Patients’ access to medical records

Preliminary results
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Patients’ E-access to Medical Records in Sweden

• Uppsala county was first with e-access to medical records 2013
• Today 9 regions have records online for all its citizens. All the other regions will follow in 2016
• By 2018 patients’ have e-access to medical records from county councils and municipal in the same portal.
National rules for the Patients’ E-access to Medical Records

- Adults from 18 years have e-access to their own medical records
- Patients can share their medical record with other adults.
- Parents have e-access to their children’s medical records until the child turns 13 years
- Access logs with information about the representatives and the health professionals who opened the medical record
- Medical records from oncogenetic, psychiatry, child psychiatry and rehabilitation center is not available

Patients’ E-access to Medical Records in Jönköping County

- Starting March 3rd 2015 for all residents in Jönköping County
- **Medical notes** from 2014-07-01. Note from office visits, enrollment, daga drawings, discharge note, telephone notes, administrative notes and care plans from all healthcare professions except psychologist and social worker.
- **Diagnoses**
- **Immunization** records for which data are available from 1972
Methods

- Three online surveys
  - 1053 healthcare professionals (6231, 17%)
  - 270 medical secretaries (477, 57%)
  - 103 patients (79+40 patient organizations)
- Simple statistics and coding of free text answers

Patients' opinions concerning benefits

- makes me more prepared before a meeting
- it is a good support after a meeting
- makes me more engaged in my treatment and rehabilitation
- I follow the advice that healthcare professionals give me
- poses a risk to me

Percent

1 (little) 2 3 4 5 (a lot)
Patients’ free text answers concerning benefits

- Get information about my healthcare condition
- Control the information in the EHR
- Increases patient participation
- Information is easily accessible
- It is my right to read information about myself
- Help relatives

n= 52, responses=77

“Get information about my healthcare condition
“Control the information in the EHR
“Increases patient participation
“Information is easily accessible
“It is my right to read information about myself
“Help relatives

“To remember what was said and done during the meeting”
“Can easily read and see if the physician misunderstood something”
“If notes are accessible, information and participation increases”
“It is an easy way to follow up that you have understood what was communicated”
“If there are misunderstandings between the patient and the physician it can be solved directly”
“It also makes me participate even more when I can discuss with my physician if there would be questions”
“I can get a more detailed response on how a specific healthcare condition has been reviewed and assessed”
“It is easier to point out things that are wrong or insufficient and get it corrected in records and notes – it will result in more reliable records and less misunderstandings”
“I feel more engaged in the treatment of my chronic disease”
Healthcare professionals’ opinions concerning benefits

Documentation

- 18% have changed the way they document (n=1046)
Transcribed information

- 85% do not experience a change (n=270)
- 24% have changed the way they transcribe (n=270)

![Pie chart showing percentages of responses to preferences in transcription]

More accurate: 52%
In a way that is easier to understand without abbreviations: 19%
Remind me that the patient will read the information: 29%
Avoid Latin expressions: 11%
Other: 1%

n= 63, responses=71

"Spell out abbreviations more and are aware of the language. Changes what the physician says so that it is not spoken language"

"Try to write in a way that is easier to understand. Spell out word instead of writing abbreviations, both Swedish and medical. Avoid old words, writes more modern"

"Try to not use abbreviations at all"

"Try to change the physicians’ dictate so it is more Swedish and the patients understand"

"When I write I am aware of that the records should be readable to someone that is not into the medical terminology and that the records should be written in good Swedish"

"I use Swedish to a higher degree and a language that everyone understands"
Patients’ suggestions on improvements

- 85% understand the content of the EHR (n=91)
- 49% want more functions or information (n=36)