Documentation Transparency- October 2020

Topic/Questions Posted:

Currently, our therapy notes are not automatically shared with families through our EMR/EPIC. Families can request copies through our Health Information Management Department.

With new CMS guidelines, the suggestion has been made that therapy notes should be changed to auto share with families through the EMR. I anticipate this is going to cause some anxiety with our staff.

Do you currently share therapy notes automatically with families through the EMR?
If yes, are there any notes that you do not auto share?

Has this caused any challenges/issues? And if so, what types?

Did your therapists change anything with their documentation practices as a result of auto sharing?

ORG A	We are about to go there. I'm interested in the feedback
ORG B	I am on the MyChart committee at ORG B. We met last month and were told about this…I guess it was originally to be put into effect in Nov, but due to COVID is now projected for Jan. This will be a big shift for us, and I think it may affect the way we document. I think that clinicians will be more selective about what they document in the subjective. I think they are also going to need to be thoughtful about writing objective findings in a way that is more succinct and easily understood. I am hopeful that it may help to continue our efforts at streamlining the documentation. However, I am worried that we will avoid writing things that may be pertinent or important out of concern for the audience.

	I did ask if marking the note "sensitive" would prevent its release, and the general consensus is that this will continue to be an option.
ORG C	Our patients cannot see their notes in My Health at ORG C
ORG D	At ORG D, we have moved to having our evals, re-evals, and DC summaries roll into the patient portal so patients/families can access them directly. We did this primarily to help families access information and to facilitate communication with community and school therapists. We have been doing this for about a year and have not had any issues arise. It did make staff a little nervous initially, but it provided a good opportunity to remind staff what should (not) be documented in the EMR and how to document potentially sensitive information. We have recently revised/updated some of our electronic templates, but this was not a result of the change in availability of records. We did review CMS, BCBS, and APTA documentation standards and we talked through various scenarios in a full staff meeting that included: Documentation of… 1. Signs of abuse/neglect 2. Subjective vs objective interpretations 3. Falls or other "occurrences" that might occur during a session 4. Parental involvement/engagement and presence/absence, etc.
ORG E	At our organization, therapy notes are not automatically shared at this time. We are looking at the same considerations that you mentioned with this upcoming change, and are awaiting more information to consider updates.
ORG F	Parents can request through medical records. Not automatically shared in EMR

ORG G	What timing as this was just announced to us today. Starting November 1, all of our therapy progress notes will be available to parents. We have always told our staff to keep in mind that parents, insurance companies, courts and request our notes at any time and to keep that in mind when documenting. I do think this will be an adjustment though as in order to be as efficient as possible our therapy notes tend to be written more for us than others. I think it will change the content of our documentation and make us give a little more detail. We also plan to tell therapists that if a family states they don't understand the progress notes, to let them know we would be happy to review that with them in the next therapy session. We also encourage our staff to verbally tell the family how the child did each day as they document the note. Since we really don't have a choice, we will just do what we always do and figure out how to live with this change.
ORG H	For audiology, we can select the note type either as "Visit" or "Visit-Confidential". The ones marked visit are available to families in the electronic portal; the ones marked confidential are not available.
ORG I	Things are a little different by different areas at ORG I. For PT/OT, families must request records through Medical Records – they can only see After Visit Summaries. I'm fairly new to leadership in this area, and we have some major Epic upgrade projects going on right now, so the ability to add access for families is frozen for the remainder of the year. I intend to add note viewing functionality. For Speech, families have been able to access anything that is labeled a "progress note" related to Speech encounters (not inpatient, which falls under the general hospital admission encounter). Telephone documentation, documentation only, Inbasket messaging, flowsheets, etc… (anything that is not labeled progress note) is not released. We have not changed our documentation processes/content of

	notes related to this change given that documentation has always been discoverable to families. We have worked to have the clinical team be very transparent with families about concerns that may exist that they may be documenting in notes (e.g. lack of compliance with home programming, the importance of compliance, barriers, and what is needed should be discussed with the family and documented in the note rather than just stating that the family is not compliant). If there is something that could be more inflammatory (e.g. family demonstrated aggressive behaviors and used inappropriate behaviors), team members are asked to include direct quotes of what the family said and objectively describe behaviors (e.g. "mother raised her voice, furrowed her brow, and took 3 steps closer to me, while shaking her fist in the air;" rather than "mother became aggressive"). In those cases, a leader is definitely notified and Patient Relations and Security are also typically looped in, especially if the clinician did not feel like the situation was resolved in the session.
ORG J	At ORG J we made all outpatient speech documentation default to "auto share" in epic but there's a quick little button at the top of every note you can unselect so it does not auto share. We are all happy with the change and haven't had any major issues so far!
ORG K	We do not currently share documentation with families unless it is requested and we also have Epic. We will print out the evaluations/progress notes upon request but don't regularly send them the daily therapy notes.
ORG L	Our current practice at ORG L: • We share all Audiology diagnostic evaluations and follow-up visit reports via MyChart and have not had any challenges with this practice. • For OT, PT and Speech, we share evaluations only. The clinician has to manually check "Share with patient" in order for this to occur. • We will be turning on the auto share function for all therapy notes

	beginning November 2nd. • We have not experienced any issues with sharing the evaluations as this has been our standard practice for quite some time, but we do anticipate some clinicians having concern about sharing all notes – especially those including statements of poor progress or compliance. • We are in the process of messaging the auto-share implementation to our clinicians and do anticipate some will choose to modify their documentation language as a result of this change. Obviously they know that patients and families always had access to request records, but with the notes being so easily accessible, our clinicians may anticipate having to spend additional time clarifying documentation content.