Open Notes: Considerations, Implementation & Implications on Practice

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Objectives

- **Understand institutional expectations in the provision of access to the MH record***
- Identify logistical steps in transitioning to Open Notes
- Define Information Blocking
- Strategies to engage and support Staff's concerns about Open Notes
- Outline best practices for documenting encounters in the legal medical record, including approaches in note writing and EHR features

* Disclaimer: We are both located in CA, The CURES Act is a Federal law, however your center's status as a healthcare entity (hospital, ambulatory, outpatient, etc) and how General Counsel interprets and applies the law to your site may vary. The information provided is within the context of CA and in both public and private universities.

Quick Review:
The 21st Century Cures Act

A federal mandate created to prevent the blocking of electronic health information between health systems, apps and devices.

- For patients, the Cures Act was intended to allow unfettered access to their personal health information.
- It is a bi-partisan law that passed in 2016.
- Does not include a provider's "psychotherapy notes."

Despite being a Federal mandate, the type of clinic /legal definition, state laws, institution values, and General Counsel's philosophy may impact it's implementation.

Clinical Encounter or Progress Notes that are part of the Part of the Clinical Record/Chart:

- medication prescription and monitoring
- counseling session start and stop times
- the modalities and frequencies of treatment furnished
- results of clinical tests, and
- any summary of the following items:
- Diagnosis,
- functional status,
- the treatment plan,
- symptoms,
- prognosis, and
- progress to date.

"Psychotherapy Notes" which are not included in Cures Act

- What most Mental health professionals r efer to as "**Process Notes**" but the regulatory term is **Psychotherapy Notes**.

- "notes recorded (in any medium) by a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record..."

- Does not include any of the items in the left column

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Timeline / Logistical Steps (1 of 2)

- Allow for 3 months planning, if possible.
- Collaborate with IT and General Counsel at each step.
  - Update Informed Consent with General Counsel.
  - Create an Opt Out option.
  - Note Addendum process for students.
  - Deciding on start date (eg, retroactive access or access as of "live date").
  - Deciding which notes can be withheld without being considered as "blocking." (Eg, Scanned Documents do not have to be made available)

Timeline / Logistical Steps (2 of 2)

- Training for staff (will elaborate in later section)
  - Note training
  - Addressing professional values, anxieties, and client advocacy
- Training and marketing for students
  - explanation of the Open Notes concept and the intended benefits
  - instructions of safeguarding private information (opt out option)
  - process for requesting an amendment to notes in the medical record
  - encouragement to discuss questions with the provider
- Updating Note Templates with the Clinical Operations Team (will elaborate on in later section)

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Defining Information "Blocking"

Cures defines info blocking as business, technical, and organizational practices that **prevent or materially discourage the access, exchange or use of electronic health information** (EHI) when an Actor knows, or (for some Actors like EHR vendors) should know, that these practices are likely to interfere with access, exchange, or use of EHI. If conducted by a health care provider, there must also be knowledge that such practice is unreasonable and likely to interfere with, prevent, or materially discourage access, exchange, or use of EHI.

8 acceptable reasons for blocking: Mental Health exception is solely related to Preventing Harm

Defining: Prevention of Harm Exception

- *"(Blocking) will not be information blocking for an actor to engage in practices that are reasonable and necessary to prevent harm to a patient or another person, provided certain conditions are met."*
- Harm is defined as information that may **endanger the life or physical safety** of the individual or another person.
- A note can only be blocked if the clinician believes that not doing so will substantially increase the risk of harm to the patient or another person.
- CURES allows for notes to be blocked for ***Risk of Harm. This will likely be rare.*** *Emotional harm is not included in this exception.*

