

OpenNotes and Results Release *Information Blocking Regulations*

November 2020

To comply with the Final Act of the 21st Century Cures Act, Sutter Health will be implementing changes to support seamless and secure patient access to their electronic health information, including clinical notes and results. The new federal regulations are designed to acknowledge the important role patients play on their care teams, and to promote patient-centered care.

However, we recognize this may represent a big change for some clinicians. The following FAQ document is intended for providers to learn about the upcoming federal regulations regarding OpenNotes and Results Release, while empowering your patients.

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Overview

1. **What is the Cures Final Act?**

This year, the Office of the National Coordinator for Healthcare Information Technology (ONC) announced a [Final Rule](#) to implement provisions of the 21st Century Cures Act. These rules require healthcare providers to electronically release most clinical notes and test results by this fall.

At Sutter Health, the following are visible to the patient:

- [Clinical notes](#) are immediately visible once they have been signed, unless a provider individually blocks the note from being released because of an allowable exception to protect the patient. This new regulation is pertinent to all care settings, including ambulatory, acute care and home health.
 - The eight (8) types of [clinical notes](#) that must be shared are outlined in the [United States Core Data for Interoperability \(USCDI\)](#), and include:
 1. Consultation notes (e.g., inpatient and ambulatory physician consults, PT/OT/ST consult, Dietary consult)
 2. Discharge summary notes (e.g., inpatient discharge summary, transfer summary)
 3. History & physical notes (e.g., annual, surgical or admission H&P)
 4. Imaging narratives (e.g., results of radiology or cardiology imaging, ECG report)

5. Laboratory report narratives (e.g., lab results except for restricted labs [see below])
 6. Pathology report narratives (e.g., non-malignant pathology [see [here](#) and [here](#)])
 7. Procedure notes (e.g., line placement, circumcision, surgical procedures)
 8. Progress notes (e.g., ambulatory visit, telemedicine visit, telephone encounters, inpatient progress, Emergency Department visit, RT progress note, care team notes)
 - The following exceptions apply to notes:
 - All clinical notes written before Oct. 29, 2020.
 - Any notes marked by users to be blocked because they meet one of the legally allowable [exceptions](#).
 - All clinical notes in teen MHO accounts (patients age 12 through 17 years of age).
- Clinical results will be immediately visible once resulted in Sutter EHR, unless their release is prohibited by law, a provider uses an allowable exception to prevent a result from releasing, or manually retracts a result that has been released to MHO.
 - Specific results are protected from automatic electronic release per California law until the clinician has spoken to patients about the following results:
 1. HIV antibody results
 2. Positive Hepatitis antigen results
 3. Positive drugs of abuse screen
 4. Pathology results that demonstrate a malignancy

Historically these results were blocked from release. Now, clinicians may manually release these results after communication with the patient, and if the patient requests the results.

2. Why is this happening?

This new regulation is a federal mandate that originated from the 21st Century Cures act that defines and outlaws information blocking. It was determined in May 2020 that as of this fall, we will be held accountable for compliance of this act and can be fined \$1 million for each violation.

3. Why was the compliance date extended and why did Sutter decide to move forward anyway?

The Office of the National Coordinator for Health IT (ONC) extended the compliance date for Information Blocking to April 2021 to allow provider organizations more time to prepare since many continue to experience significant challenges with the COVID-19 pandemic. This extended compliance date was announced on Oct. 29, 2020, the same day that Sutter Health was going live on OpenNotes and Results Release. We decided to move forward as planned since we were seeing low volumes of COVID patients and we are well positioned to implement our pandemic response.

4. I work at a Sutter hospital or other patient care location that is not on Epic. Does this information release affect me?

Sutter has several hospitals and care centers on other (non-Epic) electronic health records. Some of these systems have their own patient health information access portal. We are exploring the option of implementing these tools. As more information becomes available, we will update this document.

[OpenNotes and Results Release](#)

5. Why does Sutter refer to this change as OpenNotes and Results Release?

The federal requirement to electronically release clinical notes and test results is consistent with the international OpenNotes movement that has shown positive effects on engaging patients in their care and helping them build stronger relationships with their care teams.

OpenNotes is a concept, not a particular way to write a note. All clinicians should continue to write their notes in a logical, patient-friendly manner. Patients have long had a legal right to request access to their clinical notes. What is changing is how and when patients can view their electronic clinical notes and results. [Read more](#) on tips for writing patient-friendly clinical notes.

6. Do we have experience with OpenNotes within Sutter Health?

Yes, there are ambulatory physicians from every medical group who have been sharing their notes for a number of years. In fact, all ambulatory clinicians from Sutter Valley Medical Foundation are currently live on OpenNotes, and have been since 2016.

Feedback from participating clinicians has been overall positive and clinicians have said the release of data has often been unnoticed by patients.

7. When will these notes be released?

All clinical notes within the 8 categories noted above will be released immediately when they are signed. For ambulatory notes, this typically happens when the encounter is closed unless the provider chooses to sign the note before closing the encounter. For inpatient notes, notes will be released upon signature. If a co-signature is required as part of graduate medical education, notes will be released once the co-signer has signed. In the Emergency Department, ED notes will be released to MHO once the patient is discharged or transferred or admitted to inpatient. If admitted to observation, release will be at the end of that encounter.

8. Is it possible that patients will see results before the provider does?

Yes, it is possible. Clinicians are encouraged to set expectations with patients at the time of ordering to mitigate patient concerns. Clinicians should plan to contact patients as appropriate to discuss results.

