Open Chart and finding Bias in chart documentation.
The 21st Century Care Act

BENO 2023

21st Century Cures Act

- Shift to Transparency
- Represents a shift from a medical team communication tool to a ***patient and family*** Communication tool as well
- Potential to empower patients:
  - Up to date information, minimizes burden of disclosure at any given moment
  - Facilitates future inquiry
- BUT
  - It makes the digital divide more of a problem
  - Makes health literacy more of a challenge
  - And more challenges for the therapeutic relationship

Chart Notes and Bias

- Language used in the chart covertly signals whether the patient is Trustworthy, Deserving, a “good” patient
- Subtle word choice could suggest infantilization, Dominance, antagonism
- We are NOT neutral and purely objective Writers.

Document the WHY

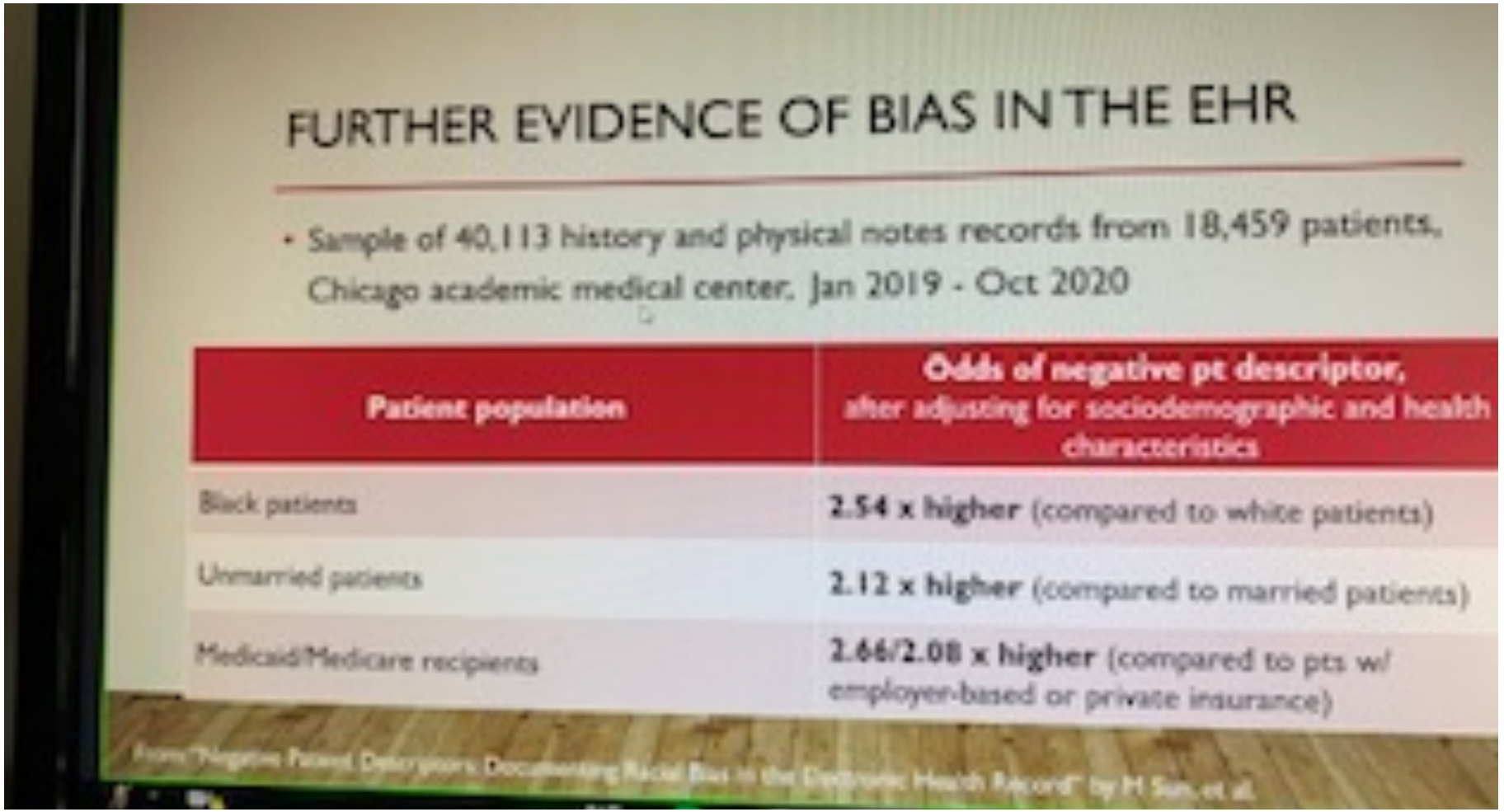
- Why is the patient requesting or deciding this?
  - Values, Priorities, Concerns, Influences, Past history with medications or treatments.
- Why is there apparent Non-adherence?
  - Importance of identifying Social determinants of Health (SDoH)
  - What Can the patient adhere with?
  - Adherence is often Mixed – may have to do with housing, support and transportation influences

