**Opening MMH to its full functionality, i.e., ‘Open Notes.’ Briefing from Dr Georgy Walton for Colleagues re Open Notes 4/6/19**

Background

Since launching MMH, we have had a consistent increasing uptake by patients. We can all see that patients have booked appointments through the portal, thereby saving some phone time and allowing us to see what the patient is coming for.

We have been able to deal with repeat prescription requests efficiently and simply, with the ability to refuse to repeat them and send a message to the patient asking them TCI if needed. This again saves some phone time and batting scripts backwards and forwards between us and nurses.

We can annotate results or send emails to the patient regarding test results. This again saves nurse phone time and the potential of lengthy conversations, as we can give the patient the option to discuss the result further by booking an appointment.

We do not have enough patients activated on the system to see a tangible difference in nurse phone time and increased efficiency in our processes of repeat scripts and results discussion yet.

The Future

It is proposed, and part of the HCH model, to use the MMH portal to its full functionality. This means opening consult notes and the option for patients to email us directly with queries. On the surface, the immediate reaction tends to be fear and hesitancy. What if we get bombarded with emails? What if I have a difficult consultation?

So why do it?

I have been researching open notes and the movement that started in the US over a decade ago by a small group of GP’s; I will attach the links to these and would encourage you to have a look if the concept is still uncomfortable after this email.

With the initial GP group in the US when they piloted open notes, the outcomes were as below:

80% of patients felt more in control of their care

80% could better remember what had been discussed in the consultation

80% felt better prepared for their consultation beforehand

70% were better at taking their medications regularly

Of the GP’s that were involved in the pilot, 99% wanted to continue with open notes.

Essentially, patients felt more engaged and involved in their own healthcare. This is empowering and ultimately increases patient compliance and participation in their health journey.

Other benefits:

* Patients can show their notes to other HCP’s, such as ED and specialists. This may reduce errors in discharge summaries and save time with secondary care trying to contact us for more information
* Patients can show their notes to other friends/relatives if they wish
* Knowing that a patient may refer to the notes means the GP and patient can formulate a robust Mx plan, hopefully increasing adherence to the plan

Business benefits

Rather than getting into elaborate phone conversations with the nurses, the patient has their notes to refer to which may reduce any queries. If they do have a query, they can email us and we can reply directly. This may also save appointment times and should reduce nurse phone time, freeing them up to physically see patients and work on the care plans/proactive care (this is to come).

Instead of getting second-hand info from the nurses that we may have tasked, we can email in our own prose straight from our brains which again may reduce the batting that can occur between the GP’s and nurses.

But what if?...

*What if the patient sends me an email full of questions?*

If an email is going to take more than 2 minutes to reply to, or it’s not possible to give a simple answer, then that patient either needs a phone consultation (to be charged, and yet to be designed – but probably what a phone consult is for), or a face to face appointment.

*What if it was a difficult consultation?*

The consult note shouldn’t be any different to what occurred in the appointment. Do not put in the notes anything you didn’t feel comfortable discussing in the consult. Imagine the patient reading the notes later and this should help guide you as to what to write. Our colleague GP’s haven’t found that they write their notes any differently to before, and I regularly ask myself if I’ve written anything that I wouldn’t want the patient to see. I don’t remember when I would have last said ‘yes’ to that question. Also remember the patient does actually own their notes and can request them any time.

*What if I am concerned the patient is a victim of domestic violence and their partner may see the notes?*

Much like the results, there is an option of ‘Do not upload to MMH’ for consult notes if safety is a concern.

There is the option not to open notes for patients if it isn’t appropriate. This would be on a case-by-case basis.

*What if the patient emails me and tells me I got some details wrong in the notes?*

Great! Then they can be amended, annotating that it was corrected after the patient contacted you.

*What if I get overloaded with emails/repeat scripts*

This means that we have enough MMH uptake to make further changes to the working day, and it will likely be necessary that an appointment is utilised for this work, much like the clinical triage appointments.

**So when do we kick off?**

Suggest XX Date

The patients will only be able to see their notes from that date forward, not historical notes.