Exceptions

9. What are the exceptions that allow me to block a note or test result from a patient?

- I. **Preventing physical harm:** A note or result can be blocked if a provider believes that viewing the note could cause substantial risk of harm to the life or physical safety of the patient or another person. Please be aware that causing mental or emotional harm is NOT an allowable reason for a note to be blocked from release.
- II. **Privacy:** A note or result can be blocked if sharing the information would result in a violation of the patient's privacy. Any direct request from patients to block a note or result from their MHO account is allowable under the privacy exception.
- III. **Legal/Administrative:** Information compiled in a note for use in civil, criminal or administrative actions or proceedings.
- IV. Although not part of the Cure's Act exceptions, Sutter has added an additional exception for purposes of results blocking -- **California Sensitive Results Exception:** California Health and Safety Code §123148. "A health care professional has been unable to orally or telephonically discuss clinical laboratory test results within this note prior to its release. Clinical laboratory test results must be related to (1) HIV antibodies, (2) the presence of antigens indicating a hepatitis infection, (3) abusing the use of drugs, or (4) processed tissue revealing a malignancy."

Please note: blocking a note due to privacy, harm or confidentiality is only blocked electronically in MHO. These notes can still be accessed through the Release of Information process managed by our Health Information Management department. Blocked notes will also be available to other care providers in the Sutter EHR.

10. Are there other exceptions?

Yes, but they will be incredibly rare. Read more about the exceptions [here](#).

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11. Many of the exceptions include the phrase, “provided certain conditions are met.” What does this mean?

The key conditions for each exception are explained [here](#).

12. Can I share historical notes written prior to Oct. 29 to a patient’s MHO account?

Although the “Share with Patient” button now appears on all clinical notes, it will not function to share/hide any notes written prior to Oct. 29. No historical notes will be shared to MHO except in the case of providers previously live on OpenNotes (any notes previously shared or hidden by those providers will not change). If any other patient/provider desires that a historically written note to be released to MHO, the recommended workflow is to direct the patient to the HIM Department at the affiliate where he/she received service.

13. Will I be audited on the notes and results that I block?

Sutter Health is committed to complying with this regulation, and will monitor blocked notes to ensure appropriateness as fines can amount to \$1 million for each violation of the federal mandate.

14. Please provide examples of exceptions of Legal/Administrative reasons that allow me to block a note or test result from a patient?

The following are examples of legal situations in which you may decide to block a note or result, but please note that concern about possible litigation (“reasonable anticipation of litigation”) is not a reason to block information.

- a) **Receive notice of litigation:** A provider receives communication or a complaint regarding a procedure they performed. In preparation for their defense, the provider then reviews the clinical notes/patient record. The provider may even call another specialist to get their opinion regarding a specific issue relating to the procedure. The provider then creates a new entry/note into the legal health record or other system. The newly created record/document can be blocked because there is now a “reasonable anticipation of the litigation” from the initial communication and/or the filed complaint.
- b) **Second Opinion – Referral from Attorney:** An attorney refers a patient to a provider to receive an opinion regarding an injury relating to a car accident. The note or any resulting documentation could be blocked because the sole purpose of this referral and the subsequent note would be for use in a civil action regarding the car accident.
- c) **Review of Records – State Licensing Board:** A provider/facility is undergoing a review by a licensing board regarding either a formal or informal complaint filed against them. In preparation for the hearing, the records of several past patients are reviewed by the provider and/or attorneys/representative. Notes/documents are created regarding the patient’s care. Those notes may be blocked from being in the record because their sole purpose is to be used in the administrative proceeding.
- d) **Treating inmates:** An inmate is referred to a facility for injuries that the patient claims are from the prison guards/law enforcement. The patient has already expressed to the physician that they intend to sue the state for civil rights violations. The resulting note or other information sent to the correctional facility could be blocked as the inmate has voiced that they will file a lawsuit regarding these injuries and it is reasonable for a physician to believe the note will be used in that litigation. However, as the provider is not directly involved in the allegations from the prisoner, there is little reason to block these notes.
- e) **Workman’s Compensation of a workforce member:** A workforce member at a Sutter affiliate is injured on the job and sent to the affiliate’s emergency department for an opinion regarding their ability to return to work. The subsequent documentation could be blocked because it is reasonable to anticipate that an on-the-job injury will result in a worker’s compensation proceeding.
- f) **Involuntary Holds:** An individual is brought in and placed under a 5150 hold. The provider performs their diagnosis and creates a note and a 5150/5157 application/forms are filled out and scanned into the record. It would not be appropriate for the provider to block any of the documents under the “reasonable anticipation” exception to disclosures without some

additional event occurring. If however, an individual challenges the hold and seeks a writ of habeus corpus, the documentation that is then created by a physician to support their decision *could* be withheld if they are created for the purpose of supporting the decision and to be used at the legal proceeding. While the documents could be withheld, it is unclear whether they *should* be withheld.

- All mental health records in these situations would be governed not only by HIPAA but also the Lanterman-Petris-Short Act. Other exceptions may apply to this information.
- g) **Extensions of Involuntary Holds:** If it is deemed that a patient should be held under a 5250 hold and a certification hearing is set, the documents that are created in support of the involuntary admission may be blocked under the reasonable anticipation of administrative proceeding exception. The only purpose of this information was in order to be used in the administrative or legal proceeding extending the involuntary hold.

Liability and Consequences of Non-Compliance

15. What is my liability if I don't block a note that I should have blocked?

Liability does not change with the information blocking regulations. Please speak with your supervisor or physician leader if you have specific concerns. You may also contact your local Healthcare Risk Officer (contact information is on the [Clinician Resource Page](#).)

16. Will I be liable for any mistake revealed (wrong antibiotic chosen, missed fracture, etc.) by the notes becoming transparent?

Liability does not change with the information blocking regulations. Please speak with your supervisor or physician leader if you have specific concerns. You may also contact your local Healthcare Risk Officer (contact information is on the [Clinician Resource Page](#).)

17. Has there been an increase in lawsuits because notes are more transparent to the patient?

No, the national experience with the OpenNotes movement has not shown that, and this mirrors our own experience for those who are sharing their notes now at Sutter.

18. Will there be penalties if I block a note and don't have a good enough reason for having blocked it (i.e., is someone going to be auditing those validations we provide?)

