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ORIGINAL ARTICLE

Providing mental health care in the context of online mental health notes: advice from patients and mental health clinicians

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ABSTRACT

Background: The OpenNotes initiative provides patients online access to their clinical notes. Mental health clinicians in the Veterans Health Administration report a need for guidance on how to provide care, write notes, and discuss them in the context of OpenNotes.

Aim: To provide mental health clinicians recommendations identified by patients and clinicians that help them effectively practice in the context of OpenNotes.

Method: Twenty-eight mental health clinicians and 28 patients in mental health care participated in semi-structured interviews about their experiences and perceptions with OpenNotes. A rapid review approach was used to analyze transcripts.

Results: Analysis of interviews identified three domains of advice for mental health clinicians: writing notes that maintain the therapeutic relationship, communicating with patients about their notes and utilizing clinical notes as a patient resource to enhance care. Specific recommendations are provided.

Conclusion: Findings provide mental health clinicians with guidance from service users and clinicians on how to leverage clinical notes to maintain – and potentially enhance –therapeutic relationships in a healthcare system in which patients are able to read their mental health notes online.

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Introduction

While patients have the legal right to request paper copies of their medical records (including clinical notes) (Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191), the process is often cumbersome and time-consuming (Fowles et al., 2004). Online patient portals enable patients to conduct healthcare-related activities such as make appointments, fill prescriptions and view care summaries. Until recently, patients were unable to view clinical notes (also called "progress notes") written by healthcare staff through patient portals. Now, an international initiative called OpenNotes encourages healthcare systems and clinics to provide patients online access to clinical notes so patients can easily and conveniently access their health information (Open notes: Patients and clinicians on the same page, 2017). This initiative coincides with recent legislation designed to increase patients' access to their health information, improve healthcare transparency, facilitate sharing information between healthcare systems, and enhance patient engagement in care (Blumenthal, 2010; Blumenthal & Tavenner, 2010; Centers for Medicare & Medicaid Services, 2016).

This expanded access to clinical notes has raised some concerns, as mental health clinical notes often contain sensitive information that could be upsetting to patients. In fact, some organizations have limited OpenNotes implementation to non-mental health settings, and many organizations adopting OpenNotes have given clinicians the option to block patient access to mental health notes (Kahn, Bell, Walker, & Delbanco, 2014). Recent research demonstrates that mental health clinicians are apprehensive that OpenNotes could cause significant harms to the therapeutic relationship, increase time spent writing and discussing notes with patients, enhance vulnerability to lawsuits or patient retaliation, and increase patient worry or sense of stigma (Denneson, Cromer, Williams, Pisciotta, & Dobscha, 2017; Dobscha et al., 2016). In contrast, most patients who read their clinical notes typically report feeling more informed, satisfied, engaged, and adherent to care (Delbanco et al., 2012; Nazi, Hogan, McInnes, Woods, & Graham, 2013; Stein, Furedy, Simonton, & Neuffer, 1979; Winkelman, Leonard, & Rossos, 2005; Woods et al., 2013). However, some patients find clinical notes challenging when they contain previously undiscussed information or perceived inaccuracies (Woods et al., 2013), and the therapeutic relationship may be positively or negatively affected by what they see in their mental health notes (Cromer et al., 2017).

The Veterans Health Administration (VHA), the largest integrated health organization in the U.S., implemented OpenNotes nationally in January 2013. VHA patients may view all of their clinical notes written since 2013 through

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VHA's electronic patient portal, My Health*e*Vet, using the Blue Button download feature. In contrast to most healthcare systems which have implemented OpenNotes, VHA does not restrict the types of clinical notes available to patients, or permit clinicians to withhold certain notes.

Mental health clinicians have reported desiring more guidance on providing care and writing notes in the context of OpenNotes (Denneson et al., 2017), yet little, if any, empirically-derived guidance exists. In this paper, we present recommendations for mental health clinicians to help them effectively practice and write notes in a setting that provides OpenNotes. These recommendations are derived directly from qualitative interviews conducted with VHA mental health clinicians and patients receiving mental health care.

Method

This study was approved by the Institutional Review Board of the VHA facility where the study was conducted. All participants provided informed consent. We have reported on these methods elsewhere (Cromer et al., 2017; Denneson et al., 2017).

Setting and samples

This study took place at a VHA facility in the Pacific Northwest that provides healthcare across 13 urban and rural facilities to approximately 85,000 patients each year. Comprehensive mental health services, including inpatient care, substance abuse treatment and other specialty programs are provided by over 250 mental health clinicians (psychiatrists, psychologists, social workers, nurse practitioners) and nurses (registered nurses and licensed practical nurses) to approximately 18,000 patients each year.

