Writing OpenNotes Check List

Be Clear and Succinct

___ When possible, enlarge the font size or use boldface text to emphasize important items such as “Check your blood sugar twice a day.”

___ Consider beginning your note with the Assessment and Plan section.

___ Do not import multiple pages of data available elsewhere in the chart; instead, include only pertinent aspects of the current visit.

___ Avoid jargon. Use electronic tools to convert abbreviations to the full spelling. Use dictation or spell checking software to review note content.

___ Caution patients about misspellings and word substitutions or include templated statements explaining the potential sources of typographical errors.

___ Consider using second person instead of third person voice. For example, “Start taking lisinopril and check your blood pressure twice a week,” rather than, “Initiated lisinopril and instructed to check her blood pressure twice a week.” More direct language may help reinforce instructions for patients.

___ Insert links to reliable online resources for educational information and clarification of acronyms or medical terms.

Directly and respectfully Address Concerns

___ Obese patients. Review their body mass index and the definitions for overweight, obese, and morbidly obese with patients so that they understand why these terms are in the chart.

___ Possible cancer. “You have some symptoms concerning for colon cancer (blood in stool, weight loss, family history of early colon cancer), so I will facilitate an expedited referral to the gastroenterologist. If it is colon cancer, we want to catch it early when there are more treatment options.”

___ Drug use. “Cocaine use is causing your extremely elevated blood pressure and difficulty with relationships.”

___ Mental health. “Increased feelings of worthlessness and thoughts of self-harm. No active suicide plan and willing to seek care if thoughts worsen. Your grandchildren remind you of reasons to live. Check in tomorrow with your counselor and don’t forget the crisis line number.”

___ If documentation could cause harm to the patient (for example, intimate partner violence if access to the patient portal is obtained by abuser), discuss this with the patient in advance. Consult with a social worker or legal counsel and consider blocking this note from the patient portal.

___ Remember that, with rare exceptions, HIPAA protects patients’ right to view records. Shielding notes from an online patient portal does not prevent patients from submitting a written request for their records.

Use Supportive Language

___ "The patient has lost 5 pounds and is motivated to continue this positive trend toward our goal of 20 pounds," rather than "The patient still needs to lose another 15 lbs."

___ "The patient chose not to pursue treatment," rather than "The patient refused treatment."

___ "The patient does not consume alcohol," rather than "The patient denies alcohol consumption."

___ Use terms that may be perceived as less judgmental or confusing:

"Shirt untucked" (rather than "disheveled")
"Short of breath" (rather than SOB)
"Follow up" (rather than f/u)
"Right eye/left eye" (rather than OD/OS)
"False alarm" (false positive)
"Enlarged heart" (rather than "cardiomyopathy"), "chronic kidney disease" (rather than "renal failure")

Include Patients in the Note Writing Process

___ Turn the computer screen toward the patient to show what you are typing.

___ Check for understanding and accuracy during the visit.

___ If dictation is available, consider dictating with the patient present.

___ Consider having the patient contribute to the note, if this option is available.

Encourage All Patients to Read Their Notes

___ "I want you to look at my notes and make sure we are both on the same page."

___ "Reading your notes may remind you about what we discussed when you get home. You can also share it with your family or caregivers if you would like."

___ Advocate to have the electronic medical record configured to automatically send reminder messages to patients after visits or prior to follow-up visits.

Ask For and Use feedback

___ "I see us as a team working together to improve your health, so your feedback makes a big difference! Accuracy is important to me, so if you see something you think might be a mistake in your note, please let me know so we can work together to fix it."

___ Give the patient a copy of the prior clinic note (paper or electronic) to review while in the waiting area.

___ Ask, "Did you have a chance to read my note from last visit? What questions or concerns do you have about what was written?"

Be Familiar With How to Amend Notes

___ "Thanks for pointing out that I wrote 'right knee' rather than 'left knee'; I'll be sure to note the correction in your chart."

___ "I understand you want your history of cocaine use removed from the medical record, but this information has important implications for your blood pressure and chest pain."

___ "I'm sorry you disagree with my assessment that alcohol contributed