

Open Medical Records

*Allowing patients access to their records increases their satisfaction.
So why are hospitals resistant?*

This is the third in a series of articles from Planetree, an international nonprofit organization founded in 1978 that's "committed to improving medical care from the patient's perspective." For more information, go to www.planetree.org.

Open medical records—those that patients, and others authorized by them, are allowed to read—are an important aspect of patient-centered care. When used properly, they let patients see themselves through the eyes of their caregivers and give them insight into diagnoses and treatment options. Having access to such information permits patients to take a more active role in decisions about their care.

But only a few hospitals have policies encouraging the opening of medical records, and many still resist it. The feasibility and value of sharing medical records with patients have been suggested by studies since the 1980s,^{1,2} so why is there such reluctance among health care institutions to do so? Several factors might be at play, including

- the sometimes accurate perception that patients are passive about their health or don't have the skill and health literacy to understand what's written in the record.³
- the fear that providing access will require large investments of providers' time.
- concerns about the potential for misinterpretation of the record and even about litigation.

The federal Health Insurance Portability and Accountability Act (HIPAA) of 1996 stipulates that "patients must be able to see and get copies of their records, and request amendments."⁴ HIPAA has been widely misunderstood; it was meant to protect patients from privacy violations but has been recast, ironically, as a means of withholding information from them, further impeding the widespread adoption of open medical record policies.

Still, the change may be inevitable as baby boomers age and consumers become more confident about making their own decisions. The greater access to information and social support permitted by the Internet has fueled consumer demand to participate in health care. *Electronic medical records* and *personal health records*—terms that are much in use and which describe a range of widely differing digitized processes and records—are now being used in numerous ways to meet the increased demand for personalized information. The time couldn't be better to closely examine the use of open medical records.

OPEN RECORDS AT GRIFFIN HOSPITAL

Open medical record simply denotes a formalized way of

allowing patients to access their medical records. It's part of a philosophy of care based on the idea that patients should have the choice to be involved in their care.

At Griffin Hospital, a 160-bed acute care community hospital in Derby, Connecticut, a set of procedures and policies is in place to inform provider and patient that the patient has the right to see her or his medical records and describe how to gain access to and best use the information in them. The primary care nurse coordinates meetings with the patient, the first of which is held within 48 hours of admission. Attendees at these patient care conferences may include the patient, family members, the primary nurse, the attending physician, and practitioners from other disciplines (such as physical therapists, dietitians, and pharmacists) who are involved in the patient's care and discharge. The goal is to integrate all the available resources to treat the patient's condition; to this end, the medical record now includes additional sections that incorporate a more comprehensive perspective. "Patient progress notes" and the patient's "personal progress notes" sections round out the information deemed important for the patient's care.

The patient progress notes constitute a chronological record combining each provider's notes into an integrated file. Although all of this information has long been included in charts, the



Holly Major, MSN, NP, QTTT, talks with a patient about his medical record at Griffin Hospital in Derby, Connecticut, while a medical student observes. Photo courtesy of Griffin Hospital.

patient progress notes section centralizes the information. The depth of detail now available to patients in these notes enhances the medical record's value as a patient education tool.

The personal progress notes section contains fill-in sheets, given to the patient upon admission and kept at the bedside, on which the patient can record (most often in the presence of a primary care nurse or an attending physician) impressions of the care being received as well as questions to pose to caregivers. This information is kept in the chart during the hospital stay, but it doesn't become a part of the permanent record.

Although patients can access any part of their medical records during these patient meetings (or whenever arrangements are made to review the chart with care providers), typically patients are most interested in laboratory test results such as cholesterol or blood glucose levels. The patient meeting is also a good time to

discuss the medications listed in the record—their indications and any precautions or possible adverse effects—as well as medication reconciliation, which involves confirming that the right dosages and types of medication are being used. Understanding what is in their medical records and being more involved in their treatments, in our experience and in limited research, increase patients' ability to coordinate their care, confirm their medications, and follow up on their care.^{3,5} At hospitals with open medical records policies, patients viewing their own medical records have identified numerous errors (for example, name, address, allergies, medications, and historical data); a recent study comparing data obtained from postdischarge patient interviews and medical records indicated that patients can help ensure their medical records' accuracy regarding adverse events,⁶ and that the safety of the care provided may be improved when

patients can view their records and correct mistakes and omissions.^{1,7}

IMPLEMENTATION AT GRIFFIN HOSPITAL Getting the physicians on board.

The move to implement open medical records at Griffin Hospital started with nurses who were champions of the Planetree model of patient-centered care, a philosophy of care that had been adopted organization-wide. The fundamental principles of patient-centered care, which include giving patients access to information; welcoming the involvement of family; and tending to patients' physical, emotional, and spiritual needs, resonated with many of Griffin Hospital's nurses in terms of their own approaches to nursing. Nurses were heavily involved in many aspects of implementing the model, including the use of open charts. Nurses encouraged patients to exercise their rights as owners of their medical information and collaborated with physicians who were supportive of the concept to develop organizational policies and practices that would support patients in accessing their medical records.