The federal mandate does specify that we can be fined \$1 million for each violation. Detailed audits will likely happen only if there are specific complaints. A draft policy on this topic is under review, and will be shared here once it is available.

How Do I? – Technical Questions

19. How do I share a note?

All notes eligible for release within the Sutter EHR have a "Share with Patient" button available and selected by default. No additional action is required by the provider to share a note to MHO.

20. How do I block a note?

If you determine that a particular note should not be shared in MHO due to an allowable exception, you must unselect the "Share with Patient" button, and then add the SmartPhrase **.MYNOTESHIDE** to the note, indicating your reason for not sharing. If you are NOT sharing the note, the button will be gray. For full instructions, read the [Note Sharing Button and Epic SmartPhrase](#) tip sheet on the [Clinician Resource Page](#).

21. Are all notes associated with a single encounter blocked if we click the button, or do I need to individually block each note in an encounter?

You need to individually block each note. The regulation requires that each note be evaluated on an individual basis for sharing or blocking.

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22. Why am I getting an alert when I try to close an encounter?

There may be one or more notes blocked in the encounter without the smartphrase **.MYNOTESHIDE** (documented reason). If a note should not be shared with the patient, please deactivate the “Share w/ Patient” button (the button is deactivated when it’s not blue), and use the SmartPhrase **.MYNOTESHIDE** to document a reason not to share the note with the patient.

If the note is not shared with the patient and no reason for blocking is given, a “soft stop” alert will pop up when the user is attempting to sign the visit. The alert can be ignored and the visit can still be closed; however, the user should go back to the note and document a reason before signing the visit. This applies to all users and various note types available within the encounter. Even if you are not closing the encounter, your blocked notes without reason can trigger the warning for the provider/clinician closing the encounter. **Please make sure the MAs and PSRs on your teams are aware.**

For more information, visit this Wiki [Info Blocking New Button and Smart Tools for Notes Activity](http://sutterapp/sites/Education/SutterWiki/Info%20Blocking%20New%20Button%20and%20Smart%20Tools%20for%20Notes%20Activity%20%28IP%20AMB%20MD%20PA%20NP%20RN%20Ancillary%20Staff%29.aspx) (<http://sutterapp/sites/Education/SutterWiki/Info%20Blocking%20New%20Button%20and%20Smart%20Tools%20for%20Notes%20Activity%20%28IP%20AMB%20MD%20PA%20NP%20RN%20Ancillary%20Staff%29.aspx>)

23. Are telephone encounter notes shared?

Yes, all patients can view telephone encounters, in addition to all notes associated with any visit encounters. Notes are released to the patient when the telephone encounter is closed.

Please remember that you can block any note by unchecking the “Share w/ Patient” button, and selecting the applicable exception in the SmartPhrase (**.MYNOTESHIDE**) For all ambulatory encounters, you will be unable to close an encounter if you have unselected the “Share w/ Patient” button and have also documented the **.MYNOTESHIDE** SmartPhrase within your note. For more information, [visit this Wiki: \(http://sutterapp/sites/Education/SutterWiki/Close%20Encounter%20Validation.aspx\)](http://sutterapp/sites/Education/SutterWiki/Close%20Encounter%20Validation.aspx)

24. How do I block a note later, after initially releasing it?

You can addend the note and un-select the “Share with Patient” button. Then use the **.MYNOTESHIDE** SmartPhrase within the note text to select and document the exception criteria.

25. How do I release a note later, after initially blocking its release?

You can addend the encounter, enter note, and select “Share with Patient” button. You will also need to remove the **.MYNOTESHIDE** SmartPhrase you previously entered, or the SmartPhrase will be visible to the patient within the note in MHO.

26. How do I block just part of a note?

This is not technically feasible at this time. Any information that meets an exception criteria and needs to be blocked should be documented in a separate note and blocked per the steps noted above.

27. Can I pre-block a result to prevent it from automatically releasing to the patient’s MHO account, or retract it after initially releasing it?

All results (except California Sensitive Results) are released to both the patient and the clinicians as soon as they are result. The Release Result order level question is defaulted to “Immediate” and will share with patient in MHO. However, if a provider needs to block the order’s result from being displayed in the patient’s MHO account, they click on “Manual Release Only” button to prevent release. The Manual Release option should only be used if provider believes receiving the result could result in harm to patient, harm to others, or if the patient requests that the order result not show in their MHO account.

For California Sensitive results:

- Negative Hepatitis and negative Drugs of abuse screen results are immediately released, unless a provider changes their release to “Manual Release Only” at the time of ordering.

- For all other CA sensitive results, although you will see that the Result Release order level question is defaulted to “Immediate,” it will not share to the patient in MHO due to other system settings. These results can only be manually released to patients using the MHO Result Release Navigator.

28. What should I do if I documented in the wrong patient’s chart?

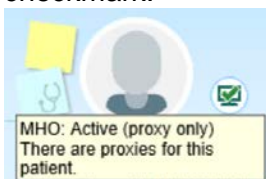
If you signed the note, be aware that it became available to the patient in MHO and there is a possibility that they viewed it. You should addend the note and delete any incorrect content. Once you do this and sign the addendum, no deleted content will be visible to the patient. You should then [submit an IS ticket](#) so the note can be deleted from Sutter EHR. For any further concerns, please speak with your supervisor or physician leader.

29. When a patient reads a note on MHO, will there be an indication to providers on which notes have been read?

Yes. On the Note/Trans tab of Chart Review, click on an individual note to see the status in the sidebar detail. Hover over the “shared note with patient” status to see if the patient has viewed the note or not.