Staff participants

All mental health division clinical staff were eligible to participate in this study. Clinician and nurse participants (hereafter referred to as "clinicians") were recruited through email messages and at staff meetings, inviting them to contact the study team to be interviewed. We conducted interviews with clinicians in the order in which they expressed interest. Recruitment was stopped once the study team determined no new themes were arising from interviews. Twenty-eight clinicians were interviewed between May and October 2014. Approximately half of the clinicians were female ($n = 16$; 57%) and represented a range of disciplines: 10 (36%) social workers, 7 (25%) psychiatrists, 5 (18%) psychologists, 3 (11%) nurse practitioners, and 3 (11%) nurses.

Patient participants

Veterans receiving mental health treatment (defined as at least two visits within 6 months) who had read their notes online at least once were eligible to participate. We used VHA patient databases to identify potentially eligible participants and used purposive sampling to recruit patients representing a range of mental health diagnoses and demographic characteristics. Potentially eligible patients were mailed recruitment letters ($n = 225$) describing the study and inviting them to contact the research team for additional screening. We screened 157 patients; 64 were not eligible and 65 declined participation. As with clinician interviews, recruitment concluded when the study team agreed interviews were not yielding new information. Twenty-eight patients completed interviews between July and December 2014. Patients ranged in age from 30 to 60, with an average age of 47. Most were female ($n = 16$, 57%), white, non-Hispanic ($n = 24$, 86%), and 29% ($n = 8$) had college degrees. Participants' mental health diagnoses included: major depressive disorder ($n = 19$; 68%), post-traumatic stress disorder (PTSD; $n = 19$; 68%), bipolar disorder ($n = 5$; 17%), and schizophrenia ($n = 2$; 7%).

Data collection

We developed patient- and clinician-specific semi-structured interview guides which were informed by our main research questions, relevant literature on patient experiences reading progress notes (Delbanco et al., 2012; Gill & Scott, 1986; Stein et al., 1979), and input from local mental health clinicians. Interview guides were slightly modified over time to explore ideas emerging in earlier interviews. Table 1 presents interview guide topics. All interviews were conducted by non-clinician master's-level research associates with backgrounds in public health and anthropology. Interviews lasted approximately 1 hour, were audio recorded, and transcribed verbatim excepting any personally identifying information. Transcriptions were validated by an independent reviewer.

Analysis

We used a rapid review approach (Beebe, 2001; Hamilton, 2013) to analyze transcripts. This approach is best used for projects that are deductive or explanatory in nature, and seek to answer specific questions. Data reduction began by

Table 1. Semi-structured interview topics.

Clinician interviews	Patient interviews
• General knowledge and attitudes about OpenNotes: familiarity, concerns, and benefits	• General practices (when, how often) and reasons for reading clinical notes
• Documentation practices and changes	• Experiences and responses to reading mental health notes
• Experiences discussing clinical notes or OpenNotes with patients	• Experiences discussing clinical notes with their mental health clinicians
• Recommendations to other clinicians and education needs regarding OpenNotes	• Recommendations and education needs for clinicians regarding OpenNotes

creating a data summary rubric to address the following questions: 1. What is concerning, difficult, or confusing about OpenNotes? 2. What are benefits of OpenNotes? and 3. What practices might help alleviate concerns or facilitate benefits? Four analysts independently reviewed transcripts and completed a data summary for each transcript. Data from each summary were compiled into a single, master summary that tracked the frequency of ideas or themes within each question. For this paper, we focused our analysis on the third question in the data summary rubric to identify recommendations for clinicians. Clinician and patient interviews were first analyzed separately to identify ideas common to each group. Then, findings for each group were compared to identify both cross-cutting and conflicting ideas.

Results

Three main topics emerged from our analysis: note writing to maintain the therapeutic relationship, communicating with patients about their notes, and using OpenNotes to enhance the therapeutic process. Table 2 provides a summary of recommendations.

Note writing to maintain the therapeutic relationship

Patient and clinician interviews revealed three main themes central to writing notes that maintain the therapeutic relationship: writing professional and respectful notes, including the right amount and type of detail in notes, and highlighting patient strengths and progress (Table 3).