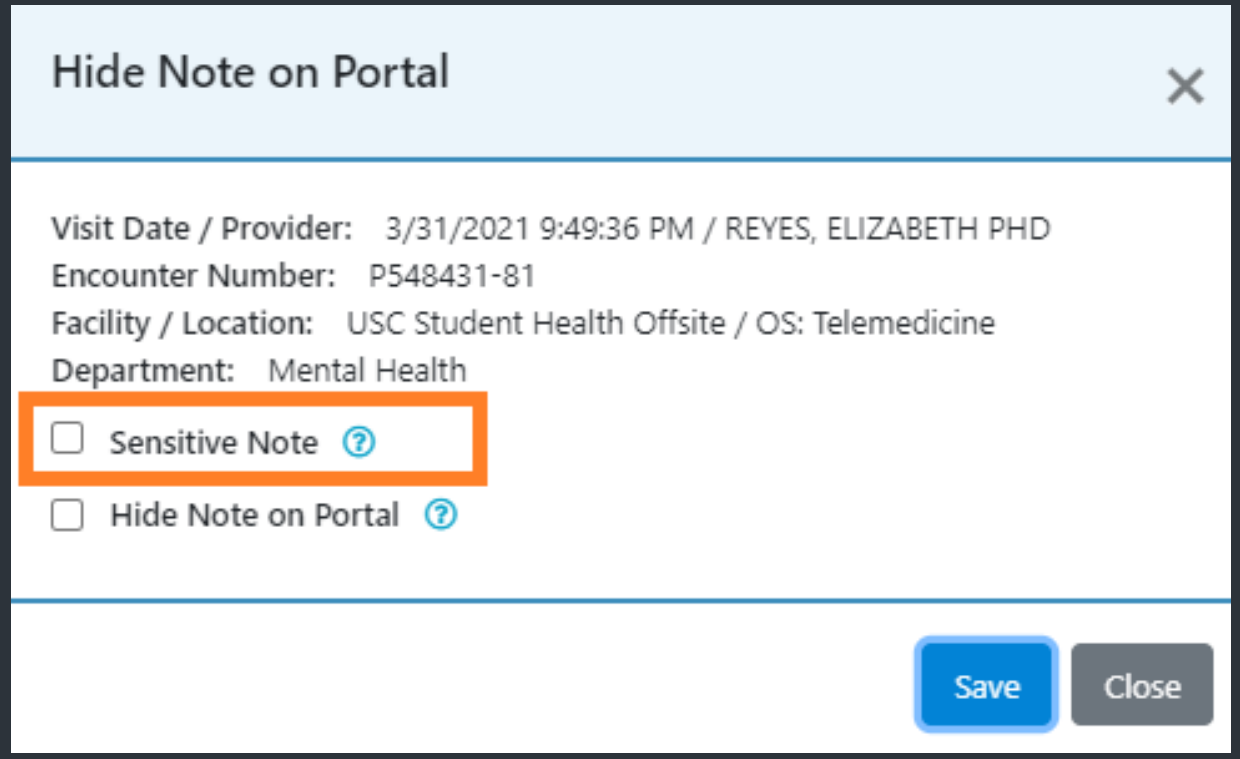
Implementation based on the Prevention of Harm Exception

- The determination of risk is based on specific facts and circumstances.
  - The specific risk/type of harm and reasons for this determination must be documented.
  - reasonable belief that the blocking will substantially reduce risk of harm;
  - blocking must be no broader than necessary;
- The blocker provides the patient the right to request review of an individualized determination of risk of harm.
- There can be fines associated with blocking access to clients/patients.

EHR examples: PnC function "Hide Note"