30. How can a provider see who has proxy access, and what type of proxy access they have, in a patient’s chart in Epic?

If there are proxies for a patient, in Epic Storyboard you will see an icon with a screen and a green checkmark:



Clicking on the green arrows opens the “MHO Administration” screen. From there, click on the “Proxy Access Administration” link and you will see the “Access Class,” which could be one of the following:

- “Online Tier 4a” – this indicates full access, such as in the case of parent to child <12, or an adult with a caregiver who has proxy access
- “Teen Proxy”- this is for teens ages 12 through 17
- “Young Adult Proxy ages 18 through 26”

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[General Questions for all Providers](#)

31. Will notes display in the MHO mobile app or on the online version of MHO?

All notes will be visible within the web and app versions of MHO.

32. What encounter types can patients see in MHO?

Sixty-four encounter types show in MHO; all others do not show. The complete list of encounter types is [here](#), and it is posted on the [Clinician Resource site](#).

33. How should I handle patient comments and requests to change the notes?

If the change is appropriate, you can amend the note to make it more accurate. In any circumstance, you can also direct the patient to the Health Information Management (HIM) Department at the affiliate where he/she received service. HIM will work with you on the requested change.

34. What is the current process for changing notes at the patient’s request, and will this change?

Providers may elect to amend a note by opening the note, making the correction and signing the note. They may also refer the patient to HIM to address the request. If you’re referring the patients, please have them contact HIM by email at S3ROIDept@sutterhealth.org or by calling Sutter Health Patient Services toll free at 1-855-398-1631, Option 3, to speak with an agent about requesting an amendment to their medical record. HIM will send the patient an official amendment form along with instructions on how to complete it and where to return it. This process has not changed.

The electronic patient record amendment request process will be ready sometime in 2021, and we will provide a link to the amendment request form for patients to complete online.

35. Will HIM modify notes without our consent?

No, HIM will not modify notes without the permission of the author of the note. When HIM receives a patient amendment request, the author of the documentation will be contacted to determine if the patient request is granted or denied. If granted, the author may make the correction themselves or request HIM make the correction on their behalf and the author of the documentation will need to sign the changed note.

36. Are there required time limits for a request to review and/or receive copies of health records?

Yes. The health care provider must allow access to the records during regular business hours within five working days after receiving the written request. If the patient or authorized representative makes a request for copies of all or part of a file, the health care provider must transmit the copies within 15 days after receiving the written request.

If HIM receives a request for medical records through the online MHO request workflow and the patient's requested delivery method is MHO, the 15-day rule is followed, although HIM's goal is to provide records within five business days.

Patients receive a PDF of their requested dates and medical records, including historical encounters and notes. If patients come into our hospitals and only want to view their records, HIM would provide access within five days, although it is very rare that patients only want to view their records and not receive a copy.

37. If a patient submitted a request for a copy of all of his/her electronic notes dating back several years, would it be provided in a single PDF document?

The maximum file size for a single PDF file sent to MHO is 10MB (Epic system limitation). HIM is able to send as many single 10MB PDF files as needed to a single patient MHO account. However, this is rare because typically most patient requests are for specific episodes of care. HIM recommends burning the information to a CD or USB for larger files such as one that might entail producing historical records.

38. What can I do if I get questions or comments about another clinician's notes?

Based on national experiences with OpenNotes, as well as at our Sutter medical foundations, we do not expect this to be a burdensome issue. Providers should continue to address patient questions as they deem appropriate.

39. Since patients can see results immediately, what is to prevent a patient from contacting us before we have the chance to review the results?

It is important to set expectations with patients at the time of ordering. The following will be included in all After Visit Summaries (AVS): *"Results for any tests that were ordered during your visit will be available to you in My Health Online as soon as they are finalized. This means you may see a result before your provider has had a chance to review it. We ask that you wait for your provider or your clinical team to contact you (typically 3-6 business days) to discuss any interpretation of the results."*

There is also similar verbiage within the MHO Test Results page where patients can view their actual result, as well as the email notifications that patients receive from MHO.

40. If we block a note and state as a reason that we are afraid a domestic violence situation will escalate, will we still need to report the situation to the local police?

The **.MYNOTESHIDE** SmartPhrase requires you to select from a list of clearly defined approved note blocking exceptions. For a domestic violence case, you may choose to select the Patient Harm or Privacy exception, depending on the specific situation. It is up to the individual provider's judgment to determine if the note should be blocked. Please see specific exception criteria above.

The blocking of a note does not negate a healthcare provider's responsibility to report the situation to appropriate authorities.

41. Can another provider unblock a note I blocked?

Yes, any provider with a treating relationship with the patient can use their professional judgement to determine to unblock a note, or whether to block a note if one of the relevant exceptions applies. It is anticipated that some blocked notes will need to be un-blocked as circumstances change, e.g., based on the passing of a harm situation, patient request, etc.

42. If I send a referral to a specialist with information included, is this visible to the patient?

While patients can view the status of a referral within MHO in the 'Referral Status' section of their account, they will not be able to see any provider-entered referral comments or information at this time. The full list of the clinical notes that are included in the USCDI Version 1 is located [here](#).

43. What do I do about documentation that can be offensive to the patient, but I feel is still medically important to include in my note (for example, difficult patient or obese patient)?

Clinicians are encouraged to use [patient-friendly language](#) in writing notes. All eligible clinical notes will be released to patients in MHO.

44. Will results be released for pediatric patients?

Yes. For children under 12 years of age and any patient with diminished capacity, notes and results will be released to parent/guardians with proxy MHO accounts. For children ages 12 through 17, everything except notes will be released to the teen's account. Immunizations are also available to parents of children under 18 years of age. For more information on pediatric patients, please refer to the [Patient Proxies](#) section of this FAQ, or review this [MHO teen enrollment & features grid](#) on the Clinician Resource Site.

45. Will a patient's family have access to OpenNotes and clinical results?

Only if they have proxy MHO account access. For children <12 years, proxy account holders will have access to all notes and results. If a patient 18 years of age or older has granted proxy MHO access to a family member, that proxy user will have access to view clinical notes and results shared within MHO. For more information, please refer to the [Patient Proxies](#) section of this FAQ.