Be professional and respectful

Above all else, clinicians and patients agreed that notes should be professional and respectful; that is, accurate, clearly written, and respectful of patients, their identities, and experiences. To achieve this, patients and clinicians emphasized being cognizant of tone, word choice, and reducing the appearance of "cutting corners." For some patients, a negative tone facilitated perceptions that their clinician was annoyed, didn't believe what they reported, or was labeling or judging them, which oftentimes led to problems in the therapeutic relationship. To assess tone, both patients and clinicians recommended that clinicians place themselves in the shoes of the patient, and not include anything that the clinician wouldn't be comfortable saying directly to the patient.

> I have these couple default questions that I ask myself: so how would it look to me if someone were writing this about me? How would I feel giving it to my Veteran? And then, lastly, how would how would I feel about a colleague reading it? (*Clinician 1026*)

Certain words, abbreviations, or medical jargon routinely used in notes can further contribute to feelings of being judged or labeled. For example, one patient described how his notes continually stated, "patient complains of…," which led him to feel that he was being described as a "complainer." Additionally, both patients and clinicians agreed that medical terminology is necessary, but some recommended using simple language or including context to reduce the potential for patient confusion or upset.

> Try to limit jargon and instead maybe use language that is more, not dumbing down, but more understandable: more descriptors, more explanation, more rational. (*Clinician 1017*)

While patients understood that clinicians have limited time to write notes, spelling errors, inaccuracies and reusing information from past notes were perceived as "cutting corners." Patients viewed this as a lack of professionalism and respect for their time in therapy and experiences as patients and veterans. Patients described good notes as explanatory, clear and organized, while also recommending that clinicians write at least 2–3 sentences that are unique to each appointment or patients' lives.

> The sense I get when I read notes is that they're in a hurry. I think that's where the copy and paste thing is from. And I get they're overworked. But [one of my clinician's] entries are long; he gives it thought and consideration. I'm not just a repeat from the last PTSD person you talked to. I'm an individual with PTSD. (*Patient 2003*)

Table 2. Key Themes and Recommendations for Mental Health Clinicians Working in Context of OpenNotes.

Domain	Recommendation
Writing	Write notes that are accurate, clear, and respectful of the patient.
	Assess tone by placing yourself in the shoes of the patient.
	Only write what you would be comfortable saying to the patient.
	Consider word choice carefully; simplify language, provide context, and avoid abbreviations that could easily be misinterpreted.
	Proofread notes for spelling errors and review for inaccuracies.
	Include unique details about the patient in each note.
	Write about patient strengths, goals, and progress over time.
	Ensure the note has enough detail so that another clinician could provide care for a patient.
	Determine whether to generalize some details for patient privacy and safety reasons on an individual basis.
	Consider asking the patient for their preference or asking colleagues for advice when documenting sensitive topics.
Communicating	Initiating conversations with patients early in treatment about their notes can help set patient expectations about notes and care.
	Convey that you are open to discussing notes.
	When a patient does voice a question or concern about their notes, use it as an opportunity for collaboration, validation, or therapeutic insight.
	Be upfront with the patient about what information will be included in the note.
Enhancing Care	Use the note as an additional way to communicate with your patient
	Include specific resources in the note (e.g. where to find further reading) or activities to do between appointments.
	Ask the patient to read the note in between appointments and follow up at the next appointment.
	Decide together the amount of detail to be included in the note, especially with more sensitive topics.

Table 3. Representative Participant Quotes on Providing Mental Health Care in the Context of OpenNotes.