- **Sensitive note”**

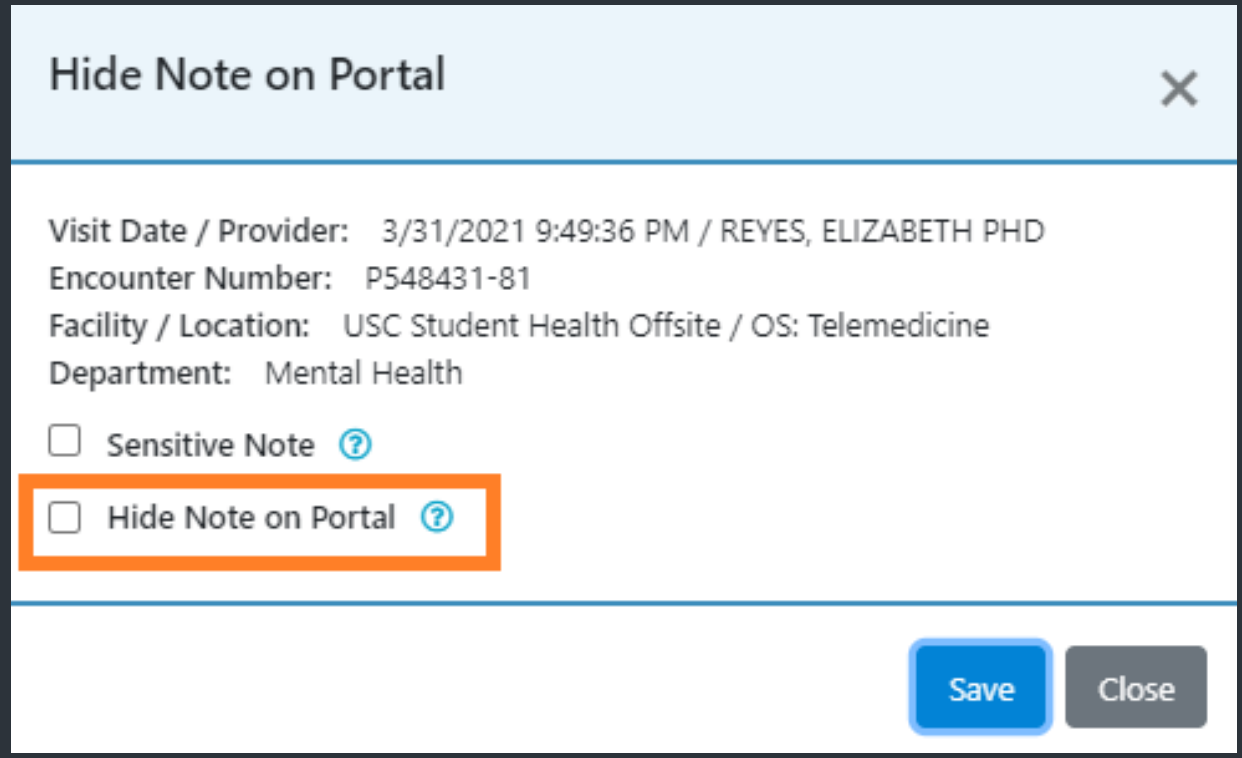
  This function refers to blocking access within the organization. For example, hiding the note will only be accessed by medical, but hidden from receptionists. **This is not related to open notes.**



PnC "Hide from Portal" Function

- **Hide from Portal"**

  There are 8 Exceptions allowed by CURES that allows information to be blocked from the consumer. The pre-populated Drop Down Menu reflects these 8 exceptions. **Typically, Mental Health would use Risk of Harm exception.**



Opt Out/Blocking Data UC Davis 9/1/21-5/15/22

- Total Clients Served: 4,111
- Total Appointments: 14,303
- Total Notes Written: 14,129 (excludes Group)

- 10 Students have completed Opt Out Forms
- 25 notes have been blocked due to student opting out

- 17 notes have been blocked by CS Providers (16 CS Dept, 1 CS Acute Care) or .1%

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Engaging Staff

- **Change process**: Consider the staff's attitude toward change and role of education, validation, and praise.
- **Historical importance:** May or may not be helpful to frame it as an Obama era law from 2016 that intended to put knowledge in the hands of the consumer.
- **Staff concerns:** Address concerns and historical beliefs to "protect the record."

- **Reviewing the purpose of Open Notes can address many concerns that staff tend to have about their professional goal to protect records.**

Staff concerns: Talking Points to address staff anxieties (1 of 3)

Open notes demonstrates respect and reducing stigma. To treat medical notes (open) and mental health notes (not open) differently may unwittingly reinforce stigma.

Open Notes Empowers Clients/Patients.

- implies that patients are competent. Promotes an open, respectful approach can mitigate inherent power imbalances in health professional-patient relationships.

Enhancing trust and the therapeutic relationship.
Note sharing can demystify what the therapist (and thinks), may promote richer dialogue about potentially difficult topics, including the patient's diagnosis, something routinely avoided by many therapists.

Staff concerns: Talking Points to address staff anxiety (2 of 3)

Organizing care and tracking progress.

- **can help patients understand their treatment and progress (or lack thereof) and remind patients of their responsibilities in their care, including 'homework' or follow-up issues to be worked on between sessions.**

Providing a tool for behavior change.

- **health professionals in the OpenNotes study found that when some patients read medical notes about sensitive subjects, including substance abuse, they were more motivated to address difficult changes in behavior**

- **Organizing care and tracking progress.**
- **can help patients understand their treatment and progress (or lack thereof) and help remind patients of their responsibilities in their care, including 'homework' or follow-up issues to be worked on between sessions.**

Staff concerns: Talking Points to address staff anxiety (3 of 3)

Making care safer.
Allowing patients to review what was said about their symptoms, medication doses, etc. helps ensure that the record is accurate. Sharing notes also serves as a cross check, improving the likelihood that the patient and health professional are on the same page. Open notes promote partnership and cooperation among all parties to promote the safety of care.

