Q: What is the overall scope of this project?

A: Since the inception of MySaskHealthRecord (MSHR), patients have asked for access to open clinical documents to support actively managing their own health care. In its 2022-23 accountability plan, the Ministry has supported making clinical documents currently in eHR Viewer available to patients in their MySaskHealthRecord account.

Patients have always had the ability access to these records via a formal request. The addition of documents to MSHR will simply make it easier and faster for patients to receive them, and provide them through a safe and secure web site.

Your support for this initiative is appreciated and will contribute to better health outcomes for Saskatchewan people.

Q: Will documents generated before the pilot and go-live dates also be made available in MSHR?

A: We have heard your concerns, and to ensure safety and mitigate risk historical documents will not be added to MSHR.

Q: What types of documents will NOT be visible to patients?

A: Only clinical documents already available in eHR Viewer will be sent to MSHR. Those that are not in the viewer (for example, mental health notes, documents deemed sensitive, and clinical notes in private/office EMRs) will not be made available.

Q: How will sensitive documents be managed in this process? Can I decide what documents my patient receives?

A: The addition of open clinical documents may mean physicians will need to use a different process for sensitive notes that should not be shared due to privacy or safety concerns. This process has been created by a Sensitive Documents Task Team, which includes technical experts, information technology vendors, and clinicians. Information will be provided on how to navigate this process, what types of documents will be considered sensitive, and technical instructions.

Q: What if there is information in my notes that may be upsetting or surprising to a patient? Will we be expected to censor our notes?

A: Sensitive or difficult issues would ideally be discussed in advance of a patient reading the information on MSHR. The project utilizes a 48-hour delay between documents being submitted to the eHR Viewer and appearing in MSHR; this time could be utilized to update the patient and share any potentially-concerning information in the documents. We recognize this could necessitate a change in your normal process and appreciate your consideration of the patient's response. Information is available on the MSHR provider page on how to address abnormal or sensitive information with patients.

Q: Will this include hand-written progress notes?

A: That is not contemplated in the current plan, but it may be considered in the future.

Q: Who is involved in making these decisions?

A: This project includes in its governance both a multi-disciplinary working group and a steering committee that provides direction on changes to MSHR. Both groups include clinicians. Task teams have also been created to manage the sensitive document process and corrections to documents; clinicians are involved in these groups as well.

Every aspect of the project is subject to approval by a Council that includes the Deputy Minister of Health and the CEOs of health system partner agencies like eHealth, 3sHealth, and the Saskatchewan Cancer Agency.

Q: What is the timeframe for the project to go live?

A: A phased approach to the rollout of open clinical documents will be used, starting with a limited scope of certain clinical documents in early 2023. The SCA will be the first organization to have clinical notes that are generated in their facilities flow to MSHR. Later in the year, documents generated in the SHA will be added using a similar phased approach.

Q: Will there be a time lag or delay between when clinical documents are available in the eHR Viewer and when they are visible in MySaskHealthRecord?

A: The initial pilot rollout for clinical document includes a 48 hour delay to allow corrections or communication with the patient to occur before the documents are released. Our current practice is no delay on most MSHR content, such as laboratory and imaging results, and a four-day delay on pathology reports.

Q: Have HIPPA concerns been addressed with the new integration of open clinical documents?

A: A process to designate a document as having content that is sensitive information and inappropriate for the patient to see is under development. The criteria uses HIPPA legislation to guide the redacting or withholding of the document. There is also a strong process to ensure patients can control who can see their own MSHR account, and for parental viewing of their child's account. Mature minors are deemed able to manage their own information starting at age 14.

A privacy impact assessment was done with the technical vendor to identify and mitigate any risks. None were identified.

Q: Will this make extra work for physicians or their office staff by triggering more questions from patients?