46. How will we handle patient questions or concerns in the inpatient setting if patients learn of the change or want to talk to someone about notes they've received?

While a patient is hospitalized, it is the responsibility of the treating provider to address questions from patients. Once a patient is discharged, patients can be instructed to refer questions to their primary care provider. If a patient does not have a PCP, they should be encouraged to establish one.

47. Will the Handoff Summary be released as part of OpenNotes?

No. The Handoff Summary is not considered to fall within one of the 8 note types that is required to be released to MHO. We still need to determine if this will be released in Nov. 2022.

48. Will Sticky Notes be visible to patients?

No, Sticky Notes are not being shared to MHO. We still need to determine if these notes will be a part of the electronic health information released in Nov. 2022.

49. Will secure messaging or routing communications be visible to patients?

No, secure messages and routing communications are not being released currently. We still need to determine if these messages will be a part of the electronic health information released in 2022.

50. Is the staff message part of the chart and discoverable?

No, the staff message is not being released currently. We are working with our Legal team to clarify if the staff message is considered part of the patient's medical record and therefore needs to be released. We will let you know once a determination is made.

51. As an emergency department provider, can I block a note from being seen by a patient?

Sensitive situations common in the emergency department do not necessarily fall within the allowable exceptions noted above. These may include substance abuse, domestic violence, child abuse, sexual assault, acute psychiatric episodes, in custody of law enforcement as a suspect or victim, seeking secondary gain, etc. The provider should use his/her discretion in determining if an exception applies.

52. Is the anesthesia record going to be visible to the patients or just the pre and post anesthesia evaluations?

The following note types have been built to share corresponding to the Anesthesia record generated in the IP EPIC Anesthesia module/notewriter. Each one of these note types falls within the Anesthesia workflow with pre, post, follow-up evaluations and anesthesia procedure notes.

- Anesthesia Preprocedure Evaluation [24]
- Anesthesia Postprocedure Evaluation [25]
- Anesthesia Procedure Notes [28]
- Anesthesia Follow-up [1000008]

53. Is there a place in the EHR where the clinical team can communicate what will not be released as part of the OpenNotes initiative?

The only notes that will be shared as part of this change are those in the 8 note types. Per the federal regulation, the current sharable note types will expand in 2022 and will include all electronic health information.

54. Are Transition of Care Messages impacted by the new regulations?

Yes. Instead of being sent 24 hours after discharge, the Transition of Care messages for all inpatients will be sent immediately upon discharge. Immediate release will mean discharge summaries not signed at the time of discharge will no longer be included in the TOC document. Please consider using the note routing functionality to assure that a follow-up provider receives the discharge summary.

55. Will patients be able to view first and last names of providers in MHO?

Yes. The first and last name of the provider and the type of provider, such as nurse, physician, therapist, etc., will be displayed within the notes that are shared.

56. Are photographs included in clinical notes visible to patients?

Yes, any images included in clinical notes will be visible to patients. This is an effective way to share select diagnostic images with patients as the EHR does not have a current technical functionality to release native image files. Scanned documents will not be shared automatically to MHO.

57. Will scanned documents be immediately released to patients via MHO?

Anything scanned into media tab will not be immediately released to patients via MHO. Providers may, however, share specific documents from the Media Tab with patients through MHO messaging. See the [MHO Wiki](http://sutterapp/sites/Education/SutterWiki/My%20Health%20Online%20-%20Epic%202020%20Upgrade%20-%20Messaging%20Updates.aspx) (<http://sutterapp/sites/Education/SutterWiki/My%20Health%20Online%20-%20Epic%202020%20Upgrade%20-%20Messaging%20Updates.aspx>) for more information under the section, "Ability to Attach Images/Documents to Patient Messages."

58. Does the regulation for releasing notes also apply to notes from nursing and ancillary services (respiratory therapy, physical therapy, dietitians, speech therapy, occupational therapy, social workers, case managers)?

The Cures Act does not limit electronic access to specific authors. Progress notes authored by nursing and ancillary staff will be shared in MHO.

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59. Can I block a note at the request of a patient (e.g., a patient is seeking treatment for a sexually transmitted disease and has shared proxy with his/her spouse)?

If a patient requests that a note NOT be posted in MHO, this is a valid reason to block the release. This is included as an exception option for specification in the SmartPhrase **.MYNOTESHIDE**.

60. Does the provider have the ability to see if a patient read a note on MHO?

Yes. In the Notes/Trans tab within Chart Review, click on an individual note to see the status in the sidebar detail. You can hover over the “shared note with patient” status to see whether or not the patient has viewed the note.

61. Will donor information remain protected for organ transplant patients? If progress notes are released, donor information may be included as part of the charting.

Information included in progress notes will be available to patients unless a specific exception is applied and the note is blocked from release to MHO.

62. How will we address newborn records that contain confidential maternal information (i.e., HIV, hepatitis, drug use, etc.)?

The data documented in the newborn child’s chart becomes part of that chart and will be available to the any designated proxy as well as to patient when they “age up” and gain access to their own records. If certain information is added to the chart *under a promise of confidentiality*, then a note may be blocked from release for that reason. However, other information such as problem list items and medications will still be visible in MHO.

63. Will we share Care Everywhere data from other organizations?

Sutter will not share third party data directly to MHO unless this data has been manually reconciled into the patient’s local record. If the patient has linked another MyChart account within their MHO account through the “Happy Together” feature, the patient will be able to view those notes and results based on the release configuration of the source organization.

64. For patients with eating disorders, can we block notes about body weight so as not to trigger a potentially negative response from patients (i.e., episodes of restrictive eating or bulimia, increased thoughts of suicide, etc.)?