Nevertheless, some providers, mostly physicians, resisted sharing information with patients. Over time, a set of what-ifs (for example, "What if the diagnosis is cancer?") developed, and solutions were devised with input from a task force that included physicians, nurses, and staff from other disciplines. Staff nurses personally addressed the concerns of those who were resistant, promoting the rights of patients and discussing open charts in the context of a patient-centered approach to care: *If something about a patient is going to be written in the chart and if the patient has the right to read the chart, wouldn't it be better to*

discuss this information with the patient? In the end, such arguments allayed physicians' fears and concerns. Physicians also assisted with developing guidelines for addressing sensitive situations, such as how much information should be shared with patients with psychiatric diagnoses.

Emphasis on patient rights.

At the time of admission, nurses inform patients that they may read their own medical records at any time during their hospitalization. A question on the patient admission assessment form reinforces this practice. Nurses remind and encourage patients throughout their stays to read their own medical records. In addition, notices posted in patient rooms encourage them to ask to see their charts, and notices are also included in the patient TV guide and the patient rights brochure.

What about HIPAA? Privacy and confidentiality are a priority at Griffin Hospital, and the patient is offered access to the medical record (or the opportunity to appoint a representative to examine the record) in private. HIPAA's emphasis on patient privacy is often invoked as a reason to restrict access to the medical chart, even though HIPAA supports patients' having access to and being able to modify their medical records. The passages and sections setting out patients' rights to view, own, and modify their records are buried deep in the text and often are not mentioned or commonly associated with the statute.

On a variety of Griffin Hospital units (medical-surgical, childbirth center, and inpatient psychiatric, for example) patients have requested that certain personal, sensitive types of information not be shared with anyone other than their caregivers. Staff

sensitivity to that desire for privacy is essential.

MEDIATED ACCESS

Although patients may also view their medical records on their own, it's usually best to have a clinician involved. In focus groups conducted by Planetree, many patients indicated that they wouldn't access their records even when it was offered because

member or significant other who has been appointed the patient's representative. And nurses can use the medical record to regularly update a patient or the patient's authorized representative. This exchange usually takes less than 15 minutes, but nurses say that it reduces the number of calls and questions that would otherwise crop up throughout the day.

HIPAA supports patients' having access to and being able to modify their medical records.

they felt they wouldn't understand the content.⁸ Many may believe that the staff will give them all necessary information anyway. A clinician can provide context and explanations for the information in the record, which is also important for guarding against complex or impersonal language in the medical record confusing or distressing some patients.⁹ Perhaps most important, research and our own experience suggest that giving patients mediated access to their medical records helps break down barriers between patients and clinicians, increases patients' confidence in the clinicians, and makes physicians feel that they better understand patients.^{1,10}

When reviewing the medical record with the patient, a nurse can determine whether the patient, a family member, or a significant other is directing the care; what the home setting for discharge is; and whether the patient will benefit most from rehabilitation at an extended care facility or at home. The open medical record is also a useful resource for a family

In acute care settings, mediated access allows patients to compare their own understanding and knowledge with that of their caregivers. The result is that patients are reassured that information is not being withheld¹⁰ and are better satisfied with their care and their communication with their physicians.² Perhaps unsurprisingly, research conducted more than a decade ago showed that patients who feel that caregivers either don't communicate effectively or withhold information are more likely to file malpractice claims.^{11,12}

PATIENTS' PERCEPTIONS

The response to open medical records can be measured with such tools as the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) standardized national survey, which evaluates patients' perceptions of their care (available at www.hcahpsonline.org/home.aspx). In the 2005-2006 HCAHPS survey, 80% to 90% of Griffin patients gave the hospital the highest rating possible for the effectiveness of communication with

nurses and physicians.¹³ That's almost 20% higher than the 2006 national average for nurses and 13% higher than that for physicians.¹⁴ Such surveys allow hospitals to see how well patients' and their families' needs are being met and offer clues about how to demystify care and decrease anxieties about illness and hospitalization.

Griffin Hospital has been monitoring patients' impressions since 2002. Each month, hospital volunteers ask a designated number of inpatients to participate in a survey. The 35-item questionnaire covers aspects of the care delivered, such as the provision of information and access to services, as well as the quality of the care. The data indicate that it took about two years for the hospital to consistently implement the open medical records policy and that patients slowly responded to this initiative. In 2002, 69.7% of the patients surveyed indicated that nurses had told them that they could read their medical records; of those, 18.3% reported choosing to see them. By 2004, 90.6% of patients said they had been informed about the open-chart policy, and 26.9% opted to review their charts. By 2006 almost 93% of patients reported being told they could see their charts, and 30.6% read them. The percentage of patients who opt to read their records remains a relatively small subset of those who are aware that they can, and we suspect that the overall culture of patient-centered care that has been cultivated at Griffin Hospital over the last several years is the cause. When patients feel that information is being shared freely with them and that their questions are being answered honestly and thoroughly, and when an atmosphere of trust and transparency exists

between patients and providers, patients may feel it is unnecessary to see their medical records because nothing is being withheld.