Potential for reducing workload for clinicians.

- **Open notes can extend the work of the session between visits. As with all medical visits, many patients have a hard time remembering what was discussed in sessions.**
- **Note sharing may help patients find what is needed without requiring additional communication with their clinician, which may lead to fewer phone calls and emails between appointments, and shorter or more efficient note writing as clinicians shift to 'plain language' when appropriate.**

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Supporting the Transition to Updated Documentation Practices

- **Training**: Provide knowledge and tools by offering a series of training:
  - Review of Open Notes/ CURES Act: Providing a brief overview that emphasizes the Framework of Client Empowerment in order to appeal to the Social Justice value at UCCs.
  - Veteran Affairs/VA Open Notes Training
  - Final Q&A with staff, if needed.
  - Using testimonies from "peer clinics" to re-assure concerns.

Revisiting Documentation Practices

- **Documentation/note <u>content</u> expectations**
  - Review purpose of notes per various Board Guidelines
  - Content guidelines
  - Offer writing samples

- **Proactively addressing Open Notes with clients**, co-creating collaborative therapeutic relationship

- **Templates as Job Aids**. Creating updated templates to support revised content expectations
  - Intentional, strength-based templates that emphasize positive traits and client strengths.
  - Consider creating strength-based progress indicators.

Content: What is "the purpose" of Clinical Notes

- Who, What, Where, When, Why: Client information, What service was provided and where and when (easily documented), Why (most variety in documentation).
- Accurately document what occurred in session. This reduces liability issues. Feedback informed treatment positively influences outcomes.
- APA Record keeping purpose & guidelines: Provide good care, assist collaboration, ensure continuity, provide training (supervision), provide information needed for reimbursement, document risk and actions taken, allow for therapist to respond to legal/ regulatory complaints.
- American Counseling Assoc. guidelines: Sufficient and timely documentation to ensure delivery and continuity of services.
- AAMFT: Accurate and adequate clinical and financial records in accordance with applicable laws.
- AASW: Accurate and reflects services provided. Sufficient and timely.

Content: Overall Documentation Guide (1 of 2)

- Consider **tone**: neutral tone, stay factual.
- Consider and try to avoid possible **misunderstandings.**
- Try to use **language** that mirrors how you talk to clients/patients.
- **Accurately** represent what clients/patients tell you.
- Focus on proper **gender references and pronouns**.
- Avoid or define medical jargon. Spell out acronyms and abbreviations (ex: “Pt is SOB”).
- Be transparent, respectful, nonjudgmental.
- Consider/change language that might be considered **pejorative**.

Content: Overall Documentation Guide (2 of 2)

- Avoid **judgmental or stigmatizing** terms ("obese", "borderline"), unless their own term.
- Include strengths.
- Engage students in documentation - discuss what you will document.
- Collaborative documentation. Writing the note together.
- Discuss diagnoses.
- Discuss potential harm of reading notes and options if there is concern about harm as well as plan if the student feels harmed.
- Consider privacy and safety (e.g. parents accessing records, victims of intimate partner violence).

Note Examples for Psychiatrists for Challenges:

- Written by a psychiatrist at BIDMC, these examples are based on scenarios encountered by health care professionals.
- ***The delusional patient***
- **Scenario:** Mr. A is a man with schizophrenia who believes that the FBI has placed "invisible" microphones and cameras in his apartment. He takes 1 mg of risperidone daily "to keep my family off my back," but you are trying to get him to take a higher dose. You have tried to discuss his diagnosis with him, but he dismisses it, and believes that "schizophrenia was made up by the FBI to incarcerate subversives."
- **Sample note:** Mr. A says he is taking risperidone 1 mg daily, but he continues to be convinced that the FBI is monitoring him. We disagree on this, as we do about whether he has a psychiatric problem in the first place. I believe that a higher dose of risperidone would help him with the anxiety he feels about being monitored, but he firmly refused to increase the dose to 2 mg daily. I nevertheless urged him to consider a brief trial of the higher dose, to see if he noticed any benefit. We will continue to assess his overall level of anxiety and how it affects his daily functioning. I am concerned that his anxiety limits his ability to feel safe on a day-to-day basis. But on a happier note, he continues to be very interested in current events and reads newspapers and books extensively.

