Open Clinical Documents

Patient-centred writing tips for providers

eHealth Saskatchewan

Overview

When it comes to open clinical documents, think **one document – many uses**. Some key things to keep in mind include:

- Clinical documents are designed as a tool between care providers.
- Patients can already access all of the information in their charts upon request. Including clinical documents in MySaskHealthRecord will make it easier for patients to access their information.
- Patients can play a huge role in their own care. Providing access to clinical documents in MySaskHealthRecord will increase patient engagement and empowerment. It can improve trust in providers and strengthen patient-provider relationships.
- The majority of patients will be able to get the information they need on their own from clinical documents. Some will need help understanding the information.
- You will have an additional way to flag personal health information (PHI) for exclusion from MSHR if you don't want to share with the patient based on privacy or safety concerns in accordance with HIPA Section 38(1). Education on when and how to flag PHI for exclusion from MSHR will be available to providers in advance of the SHA Phase 2 implementation.
- Historical clinical documents will not be added to MySaskHealthRecord.
- You may already be doing many of the things suggested below, such as sharing copies of clinical documents/reports with patients.

Tips for Providers

These tips are based on what providers in other jurisdictions have experienced when sharing clinical documents with patients and how their dictation/writing has evolved. You may find these tips helpful to consider.

Be clear and concise

- Try to use direct and simple language when possible, remembering that the patient will read the note.
- Avoid jargon or abbreviations when possible.

Be direct and respectful – consider word choices and tone

- Discuss what you dictate/write and dictate/write what you discuss. Include topics you've discussed with your patient to help reinforce their memory of their care plan.
- Address sensitive issues directly. Examples include obesity, malignancy, substance use. Be clear and remember that patients are likely concerned about these.
    - Obesity: review BMI and definitions for overweight, obese and morbidly obese and focus on positive changes the patient has made with diet, exercise and weight loss.
    - Malignancy: outline specific symptoms concerning for cancer and note referral or tests for prompt diagnosis.
    - Substance use: explain the connection between substance use and the patient's condition.

Be positive and supportive

- Use direct but caring words. Be objective. This can help to overcome denial, destigmatize and even motivate behavior change. Dictate as though the patient is with you, hearing you.
- Focus on patient's strengths and achievements. Consider using notes to motivate patients and give positive feedback. Consider placebo effect e.g. He's done a great job.
- Be objective but not judgmental e.g. use "declined" rather than "refused" or "patient chooses not to" rather than "patient is noncompliant."
- Eliminate any language that might be critical of the patient or another provider.
- Be respectful and supportive of other healthcare providers. Include information constructively to assist other providers in delivering the best standard of care.

Include patients in the note-writing process

- Think of clinical notes as a communication tool.
- Explain to your patient that they can read their notes in MySaskHealthRecord and encourage them to do so.
- Check with patients during their visit to be sure they will understand the content that will be provided in the note.

Follow-up and use of clinical notes to engage patients

- Complete notes after the visit in a timely manner.
- Draw attention to follow-up or future actions.
- Consider using notes for patient feedback and follow-up.

Additional reading information:

1. OpenNotes. https://www.opennotes.org/
2. The Canadian Medical Protective Association (2020, March). Writing with care. https://www.cmpa-acpm.ca/en/advice-publications/browse-articles/2020/writing-with-care
3. Wolff, J. L. et al. (2016, August 7). Inviting patients and care partners to read doctors' notes: OpenNotes and shared access to electronic medical records. *JAMIA*, 24(e1): e166-e172. https://doi.org/10.1093/jamia/ocw108
4. Hägglund, M et al. (2022, September 29). Patient empowerment through online access to health records. *BMJ*, 378:e0171531. https://doi.org/10.1136/bmj-2022-071531
5. Blease, C. et al. (2020, November 27). Does patient access to clinical notes change documentation? *Frontiers in Public Health*, 8(577896). https://doi.org/10.3389/fpubh.2020.577896
6. Leveille, S. G. et al. Patients evaluate visit notes written by their clinicians: a mixed methods investigation. *J GEN INTERN MED* 35, 3510-3516. https://doi.org/10.1007/s11606-020-06014-7
7. DesRoches C. M. et al. (2020, March 27) The views and experiences of clinicians sharing medical record notes with patients. *JAMA Network Open*, 3(3): e201753 10.1001/jamanetworkopen.2020.1753
8. Klein, J. W. et al. (2016, June 8). Your patient is now reading your note: opportunities, problems and prospects. *The American Journal of Medicine*, 129(10): 1018-1021. https://doi.org/10.1016/j.amjmed.2016.05.015 .
9. Parikh, R. B. et al. (2022, May 31). Digital health applications in oncology: an opportunity to seize. *Journal of the National Cancer Institute*, 114(10): 1338-1339. https://doi.org/10.1093/jnci/djac108