Using data drawn from 2,060 patient interviews from 2002 to 2007, we compared answers to several questions about care that were given by "empowered" patients (those who were presented with the option to view their medical records) and "passive" patients (those who were not given the choice). "Passive" patients were less likely than "empowered" patients to find meeting with their physicians and nurses helpful (1.2% versus 7.3%) and less likely to feel that their physicians kept them informed about their treatment (1.4% versus 7.6%), suggesting that patients who are more passive may in fact be frustrated by not having their needs anticipated by caregivers.

At Griffin Hospital the question of whether the open chart policy had an effect on overall patient satisfaction was explored using information collected along with the HCAHPS survey of 1,134 patients from January 2006 to March 2007. More patients who were told they could read their medical charts (87.8%) were "very satisfied" with their overall experience at the hospital, compared with those who were not told (77.1%).

This association between patient satisfaction and having access to the medical chart was also found in a larger data set of 3,504 patients at four Planetree-affiliate hospitals (including Griffin Hospital) from February to December 2006. These hospitals added questions about accessing medical records to the HCAHPS survey. The two HCAHPS questions on overall patient satisfaction ask patients

to rate their likelihood of recommending the hospital to others and their overall assessment of the hospital on a scale of 0 to 10. Of patients who were told they could read their charts, 80.2% said that they would definitely recommend the hospital to others and 69.7% said they would rate the hospital as either a 9 or 10 on a 10-point scale. In comparison, 69.3% of those who were not informed about their right to access their medical records said they would recommend the hospital to friends and family and 62.3% gave Griffin the highest ratings (9 or 10).

MOVING TO ELECTRONIC MEDICAL RECORDS

Griffin Hospital is now in the process of changing from paper to electronic medical records (EMRs), and we had to consider how our open chart policy needed to evolve to accommodate the new medium. We are currently operating in a hybrid state, with most, but not all, of the medical charts in electronic form. We developed a two-to-three-page summary that captures the patient's test and laboratory results and the progress notes from the preceding 24-to-36-hour period. This summary is printed out and shared with the patient. In the future, we intend to explore the feasibility of having a password-protected system that would allow each patient to electronically access her or his medical information while hospitalized.

Physicians are beginning to accept the idea of open medical records. The Commonwealth Fund 2003 National Survey of Physicians and Quality of Care found that 83% of primary care physicians thought patients should "definitely" or "probably" have easy access to their own medical records.¹⁵ But in

the same survey, 63% said that their own lack of knowledge and training were barriers to their adopting EMRs. Some physicians also wonder whether the computer screen will detract from the interaction between provider and patient. One study found that physicians using EMRs were less likely than physicians using paper medical records to address the patient's agenda, to explore psychosocial and emotional issues, and to discuss how health problems affect a patient's life.¹⁶ In a more recent study, providers, including nurses and physicians, were asked whether the EMR allowed them to better focus on patients.¹⁷ Only 22% felt that it did.

As the prevalence of EMRs continues to grow, closer scrutiny of their use has revealed the complexities of this technology and its perceptible but still undefined impact on the therapeutic relationship. Several areas influenced by the use of EMRs include¹⁸

- changes in the use of physical space.
- differences between patients' and physicians' perceptions of the technology.
- proficiency with the tool.
- institutional forces, including cost of the technology.

As electronic applications designed for medical information evolve, online access to medical records both in the hospital setting and from the patient's home will further complicate issues at the intersection of open medical records and EMRs. Giving patients online access to limited, provider-approved pieces of information from the record is being experimented with at institutions such as the Cleveland Clinic (MyChart; <https://mychart.clevelandclinic.org>) and some Veterans Health Administration sites (My HealthVet; www.myhealth.va.gov). However,

urgent concerns about Internet security and the sensitivity of personal health information remain. (For more on this topic, see *AJN Reports* and *In the News*, "Health Information Technology: Is It a HIT with Nurses?" both in the July issue.) The demand for the convenience EMRs offer to patients obligates clinicians to find ways to address these challenges. And whatever format is used, it should further the patient-centered approach to care.

Although much of the literature on open medical records has focused on physician-patient interaction, nurses can also use these records to elevate the importance of their documentation in patients' healing and recovery. With the increased transparency in medical processes, nurses are in a position to synthesize and communicate the information in the record and to assist patients in understanding their own and their providers' roles in their care. ▼

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