Note Example for Therapists

- Working with a client who presents with interpersonal struggles, self-injury, difficulty engaging in changes and making changes in treatment.
- Judgmental Language: CT presents as oppositional to treatment and therapist suggestions. Despite encouragement to explore DBT TX objectives, positive boundary setting in relationships, and connection in session, CT has remained stuck in patterns and continues to use daily masturbation as the primary outlet. CT also will not agree to stop superficial cutting as a means of distress tolerance.

- Open Language: CT and provider have discussed the stuck point they have reached regarding steps that could be taken to improve interpersonal relationships and stress tolerance. At this point, CT is choosing to continue to use their relied upon methods of stress release which they feel is helpful to maintain balance. CT is still open to continued therapy and agreed to schedule follow up session to explore other options of distress tolerance. Provider will continue to assist CT in identifying other methods of stress release less harmful than cutting, and will encourage connection to self and others in healthy ways.

Additional Considerations

- Biggest Note Issues: Judgmental language about client/situation, too much personal information in detail, provider jousting, too little information (impersonal).
- From note trainings: Identify 3 main concerns, and 3 interventions.
- Make a clear plan other than: "Continue therapy with CS." Instead, outline timeline with measurable steps toward progress and any steps you asked clients to complete in between sessions.
- Reduce jargon / abbreviations.
- Note strengths, note cultural considerations, note protective factors.
- Name collaboration with client or plans to collaborate with others in note.

How to Introduce Open Notes to clients

- Example: SHCS is compliant with the CURES Act, which allows you to access your medical and mental health notes via your HeM portal. Please be aware that anyone you give your password to will have access to these notes.
- If you choose to look at one of our notes, you will see the documentation of what we discussed in session, which can serve as a helpful reminder of your goals for therapy and what you are working on in between sessions. These notes will not contain everything we discussed, just the important facts that I need to document. Occasionally abbreviations are used.
- If you have any questions or concerns about the notes, I invite you to bring them to my attention in our next meeting or via a HeM. There is also a process to add an addendum to the note that we can discuss if needed.

Consider educational text about Open Notes in all templates. Eg, USC note templates include:

Open Healthcare Records are intended to inform and empower consumers about their health. In the interest of advocacy and support, Student Health encourages students to review the records together with their provider. This allows for immediate support or clarifications for questions that may arise. Notes are best understood in consultation with a provider.

Process of Developing Strength Based Templates / Use of Peterson & Seligman

- Clinical Operations Committee
- Feedback from team members
- Focus on 3 sections for notes: Academic issues, Strengths & Traits, How to Indicate Progress
- Temporary template – gather feedback before going live
- Demo final template for staff

Adding Strength-based documentation

STATES AND TRAITS

< Enter text here >

Therapist has observed and/or client has expressed strengths in the following states and traits.

Please check all that apply if not indicated elsewhere in the note

- [ ] autonomy/sense of agency/self-efficacy
- [ ] community involvement
- [ ] cultural connection
- [ ] engagement in cultural, spiritual or self care practice
- [ ] engagement in enjoyable activities
- [ ] has demonstrated persistence, courage or bravery
- [ ] has meaningful relationships
- [ ] interest in personal growth
- [ ] leadership role in an organization/club/group
- [ ] moral alignment (actions aligned with beliefs)
- [ ] optimism or positive outlook
- [ ] positive academic functioning
- [ ] positive emotions (happiness, satisfaction, pride)
- [ ] positive self-view (can name own strengths)
- [ ] pride in identity (any facet of identity or layered identities)
- [ ] recognition of accomplishments
- [ ] resiliency or perserverance
- [ ] resourcefulness
- [ ] self acceptance
- [ ] self-esteem evidenced
- [ ] sense of belonging
- [ ] sense of humor
- [ ] sense of purpose
- [ ] sense of self mastery
- [ ] shows creativity, curiosity or open-mindedness
- [ ] spiritual connection
- [ ] temperance (self-moderation, forgiveness, humility)
- [ ] other

Making Strengths/Progress Easy to Name

Client has demonstrated strengths and progress in the following ways

- [ ] lowered distress
- [ ] improved mood/sleep/functioning
- [ ] reduced symptoms
- [ ] improved coping skills
- [ ] reduced risk issues
- [ ] increased self-care activities
- [ ] increased academic focus
- [ ] utilization of skills discussed in sessions
- [ ] improved relationships or communication skills
- [ ] is connected to therapy process and actively participates
- [ ] has reported positive changes in general
- [ ] healthier relationship with substances / food / electronics
- [ ] increase in positive self-image / and or body image
- [ ] increased mindfulness and attention to emotional process
- [ ] demonstrated transferability of therapeutic tools into areas of life
- [ ] ability to change unhelpful behaviors, and or reframed unhealthy thought patterns
- [ ] has re-engaged in enjoyable activities, or is increasing positive output
- [ ] actively engaged in session process, homework assignments, steps toward change
- [ ] improved sense of belonging
- [ ] increased community engagement and connection
- [ ] reduction of addiction patterns
- [ ] other