No, part of a note cannot be blocked. It is also not possible to block patient weight data from appearing in MHO where vital signs are listed. If appropriate, clinicians can discuss with patients the possibility of not looking at notes in MHO if this is a concern for specific patients. Clinicians are advised to use their clinical judgment regarding risk of harm to block particular notes as an exception. In this example, the exception of physical harm may apply.

Radiology

65. What happens to radiology notes that include pathology specimens or tissue (for example, ultrasound-guided biopsy)?

Ordering providers or their proxies will be able to manually release these results after having an oral discussion of the findings with the patient.

66. Are images themselves released, or just reports?

The reports are released, but we do not currently have the capability for patients to view their radiology images online unless a provider has specifically copied and pasted an image into a note. Patients can request a CD of imaging studies through local care centers.

67. Are reports of archived outside studies released, or just Sutter studies?

Reports for outside studies that are archived within a scanned document type will not be released immediately to MHO, and can only be released to the patient through an HIM request.

68. Are addendum reports released, or just the original reports?

Any signed addendums to final reports will be shared immediately through MHO.

[Pathology](#)

69. Will pathology results be automatically released?

All pathology and cytology reports must be manually released by providers. Per California law, malignant diagnoses must be orally discussed with the patient prior to manual release of pathology reports. In the future, we hope to be able to automatically release non-malignant cytopathology results to patients avoiding the need for these to be manually released by ordering providers. We are currently working on making it possible for patients to view the full pathology reports once manually released by a provider using the MHO Results Release Navigator within the Sutter EHR. We will update this FAQ document once this is resolved and working appropriately.

[Nurses, Medical Assistants and Ancillary Services](#)

70. Why does my full name need to display?

The regulation requires that the first and last name of the provider and the type of provider, such as nurse, physician, therapist, etc., be displayed within the notes that are shared.

71. Is there a full list of note types that have this Share w/ Patient button automatically selected?

The full list of note types is posted [here](#) on the [Clinician Resource Page](#) under “Resources.”

72. Why do nursing notes (Care Team Note type) need to be shared at this time?

Care Team notes are shared as this is where many clinicians document patient progress. Care Plan notes are not considered progress notes so will not be released initially. By 2022, the prohibition against Information Blocking expands to include ALL electronic health information included in the “designated record set” as defined by HIPAA. At that time, it is likely that Care Plan notes will be included as part of the released data.

73. ED Staff document in the Narrator. I do not see that included in the list of notes being released release. Can you clarify?

ED notes written via the Narrator **will not be shared** due to technical limitations of our current version of Epic. This issue will be fixed during one of the 2021 upgrades. During that upgrade, we will enable sharing the notes in the ED Narrator based on allowable exceptions.

If you write notes through the Notes Activity, then you may block a note using one of the provided exceptions.

74. When a patient arrives in the ED as an alias patient (e.g., Doe, Jane), and charts are later merged, when will those notes cross over?

ED notes are released to the patient upon discharge, transfer or admission, once the note is signed. Once the notes entered in an alias chart are merged with the patient’s personal record, those notes will be made available via MHO.

75. How quickly will the notes display in MHO?

All clinical notes within the 8 categories will be released immediately when they are signed.

- For ambulatory notes (including telephone encounters), this typically happens when the encounter is closed unless the provider chooses to sign the note before closing the encounter.
- For inpatient notes, notes will be released upon signature.
- In the Emergency Department, ED notes will be released to MHO once the patient is discharged or transferred or admitted to inpatient. If admitted to observation, release will be at the end of that encounter.
- If a co-signature is required as part of graduate medical education, notes will be released once co-signed.

- 76. Will patients receive a notification on MHO every time a new note or test result is shared?**
There will be no changes to the way notifications work in MHO. Patients will not receive any notification when new notes are available in their MHO account. Patients will continue to receive an email notification for various other features, including a new message, new test result, new after visit summary (AVS), and for updates to MHO account settings. Patients will get only one email per notification type in a 24 hour period if they do not log into their MHO account. If, for example, a patient logs into their MHO account to view a new result, the 24-hour clock will reset and they will receive another email if a new result (or result comment) is posted to their MHO account that same day.
- 77. What are some examples of appropriate reasons nursing and ancillary staff may choose to not share a note?** If there is information in a note that is likely to cause physical harm to a specific individual (e.g., author of note, family member, patient, etc.), this is a legitimate reason to block the note and a treating healthcare professional may do so. You can block the note by unclicking the 'Share with Patient' button and using the SmartPhrase **.MYNOTESHIDE**, selecting the appropriate exception.
- 78. Are home health notes in Homecare/Homebase being released to patients under this new regulation?**
Yes, we are required to release Homecare/Homebase (HCHB) notes; however, we are still evaluating the HCHB portal to determine how to accomplish this. We do know that HCHB notes are flowing to Sutter EHR for Sutter patients. Once we confirm how we can release these notes, we will let HCHB staff know.
- 79. Are staff messages or routine communications being released, or only if the messages are copied into a telephone encounter?**
Staff messages and routing communications are not being released to patients. If the contents of a Staff Message are copied into the notes within a Telephone or other encounter they will be shared.
- 80. Will Diagnostic Imaging technologist worksheets be released to patients?**
No. This is not a releasable note type.

Behavioral Health/Mental Health

- 81. Will behavioral health historical notes be released?**
All clinical notes, including behavioral health progress notes dated prior to Oct. 29, 2020 will not be automatically released to MHO.

Historical behavioral health notes will be available for manual release upon patient request through the HIM/ROI process. Providers may also share historical behavioral health notes upon patient request by selecting the "Share with Patient" button. Any behavioral health notes written after Oct. 29 will be shared automatically to MHO unless the provider blocks the note due to an allowable exception.
- 82. Is our HIM prepared to support providers who receive complaints from patients about what they read in their note?**
Yes. If a patient finds what they believe to be an inaccuracy or error in their clinical note that they believe should be corrected, please have them contact the Health Information Management (HIM) department by email at S3ROIDept@sutterhealth.org or by calling Sutter Health Patient Services toll free at 1-855-398-1631, Option 3, to speak with an agent about requesting an amendment to their medical record. HIM will send the patient an official amendment form along with instructions on how to complete it and where to return it.

