitive topics, and remember patients always have rights under HIPAA to access their record
- Avoid writing anything in your notes that you have not already discussed with the patient
- Tell patients in advance that they will be able to read what you write and to discuss anything they don't understand

Discuss what you write, and write what you discuss.

Information sourced from:

- https://www.opennotes.org
- https://www.opennotes.org/onc-federal-rule-interoperabilty-information-blocking-andopen-notes/

Additional information about the Cures Act:

- https://www.healthit.gov/curesrule/what-it-means-for-me/clinicians
- https://www.healthit.gov/curesrule/final-rule-policy/information-blocking

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