medbridge

The case for patient records: Why it's time to move off access codes

Your clinicians are already busy. Patients shouldn't be juggling codes, losing track of which program belongs to which clinician, or arriving at a follow-up with no record of what came before.

7 out of 10

trials showed significantly better adherence when digital support was added to home exercise programs.

Lang, McLelland, MacDonald, Hamilton, et al., 2022, BMC Health Services Research

Patients reported increased motivation and accountability

when using digital platforms, with reminders and progress tracking reinforcing adherence.

Hinman et al., 2017, Arthritis Care & Research

Improved patient outcomes

as well as improved pain, function, and quality of life were seen with digital MSK rehab compared with standard care.

Cottrell et al., 2017, Journal of Telemedicine and Telecare

Access codes are fast, but speed without continuity has a compounding cost

Programs rebuilt from scratch

At follow-ups, nobody has the old code handy, so the program gets rebuilt. Every edit creates a new code.

Codes lost between visits

Patients carry the burden of managing codes, and your staff sorts it out when one goes missing.

No continuity of care

No view of follow-through between visits, outcome trends, or how a patient's care has evolved.

Episode data that can’t be recovered

Once an episode closes on an access code, that data is gone for good.

What your subscription can do with patient records

Access Codes	Patient Records
Program delivery only	One place for all programs, from every clinician
No adherence or engagement data	Full adherence and engagement tracking
No patient record or history	Outcomes data across every episode of care
No RTM or PRO documentation	RTM and PRO support
No care team messaging	Care team messaging and shared access
Cloud-episode data can’t be recovered	Continuity across every episode of care

Why investment now saves time later

“Isn’t this an extra step?” Yes. Creating a record takes a few extra minutes up front. But after that, every follow-up picks up where the last one left off: no hunting for codes, no rebuilding programs that already exist.

Day One
A few minutes to create the record

Every visit after
Context, continuity, and no rebuilds

Two ways to save time during patient appointments

1. **Build the process into morning chart review**
   Clinicians create records before patients arrive, as part of prep time rather than chairside.
2. **Hand it off to the front desk or an aide**
   Support staff create the record so clinicians can focus on building the program during or after the session.

Record first, program second.

A program built under an access code can't be attached to a patient record later, so that episode's data stays disconnected.

For your patients: One place for everything

Today, patients manage the codes:

- Code from Clinician A
- Code from Clinician B
- New code from edited program

Confusion and time spent hunting down the correct code deters patients and creates barriers to HEP adherence.

But with one patient record:

- Every program from every clinician on the care team is in one place
- History that carries forward across episodes
- Clinicians continuing care never have to start from scratch

Your data story: Why the data matters with or without RTM

Patient records build a picture of care across episodes, across clinicians, and over time. Everything else is built on that foundation, even if you're not doing remote therapeutic monitoring.

Individual Patients	Whole Patient Population
Adherence trends between visits	Which programs are working
Outcomes across each episode of care	Outcome trends across clinicians and time
Early signs a patient may be disengaging	Identify struggling patients that need outreach

But if your organization does RTM, patient records are a requirement, not an add-on

Remote therapeutic monitoring requires documented patient engagement data, which access codes can't provide. If you bill for RTM, every patient needs a record, and any patient still on an access code is a missed billing opportunity.

How to make the switch to patient records

New evaluations start with a patient record on day one. Existing access-code patients continue as they are until their next visit, with no disruption to active care.

1

Prepare

2-4 WEEKS BEFORE

Confirm the handover approach, pick 1–2 clinical champions, and configure care settings.

2

Train

1-2 WEEKS BEFORE

Assign "Getting Started with Patient Management" and run short live sessions on records and program assignments.

3

Go-Live

LAUNCH DAY

All new evaluations use patient records and champions offer on-floor support the first week.

4

Reinforce

1–3 WEEKS AFTER

Share early wins like adherence data, RTM documentation, and patient messages sent.

PRO TIP: Rebuild active patients in seconds

No need to rebuild exercise by exercise! Copy an existing access code, save it as a template, and apply it to the new patient record.

Ready to make the switch? The best time is right now

There is no low-disruption moment to make this change. Every week on access codes is another week your patients are managing codes on their own, another week your clinicians are working without context, and another week of episode data that can never be recovered.

If RTM applies to you, it's also another week your billing window is closed.

Schedule a transition planning session

Contact your Account Manager or our Support team to schedule a transition planning session where we'll help you configure your settings, train your team, and go live within weeks.