83. Does OpenNotes apply to telephone encounters or just appointment encounters?

Clinical notes include in-person, telemedicine and telephone encounters. Notes are released to the patient when signed, which typically happens on encounter closure, unless a provider chooses to sign the note before closing the encounter. Telephone encounters are released when closed.

84. Can the patient only see the note after it is closed? Some of us close our charts at the end of the month vs. same day.

Clinical notes will be immediately viewable once they have been signed. If you keep your charts open, you can manually sign the encounter to send the note to the patient. It is important that providers do not have a practice of not signing notes so that it may not interfere with the information blocking regulation.

85. How will behavioral health notes be shared with proxies for children's accounts?

Behavioral health notes prior to Oct. 29, 2020 will not be viewable in MHO.

- AGES younger than 12: Proxies will be able to see all allowable notes and results for children under 12 years old, unless the provider blocks the note with an allowable exception.
- AGES 12 through 17: Notes will not be shared with teen MHO accounts at this time.

See [Patient Proxies](#) section for more details.

86. I am unable to use Copy/Forward functionality for behavioral health notes written prior to Oct. 29. Is there a workaround?

Providers may have included psychotherapy or other protected/sensitive information in notes written prior to Oct. 29, and these notes should not be released electronically to other organizations through Health Information Exchanges (HIEs). The Sutter IS team is running a program to add Epic's "sensitive" designation to all behavioral health notes written on or before Oct. 28, which will prevent those notes from being released on HIEs/CareEverywhere. However, the Epic software program doesn't allow Copy/Forward of notes that have "sensitive" designation.

We are working with Epic to see if programming or configuration can be changed, but in the meantime, this workaround is available now: **Copy/Paste - Highlight content in a prior note, copy the text, paste it into a new note.** To do this, follow these steps: Highlight old note content. Press <CNTRL> & <C> keys at same time to copy the highlighted text. Click into your new note, and use <CNTRL>&<V> together to paste content into your new note. Copy/Pasted text will not have any "smart" functionality. Smartlinks not refreshable. Important to know: if you try to edit a previously designated sensitive note, it will lose its sensitive designation, and be available to all healthcare institutions via CareEverywhere.

87. Please explain why our behavioral health notes are not considered "psychotherapy notes"?

Unlike psychotherapy notes, progress notes are considered part of the patient's record, and must be shared as part of this new federal regulation. The [HIPAA privacy rule](#) protects psychotherapy notes and explicitly states that these notes are kept separate from the rest of a patient's record.

Psychotherapy Notes are defined in the HIPAA Privacy Rule^[1] as "notes, recorded ... by a health care provider who is a mental health professional, documenting or analyzing the contents of a conversation during a counseling session that are separate from the rest of the patient's medical record. Psychotherapy notes excludes 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 excludes 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." - ^[1] HIPAA's definition of Psychotherapy Notes is in the Code of Federal Regulations - Title 45: Public Welfare -- [Part 164-Security and Privacy](#) -- [Subpart E-Privacy of Individually Identifiable Health Information](#) -- Section 501-Definitions. (45 CFR §164.501)

^[1] HIPAA's definition of Psychotherapy Notes is in the Code of Federal Regulations - Title 45: Public Welfare -- [Part 164-Security and Privacy](#) -- [Subpart E-Privacy of Individually Identifiable Health Information](#) -- Section 501-Definitions. (45 CFR §164.501)

Patient Proxies (Including Children and Adolescents)

Patients under 12 years of age:

- 88. Which notes and results will proxies be able to see in MHO for children under 12 years old?**
Proxies will be able to see all allowable notes and results for children under 12 unless the provider blocks the note with an allowable exception.
- 89. Am I able to block notes for one proxy only? For example, if a child’s proxies are divorced parents, can I block a note so only one proxy can see it?**
No. There is no current capability to provide different access to different proxies.
- 90. What action should I take if I am asked to change a note by a proxy?**
If the change is appropriate, you can amend the note to make it more accurate. In any circumstance, you can also direct the patient to the HIM Department at the affiliate where he/she received service. HIM will work with you or the note’s author on the requested change. Read [here](#) for more information on the process for amending notes.
- 91. Can I block a note from a parent proxy at the request of the pediatric patient (i.e., my 10-year-old patient told me he thinks he is transgender, and doesn’t want his mother to know; my 12-year-old patient thinks she is pregnant)?**
A provider may block the note at the request of the patient or proxy for privacy or under the promise of confidentiality purposes.

Patients 12 through 17 years old:

- 92. How will this affect teen-age patients who have their own MHO accounts?**
Teens 12 through 17 years of age can request full access to their own medical records within MHO. As such, they will be able to see all allowable notes and results unless the provider blocks the note with an allowable exception. The proxy (parent/guardian) will not be able to view the teen’s clinical notes within the proxy MHO account.
- 93. Does the new law impact our obligation to protect adolescent confidentiality?**
No, we are still obligated to protect adolescent confidentiality by California state law.
- 94. With more sensitive information possibly being released into teen or proxy MHO accounts, how can we help families protect confidential information?**
With ONC delaying information blocking compliance until April 2021, we have temporarily halted the release of clinical notes affecting teens (ages 12 through 17) as we review and standardize processes that healthcare professionals can use to protect confidential information. Despite the fact that the note is defaulted to “Share w/ patient” in Epic, providers will see a yellow yield sign indicating that due to other system settings, the note will not be visible to the patient.
- 95. Can parents block their children from seeing notes in their medical records? I have situations where parents don’t want their children to know certain information that may be accessible in the notes.**
Patients under 12 years have proxies (parent/guardian) who can see all allowable notes and results unless the provider blocks the note with an allowable exception. Children <12 years old cannot see these notes unless shared by the proxy.