Subtheme	Representative Quote
Be professional and respectful	"Her notes are very sloppy. Every third word is misspelled, and just kind of childish. I feel like this is very serious. I'm putting myself out there, I would like you to take it seriously too, not just spit something out on paper and not proof read it and hope for the best. It sounds like she doesn't take her job seriously, or doesn't care about my time being there." (*Patient 2005*)
	"Don't write anything you wouldn't be comfortable saying to the patient in-person. I think it's just a way for me to unconsciously check-in with myself that what I'm saying to the patient is something I'd feel comfortable charting and vice versa." (*Clinician 1003*)
Include the "right" amount and type of detail	"It should have been 'dealing with stress, life events that are causing stress.' Things that can just highlight what exactly is going on without really getting into the really sordid details. There was no need to write in my record that my daughter had gotten caught shoplifting and that I had grounded her and taken her phone." (*Patient 2024*)
	"Obviously, I have to tell the truth about what we talked about, but I would definitely be open to, except for things that I am mandatorily required to report, to be more vague if [the patient] wanted, or to give context, or more details.' I'm totally open to that. I would let them read it and sometimes we'd do it right here." (*Clinician 1018*)
Highlight patient strengths and progress	"You get stuck in a rut as a patient sometimes, you just don't see yourself doing better. But to see a clinician say that they see improvement or they see a particular struggle that they're going to address the next session, I think that can be very helpful to patients." (*Patient 2020*)
	"If someone before had been very tearful, or very disorganized in their speech and now they're not, I don't want [other clinicians] to just skip over that, but I want them to note changes, I want them to note progress, I want to them to note insights." (*Clinician 1017*)
Be transparent about note content	"I think being open and saying, 'Well this is what I'm going to put in your note' rather than having it come as a surprise. Because once I discovered that … and maybe they have a different perspective on it than I do. Yes, they have the doctorate, but I'm the person living through it, so who has the right perspective?" (*Patient 2028)*
	"That maybe they take into consideration that a discussion with a person, while they're in front of you, prevents a lot of problems later. So that when they read it, they can go, 'Oh yeah, we talked about it. I didn't like it then, I don't like it now, but we talked about it.'" (*Clinician 1017*)
Be open to discussing the notes	"The way forward for the patient and clinician is through open dialogue. Maybe it should be the kind of thing where every now and then we just chat about the notes and the impressions so there is no misunderstanding." (*Patient 2010*)
	"I guess part of it would be … being prepared to have those tough conversations about what was discussed in the notes, in a way that is collaborative and respectful, rather than leading into 'you said this.' Rather than kind of leading to people just digging in their heels." (*Clinician 1012*)
Write notes knowing the patient will read and use the information	"You need to write notes realizing the patient is going to read the notes, and take what you say to him or to her so they can get value out of your notes and study your notes and practice and do the things that you suggest." (*Patient 2016*)
	"It's not just the patient might read what I write about them. My treatment plan is asking you to read what I write about you. For them, to not think of it as incidental." (*Clinician 1004*)
Write collaborative notes	"I chart collaboratively with veterans sometimes. I pull up my laptop in a meeting, and I'm like, 'Hey, let's get this in the chart, are you okay with that?' There's a discussion." (*Clinician 1021*)
	"When I first started learning about [OpenNotes] I said, 'so how are you going to report this?' I felt that I have a right to ask that. I mean, again, because I don't want things to be put in that are going to be misleading or not correctly reflect what I said." *(Patient 2008)*

Include the "right" amount and type of detail

The amount of detail in notes emerged as a common topic, though advice on how much to include varied. Most patients expressed a preference for detailed notes that thoroughly summarized each appointment, as this provides patients a more complete picture of their mental health and the feeling that their clinician understood them. In addition, some details provided patients with unique insight to themselves, such as how they come across to others.

> For me at least, when it comes to mental health, because of some of my issues, the more detailed the better. Because certain things can be described one way and really mean something else. And it helps remind me how far I've come. (*Patient 2021*)

In contrast, most clinicians recommended writing concise, less detailed notes. A common consideration was writing notes appropriate for the multiple purposes and audiences of clinical notes (e.g. self, the patient, other clinicians, VA Compensation). A few clinicians warned that more detailed notes could increase potential for misinterpretation, disagreements, fractures in the therapeutic relationship or other adverse outcomes. Many recommended including just enough detail so that another clinician could provide care for a given patient, if necessary.

> I'm always upfront with [my patients] that I have to chart what I think is clinically and ethically necessary. But there are certain details that are not necessary for everyone to be able to see. (*Clinician 1014*)

Clinicians and patients agreed that notes should generally not include details of traumatic experiences. Patients felt this could be upsetting and clinicians were concerned it could lead to adverse outcomes, such as disengagement from care. Further, clinicians advised their colleagues to

generalize some details of trauma for privacy and safety reasons. Many clinicians recommended assessing what to include on a case-by-case basis, and to consider asking the patient for his or her preference, especially regarding more sensitive topics.

> Just be very, very cognizant of quoting patients, and of assessing for triggers. If they decided to read their notes, would x, y and z charted, exacerbate their existing symptoms? (*Clinician 1014*)

Highlight patient strengths and progress

Patients and clinicians emphasized the importance of writing notes that showcase patient strengths and progress in treatment. These details reminded patients of how far they have come and for some, why they continue to engage in mental health care. Reading notes that documented strengths helped patients focus on the positive and feel supported and valued by their clinicians. Patients also appreciated when clinicians noticed the efforts they were making toward recovery.