How to note Academic Issues w/o Issues: Strength Based Approach

Academics

Not presented by student as a concern or treatment goal Presented as a concern and/or growth area to explore

Presented as a concern and/or growth area to explore

Interests in campus resources Exploring academic options or changes Exploring identity as a college student

Please practice mindfulness/sensitivity in documentation of academics and not perpetuate judgmental/shaming academic labels/status that can be wrought with meaning when read out-of-context

Demonstrates the following strengths around this concern:

Seeks out and utilizes campus resources for support
Considers range of academic options and opportunities
Follows academic advisement
Embraces challenges as opportunities for growth (growth mindset)
Builds and collaborates with academic support network
Addresses concerns and identifies range of solutions
Practices thoughtful/goal-oriented decision-making
Persists in the face of challenges
Sees effort as path to achieving goals
Challenges self to consider alternatives (vs rigid mindset)
Recognizes and draws upon own strengths
Motivated to address concern(s)
Accepts feedback
Use of increased or new types of support and creative solutions
Practices accountability
Pursues holistic understanding of concern(s)
Considers academics as just one area of life
Recognizes broad range of learning styles and processes
Finds lessons and inspirations from others' success
Exhibits leadership during difficult situations
Motivated to learn from experience
Other

Staff Survey Feedback - UC Davis

How prepared did you feel to discuss Open Notes in your informed consent: 89% felt adequately to completely prepared 11% felt somewhat prepared

- How well did you understand how and when to use "Block Note" exception:: 61% felt adequately to completely 28% felt somewhat 11% felt not at all

- How well did you understand how to use our new strength-based template or write a strength-based note:

98% Adequately to completely 2% felt somewhat prepared

- How has it impacted your note style? (multiple responses allowed)
- Most frequent: I am cautious with how I word things (18) I leave out details I might have included before (16) I include things in the note to remind the client between sessions (12) my note is more strength based (10) I don't use as many acronyms (10) more cautious with DX (9) my note is shorter (8) I write from the lens of the CT (7) Style not changes (6) I include more direct quotes (5) My note takes longer (4)

- What is the impact in terms of CT report back to you: (multiple allowed): 21 of 28 The clients have not mentioned an impact, 4 positive impact 3 negative impact 3 reported using it as a reminder between sessions

- What best prepared you to go to Open Notes:
- The actual experience & the training(s) attended followed closely by having a strength-based section in the notes

- How could we have better prepared you? More note examples, regular refreshers of exceptions / how to block

- Do you need more training this summer 56% no 44% yes: How to guide students through the Opt Out process, Understanding Exemptions & Note Writing

Resources to Share with Staff

Sharing Mental Health Notes with Patients: Webinar Recording

January 12, 2021. Sharing Mental Health Notes with Patients: Webinar In this webinar two of the nation's top experts on "open mental health notes" cover what clinicians need to know about sharing therapy notes with patients, and the nuances associated with an upcoming federal mandate that requires visit notes be shared with patients.

Open Notes & Notes Best Practices

American Psychological Association (APA) put out some FAQ :
https://www.apaservices.org/practice/business/hipaa/information-blocking-rule-faq
CrowdCast training on "what should be in your notes,"

https://www.opennotes.org/news/sharing-mental-health-notes-with-patients-webinar/

Other Resources on Open Notes:

VA Open Notes Mental Health Course – as recommended through OpenNotes.Org (pls note, does not work well in Google Chrome).

AMA Modules on Open Note and Partnering with Patients/Clients

The OpenNotes website also has some helpful info about writing notes and examples. Scroll down to "Writing open therapy notes".

https://www.opennotes.org/news/sharing-mental-health-notes-with-patients-webinar/

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References (3 of 3)

- CURES ACT, the bill in its entirety:
- 21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program
- Patient Access to Health Records [123100 - 123149.5]
- Open Notes for Healthcare Professionals
- Cures Act Final Rule: Information Blocking Exceptions

Thank you

Questions?