^[2] Per Health and Human Services “HIPAA Privacy Rule and Sharing Information Related to Mental Health” summary, <http://www.hhs.gov/hipaa/for-professionals/special-topics/mental-health/> on 7/6/2016

Parental consent is required for teens to sign up for MHO beginning at age 12. Teens 12 through 17 years of age whose parents have consented for them to have their own MHO account have full access to their own medical records within MHO and may be able to review results; however, we are not sharing NOTES for teen accounts at this time.

If the proxy doesn't want the teen to have this access, they can choose to deny consent for the teen to enroll in MHO. However, clinicians should remind proxies that when the child turns 18, the medical record will become theirs by law and they will have access to all information.

96. Can proxies of teens request us to hide a note from the teen for privacy reasons (e.g., “I don't want the patient (teen) to know I called you with concerns about his/her mental health.”)?

Yes. Information obtained from a third party (not the patient) under a promise of confidentiality can be blocked from online release based on the privacy exception within the SmartPhrase .MYNOTESHIDE.

97. Does Open Notes change anything for parents who currently have full proxy access for their teen-age children diagnosed with developmental disabilities?

No, this does not change. Parents still have the ability to gain full proxy access for children with diminished capacity regardless of the patient's age.

Patients 18 years and older:

98. Which notes and results will proxies be able to see in MHO for patients 18 years and older?

Proxies will have the same MHO access as the patient. Both will be able to see all notes and results.

99. Is there a way to block notes or results from being shared to the proxy, but not the patient?

No. There is no current functionality to provide different access between patient and proxy MHO accounts.

100. What do we tell an adult patient who does not want their proxy to have access to their notes?

In this situation, the patient would need to remove their proxy from MHO. This is the only way to prevent a proxy from being able to access the patient's notes. You can refer patients to the MHO FAQ online for instructions on how to do this.

101. What if a patient asks me not to share his/her notes with other providers?

The functionality does not currently exist to block notes from certain providers. All providers who have access to this patient's medical records can see the notes.

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How Do I Support My Patients With This Change?

102. How will this release of information affect my patients?

Patients have been able to request their paper medical records from HIM under HIPAA regulations. The new Cures Act regulation makes the patient notes and results information available electronically and more conveniently through MHO.

103. How will patients become aware of this change?

There will be no active notification sent to patients about this change. Patients are able to view notes and results within their MHO accounts.

The following will be included in all After Visit Summaries (AVS): *“Results for any tests that were ordered during your visit will be available to you in My Health Online as soon as they are finalized.”*

This means you may see a result before your provider has had a chance to review it. We ask that you wait for your provider or your clinical team to contact you (typically 3-6 business days) to discuss any interpretation of the results.”

There will also be similar verbiage within the MHO Test Results page where patients will be able to view their actual results.

Patient information related to this new regulation will be available on the [Sutter Health MHO FAQ website](#). In addition, a Patient FAQ is now available on the [Clinician Resource Page](#).

- 104. How will patients receive the notes and results if they’re not enrolled in My Health Online?**
Patients should be encouraged to enroll in MHO. Information on how to enroll can be found on the [Sutter MHO Wiki site](#). If a patient does not have access to MHO, they can request copies of their information through HIM.
- 105. Is there someone to whom we can direct patients to answer their questions?**
Patients should be encouraged to discuss content within the notes and results with the author of the note, or the ordering provider. Additional questions can be referred to their primary care providers.

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- 106. Will patients be told they can change the notes if they ask their doctor to do so?**
No. However, patients may still make such requests. If the change is appropriate, you can amend the note to make it more accurate. In any circumstance, you can also direct the patient to the HIM Department at the affiliate where he/she received service. HIM will work with you on the requested change.
- 107. Will there be guidance for patients if they have concerns about results after 5 p.m. on Friday or over the weekend?**
Not specifically. Providers are encouraged to set expectations with patients during the clinical visit regarding notes and results. As noted above, After Visit Summaries and the MHO website will contain verbiage notifying patients that providers may not immediately review results. The Call Centers may be able to assist with scheduling the patient for a follow-up visit, and or sending a message to the care team.
- 108. Will patients be given a general guide to notes and clinical terminology?**
[MedlinePlus](#) provides explanations of common abbreviations automatically linked to terms on MHO to help patients better understand medical jargon. Clinicians are encouraged to share this useful tool with their patients.
- 109. How do I rephrase notes to be more patient-friendly?**
Read these OpenNotes [tips](#) for writing patient-friendly clinical notes. For further suggestions, you may wish to review this paper published in the [American Journal of Medicine](#) or [read this blog](#) written by a clinician informaticist.

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[Resources and Links](#)

Information Blocking

Per the [HealthIT.gov website](#), the specific definition of information blocking *is a practice by a health IT developer of certified health IT, health information network, health information exchange, or health care provider that, except as required by law or specified by the Secretary of Health and Human Services (HHS) as a reasonable and necessary activity, is likely to interfere with access, exchange, or use of electronic health information (EHI)*. This website provides specific and clear information about the new regulation.

ONC's Cures Act Final Rule

ONC, or The Office of the National Coordinator for Health Information Technology, announced the [Final Rule](#) of the 2016 Cures Act earlier this year.

OpenNotes

OpenNotes is the international movement supporting and studying the effects of transparent communication. It helps patients, families, doctors, nurses, therapists and others to prepare and share meaningful notes describing a telehealth or office visit. This [OpenNotes website](#) provides valuable information for providers and patients alike.

Sutter Clinician Resources Page

OpenNotes and Results - Resource Page for Clinicians: This [Clinician Resource Page](#) is intended for all clinicians who care for Sutter patients, and can be opened from inside or outside the Sutter network.

Notice to Sutter Community Connect Providers

If you are a provider using Sutter Community Connect (SCC), please refer to communications on the [SCC Client Portal](#).

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