> [My clinician] sees me as a human being and I'm going through this stuff, and he focuses on seeing my strengths … So when I review it, I go, 'You're getting better.' (*Patient 2003*)

> If patients are going to have access to their medical records, then clinicians need to focus on a strengths-based approach. It can be very disheartening for a mental health patient to see that even the clinicians don't have much hope for them. (*Patient 2020*)

Clinicians echoed the importance of identifying patient strengths and detailing progress towards goals. Some clinicians utilized the note to demonstrate that the clinician heard and understood the patient's perspective. Clinicians warned that highlighting only patient problems could lead to mistrust in their relationship.

> If I'm working with someone and they are presenting with a problem, try to think of including in the note something positive that they're doing about the problem and what we're doing together about the problem. So maybe some hope and some validation of what the person is doing. (*Clinician 1026)*

Communicating with patients about their notes

Both clinicians and patients described communication about notes as helpful for maintaining a positive, therapeutic relationship. Recommendations included being upfront about what will be written in patients' notes, while also being open to discussing patient questions or concerns. Open communication was felt to be especially important when documenting sensitive or potentially surprising information, such as diagnoses.

Be transparent about note content

Conversations about what would be written in notes were thought to help ensure that the content of the notes matched what was discussed during appointments, which was an important issue for patients. Patients reported instances of feeling blindsided when discovering information in their notes that were not previously discussed, such as new diagnoses. These instances led to confusion and frustration; for example, one veteran assumed a diagnosis he discovered in the note must have been an error since it was not mentioned previously. In general, many patients and clinicians agreed there is a benefit to being open and upfront about what goes into the note *before* a patient reads it.

> If a clinician assigns a diagnosis to somebody, that diagnosis should be thoroughly explained to the client. And so I think that, like me, who was surprised by having a borderline personality diagnosis all-of-a-sudden slapped on my records. (*Patient 2020*)

Even in cases in which clinicians needed to write about difficult topics, most patients and some clinicians agreed it was important to convey such information to patients ahead of time to allow for more context and preparation. However, some clinicians recommended not discussing such notes or sensitive topics with some patients, as these conversations might be harmful.

Be open to discussing notes

Despite agreement on the importance of communication about notes, both patients and clinicians avoided initiating such conversations. The primary reason was worry about the other's response; some clinicians were concerned that patients may request changes or challenge them, while some patients were worried about offending their clinician or being perceived as a "difficult." Other than a few patients who preferred not to use appointment time discussing notes, many patients reported that it would be helpful for their clinician to periodically initiate conversations about notes, such as to address any questions or concerns. This also conveyed that the clinician was open to discussing notes.

> When [my clinician] found out that I was reading the notes, she would ask me if there was anything that was unclear, if I needed clarification on anything, if there was something that wasn't addressed. And I know that a lot of providers don't always take that time. *(Patient 2022)*

If patients do voice an issue with their notes, some clinicians advised their colleagues to utilize it as a therapeutic opportunity to discuss something that might otherwise not come up, or to destigmatize and normalize patient concerns and experiences. In rare circumstances, however, clinicians thought that conversations with some patients could be therapeutically harmful.

> I think the process of being open to having the conversation and seeing their concerns is often more powerful than whatever is in the record or they want to change. I think the key is being open to it and not just being like, 'I'm a clinician, I know what I'm doing and I'm right all the time, and they're just a patient.' It's being able to hear them out and make changes if you can, but I think a lot of times it's not even about that. (*Clinician 1012*)

Using OpenNotes to enhance care: moving beyond the basics

Patients and clinicians believe that OpenNotes presents a unique opportunity for enhancing care by increasing opportunities for communication and collaboration.

Write notes knowing the patient will read and use the information

A common recommendation from patients was that clinicians should write notes with the patient in mind, knowing that the patient might use and apply the information. For example, one patient looked at his notes between appointments to be reminded of goals, while another read her clinical notes and her own personal notes to measure progress over time. Clinicians suggested using the note as a patient resource by reemphasizing important points, documenting goals, providing educational resources, or even referencing a relevant community event. To accomplish this, clinicians recommended incorporating OpenNotes into the treatment plan by asking the patient to read the note between appointments, then revisiting the topic at the next appointment.