How Chart notes can Hurt the therapeutic Relationship

- Cascade of Bias – One Biased note or error can lead to many More from current and future Healthcare professionals
  - It is difficult to erase an error once it is in the EHR
    - When Epic first was fielded in Dayton, patients with DM were listed with Dermatomyositis – it took about 2 years to correct.
- Some Biases may be explicit in the chart, others may be implicit but still Taint documentation and interactions.
- It can be difficult to go into a room when you read that a patient or family member is “difficult” “unrealistic” or “crazy”

What Else could be Biasing or Concerning?

- Leading your note with history of ilicit drug use, incarceration, or sensitive social information that is irrelevant to the current Medical issue or Management
- “Difficult patient”
- Incorrect pronoun or name
- Diagnosis first or Disability First Language, vs person first language



Negative Patient Decriptors Documenting Racial Bias in the Academic Health Record, M. Sun et al

Ways to reduce bias in the Chart

- Invite the patient to read your note in real time and offer input
  - “I’m going to write a letter to your doctor now, so if I say something you don’t understand or agree with, let me know
  - If the patient disagrees with something, Edit or explain why it needs to be kept in the record. Offer to add ”patient disagrees with X because ….”
  - Alternatively, ask yourself : would the patient agree with this?
- Health Literacy best practices
- Emphasize partnership and care, Include positive comments and encouragement

Ways to reduce bias in the Chart

- Be clear and succinct
- Directly and respectfully address concerns
- Include the patient’s input in the note writing process
- Use supportive language
- Encourage patients to read their charts
- Invite feedback from the patient/ family and utilize it where possible.

When is it appropriate to Exclude access to your note?

- www.Opennotes.org
- The Interoperability and Information Blocking Rule 2021
  - Allows situations in which a note or info can be blocked.
    - Preventing Harm
    - Privacy
    - Security
    - Infeasibility
    - Health IT performance

When is it appropriate to Exclude access to your note?

- www.Opennotes.org
  - Preventing Harm / security
    - Cases of spousal abuse
    - May need to block access to the portal so location of the patient is not identifiable
  - Privacy
    - Diagnosis may be stigmatizing
  - Harm to patient themselves
    - Case of a patient needing a medication but refusing.

Be Clear and Succinct

- Clear and organized notes allow patients to identify key information, facilitating education and engagement
- Brevity improves Readability and speeds up documentation.
- Direct and simple language, with minimal abreviations or Jargon, helps prevent confusion for patients and other providers