A: We cannot say for sure, but feedback from other jurisdictions who have gone through this process suggests it will not create a substantial increase. An extensive environmental scan of lessons learned and mitigation strategies is underway. We have already learned from Interior Health in BC, where a comprehensive system was put in place in 2016 to support responses to patient-identified errors, that a low volume of two to four errors were reported each month. The NHS in England has had open clinical notes for twenty years, and the United States health system has seen the use of secure patient portals expand extensively since 2010, with federal legislation passed in 2021 mandating all U.S. health-care systems to electronically share clinician notes with patients at no charge.

The Saskatchewan health system learned how to mitigate risks and minimize burden clinicians when previous open clinical documents, such as laboratory, imaging, and pathology reports, were made available to patients.

There is potential for reductions in work, as patients may be better prepared at scheduled appointments to communicate results or treatments, and experience the benefits of active involvement in their own care.

We encourage you to make patients aware of their ability to view clinical documents when the changes roll out, and to encourage patients to use MSHR if they are not currently.

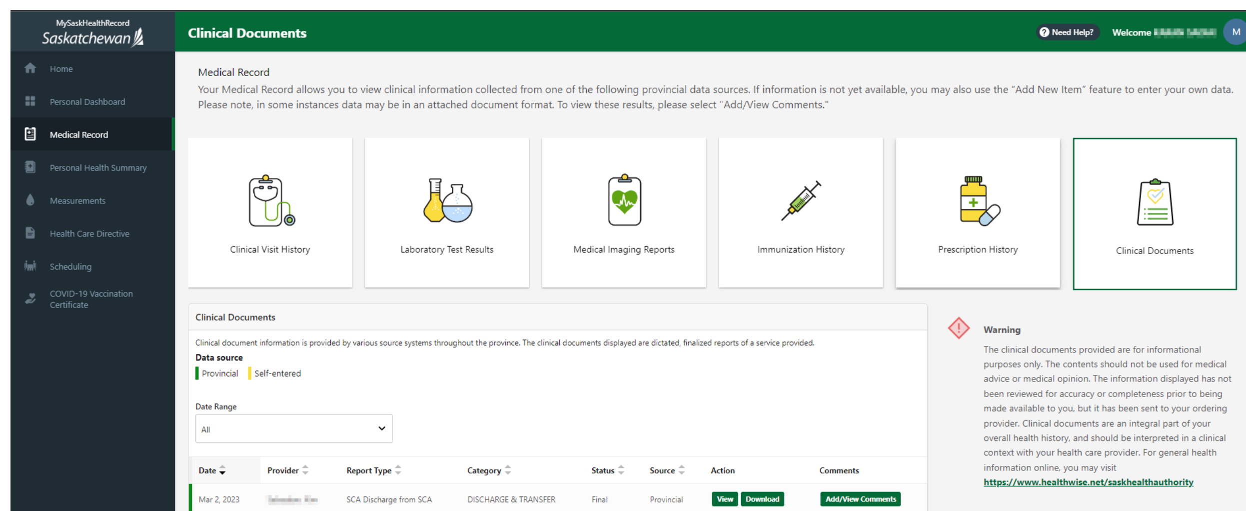
Q: How can my patients get access to their open clinical documents if they don't have a MySaskHealthRecord account?

A: Patients can still utilize the existing manual process to request their clinical documents. They will have two other options:

- Sign up for a MySaskHealthRecord account with their Health card number and their SGI driver's license number: https://www.ehealthsask.ca/MySaskHealthRecord/MySaskHealthRecord/Pages/Register.aspx
- Make a request for their information through eHealth at this link: https://www.ehealthsask.ca/PrivacyandAccess/Pages/Requesting-access-to-information.aspx

Q: How will my patients see their open clinical notes in MySaskHealthRecord?

A: Patients will log in to their MSHR account and navigate to the "Clinical Documents" widget from the home screen. Any data available will be visible in a list on the page.



Q: Is there a forum for me to ask further questions I may have about the project and what it means to my practice?

A: We welcome all questions. Please forward your questions with the subject line "open clinical documents project questions" to MySaskHealthRecord@eHealthSask.ca.