> So, maybe you should write it more to me—know that I'm one of the readers. And maybe you could put something in it that's going to remind me of something that we talked about it or advice you'd given me or I should be doing or whatever. (*Patient 2008*)

> [The notes] could be more of a tool for re-explaining or a tool for a different learning style for someone who needs to review information in a different way or see where they are at in their treatment. It would be cool if it ended up being a reminder tool where a clinician would be like, 'Hey, before next session, go to OpenNotes and review the ACT homework assignment.' (*Clinician 1011*)

Write "collaborative notes"

Some clinicians saw OpenNotes as having the potential to enhance patient–clinician collaboration. Clinicians recommended engaging the patient in the note writing process, which they described as "collaborative note writing." This entailed asking the patients how they want to be represented, deciding together on the specific details to include, or even looking at the note together with the patient. This approach was described by several clinicians as being useful when there was concern about how the patient might react to a particular note, such as one addressing past trauma, or violent behaviors or concerns.

> There's actually kind of note writing where at the end of your session you write a note, and you write a summary. 'This is what we talked about,' and get their agreement. I think it's useful. This is what we talked about or these are the tasks that you're going to work on between sessions, and you give it to them. (*Clinician, 1022*)

Discussion

This qualitative study aimed to use clinician- and patient-derived information to guide mental health clinicians practicing in the context of OpenNotes. Overall, we identified three primary domains of recommendations: note writing to maintain the therapeutic relationship, communicating with patients about notes, and using OpenNotes to enhance care. Key themes centered on the need for clinicians to consider patients as note readers; writing notes that are respectful, clear and representative of patients' experiences and identities; and communicating with patients such that notes become an extension of the appointment.

While clinicians and patients often offered similar recommendations, some differences are worth further discussion. First, patients and clinicians provided wide-ranging advice regarding the level of detail appropriate in notes. Many patients emphasized the importance of notes that thoroughly summarize appointments and provide unique insight into their health and treatment, which could possibly improve self-management and engagement in care. However, not all patients agree about the type or quantity, especially when considering the multiple audiences notes address, and the sensitive information that mental health notes often contain. Clinicians generally preferred writing less, aiming to prevent patient confusion, miscommunications and disagreements. Klein et al. (2016) recommend brief notes for readability purposes, and, in a study of mental health clinicians, 69% surveyed reported they now write less detail in clinical notes as a result of OpenNotes (Dobscha et al., 2016). One area of agreement between patients and clinicians, however, is that notes should generalize information about patient experiences of trauma. An exception to this might be patients seeking disability compensation, particularly for PTSD, as this process relies heavily on documentation in clinical notes. In our prior work, PTSD diagnosis was associated with both a stronger alliance with clinicians and with experiencing negative emotions in response to reading mental health notes online (Denneson, Chen, Pisciotta, Tuepker, & Dobscha, 2018). Patients with PTSD are also more likely to read their notes than other veteran patient groups (Dobscha et al., 2018). Clearly, there is no "right" recommendation regarding the level of detail, though clinicians should include detail on a case-by-case basis, and consult with the patient or colleagues as needed.

Second, patients wanted their clinicians to discuss notes with them, but most clinicians were hesitant to initiate these conversations. Some clinicians believed that upfront communication is helpful to proactively inform patients about the potential benefits and harms of reading notes. Other clinicians disagreed, as they were concerned that informing patients about OpenNotes could potentially increase the number of negative outcomes. While some patients report negative outcomes related to OpenNotes (Denneson et al., 2018), increased communication about note content greatly fosters trust (Cromer et al., 2017). Given that patients often do not inform clinicians they are reading notes, and that note content can affect their trust of their clinician (Cromer et al., 2017; Denneson et al., 2018), our findings suggest that the potential benefits of communicating with patients about OpenNotes may generally outweigh potential harms.

There are several limitations to this study. This was a small qualitative study of Veterans and clinicians at one VHA facility in the Pacific Northwest; as such, there may be limited generalizability to other patient and clinician

populations. We note that our Veteran group was slightly more educated than the broader Veteran population, but perhaps more similar to the broader population of patients who might access their notes online (Dobscha et al., 2018; Peacock et al., 2017). Further, we enrolled clinicians with a range of disciplinary backgrounds and used purposive sampling to recruit patients across a range of mental health diagnoses and demographic characteristics. It is unclear to what extent our findings may apply to primary or other non-mental health specialty settings.

The study findings should encourage clinicians to make minor adjustments to note writing and patient communication to maintain therapeutic relationships and reduce the potential for negative outcomes with patients who read their notes. Clinicians should maintain a respectful tone, include clinically meaningful details, and note patient strengths and progress. Open and proactive communication about notes and inquiring about patient preferences early in treatment may also be beneficial for supporting therapeutic alliances and avoiding misunderstandings. Importantly, clinicians should consider that patients may be reading their notes and determine note content on a case-by-case basis. Further research is needed to determine whether these practice changes impact patient outcomes or quality of care.

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