Directly and Respectfully address Concerns

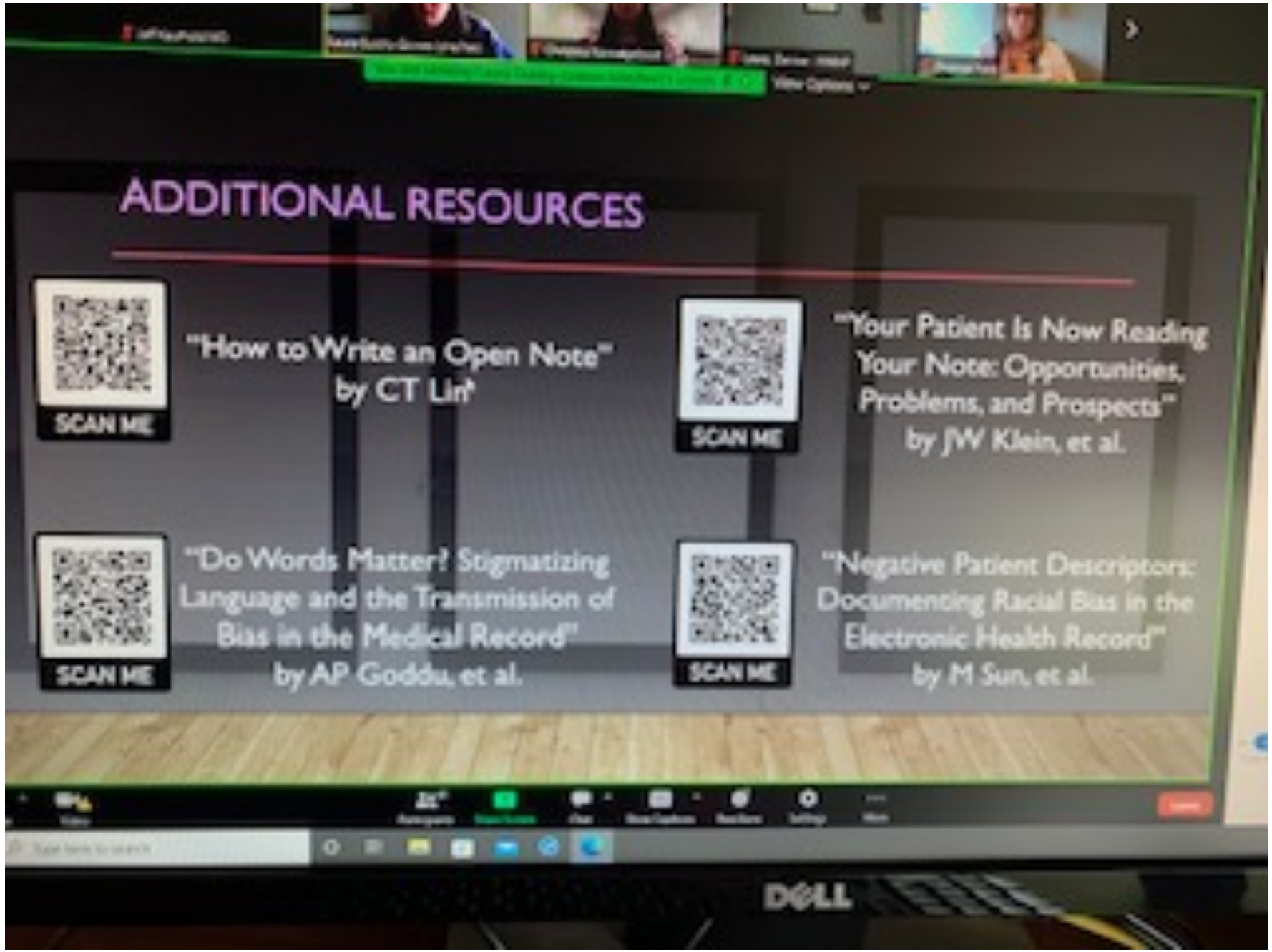
- We have all struggled to record sensitive issues, a good rule of thumb is to discuss what you write, and write what you discuss.
- Candid wording and clear follow up plans may allay fears among anxious patients who might otherwise feel overwhelmed or assume the worse possible scenario.
- Seeing a diagnosis in the note can feel more tangible to patients, and using frank but caring words might help overcome denial and de-stigmatize a condition.

Use Supportive Language

- Rather than focusing exclusively on problems, The medical record can also underscore patient accomplishments, encouraging and empowering patients to make positive changes.
- We often focus on positive change during conversations as a way of motivating patients, so include those statements in the notes.

Include patients in the Note Writing Process

- Encourage patients to read their notes/ review their chart.
- Seek clarification and act upon mutually agreed plans
- Systems that notify patients a note is available can substantially increase reading rates.
  - Some patients will choose not to
- Ask for and utilize Feedback
  - Requesting feedback to clarify misunderstandings can provide insight about the patient's level of understanding of their health and the care plan
  - Can strengthen a sense of partnership.


ADDITIONAL RESOURCES
SCAN ME
"How to Write an Open Note"
by CT Lin
SCAN ME
"Your Patient Is Now Reading Your Note: Opportunities, Problems, and Prospects"
by JW Klein, et al.
SCAN ME
"Do Words Matter? Stigmatizing Language and the Transmission of Bias in the Medical Record"
by AP Goddu, et al.
SCAN ME
"Negative Patient Descriptors: Documenting Racial Bias in the Electronic Health Record"
by M Sun, et al.
DELL