



Separate may not be equal: A preliminary investigation of clinical correlates of electronic psychiatric record accessibility in academic medical centers

Dana E. Kozubal^a, Quincy M. Samus^a, Aishat A. Bakare^a, Carrilin C. Trecker^b, Hei-Wah Wong^b, Huiying Guo^b, Jeffrey Cheng^b, Paul X. Allen^c, Lawrence S. Mayer^a, Kay R. Jamison^a, Adam I. Kaplin^{b,*}

^a Johns Hopkins Department of Psychiatry, United States

^b Johns Hopkins Departments of Psychiatry and Neurology, United States

^c Johns Hopkins Department of Casemix Information Management, United States

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ABSTRACT

Objectives: Electronic Medical Records (EMR) have the potential to improve the coordination of healthcare in this country, yet the field of psychiatry has lagged behind other medical disciplines in its adoption of EMR.

Methods: Psychiatrists at 18 of the top US hospitals completed an electronic survey detailing whether their psychiatric records were stored electronically and accessible to non-psychiatric physicians. Electronic hospital records and accessibility statuses were correlated with patient care outcomes obtained from the University Health System Consortium Clinical Database available for 13 of the 18 top US hospitals.

Results: 44% of hospitals surveyed maintained most or all of their psychiatric records electronically and 28% made psychiatric records accessible to non-psychiatric physicians; only 22% did both. Compared with hospitals where psychiatric records were not stored electronically, the average 7-day readmission rate of psychiatric patients was significantly lower at hospitals with psychiatric EMR (5.1% vs. 7.0%, $p = .040$). Similarly, the 14 and 30-day readmission rates at hospitals where psychiatric records were accessible to non-psychiatric physicians were lower than those of their counterparts with non-accessible records (5.8% vs. 9.5%, $p = .019$, 8.6% vs. 13.6%, $p = .013$, respectively). The 7, 14, and 30-day readmission rates were significantly lower in hospitals where psychiatric records were both stored electronically and made accessible than at hospitals where records were either not electronic or not accessible (4% vs 6.6%, 5.8% vs 9.1%, 8.9 vs 13%, respectively, all with $p = 0.045$).

Conclusions: Having psychiatric EMR that were accessible to non-psychiatric physicians correlated with improved clinical care as measured by lower readmission rates specific for psychiatric patients.

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* Corresponding author at: Johns Hopkins Hospital, Departments of Psychiatry and Neurology, 600 North Wolfe St., Meyer 121, Baltimore, MD 21287, United States. Tel.: +1 410 955 2343; fax: +1 410 614 5913.

E-mail addresses: dana.kozubal@gmail.com (D.E. Kozubal), qsmiles@jhmi.edu (Q.M. Samus), abakare1@jhu.edu (A.A. Bakare), frecker777@gmail.com (C.C. Trecker), heetyty@gmail.com (H.-W. Wong), ying4687@gmail.com (H. Guo), jeffreycheng@jhu.edu (J. Cheng), pallen@jhmi.edu (P.X. Allen), lmayer3@jhmi.edu (L.S. Mayer), moods@jhmi.edu (K.R. Jamison), akaplin1@jhmi.edu (A.I. Kaplin).
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1. Introduction

The United States is currently considering reforming many aspects of healthcare, including the universal implementation of EMR. Demonstrating and quantifying the potential improvement in patient care from the adoption of an EMR system can be difficult but is important if implementation is to occur in the near future [1–5]. Amarasingham and colleagues recently reported that each 10-point increase in the “automation of notes and records” score from the Clinical Information Assessment Tool contributed to a 15 percent lower odds of dying while hospitalized [6].

Psychiatry has lagged behind other medical disciplines in its adoption of EMR [3,5,7–9]. One potential explanation for this is the restricted access to psychiatric records within hospitals. It is often assumed that psychiatrists and patients both desire greater restrictions on access to psychiatric records. However, patient and psychiatrist opinions on this matter have been studied on a limited basis. At the University of Michigan Health System Department of Psychiatry, researchers found that of patients who did not want their psychiatric records transferred to an electronic system, a significant number cited fear of breach of confidentiality as their primary concern [10]. However, only 5% of their total patient population refused the transfer of their records, suggesting that actual patient opposition to electronic psychiatric records is rather small. While the desire to protect intimate details of a patient's psychiatric history emerges from the best of intentions, it may also be that the assumption that these records should be treated separately is related to the stigma surrounding psychiatric disorders.

A negative attitude towards a person with a psychiatric illness based on societal assumptions, prejudices, stigma and often a lack of knowledge of an illness, can initiate a vicious cycle of discrimination and often a worsening of mental illness [11–13]. Current literature points to the stigma of mental illness as a causal factor for lower quality care. It also suggests stigma is a barrier to receiving care; specifically, the fear of stigmatization by society often prevents patients from seeking care for a mental illness. Surprisingly this fear is inadvertently perpetuated even in the healthcare profession, where professionals are expected to have an understanding of the importance of psychiatric care.

Medical students admitted hesitation to seek help for a mental illness for fear of discrimination by peers as well as instructors [14]. The study found that the major barrier to help-seeking behavior was the perceived stigma of mental illness and stress. In addition to the fear of stigma, it was noted that apprehension about the confidentiality of services would not be maintained was also a reason that medical students did not seek help from services offered by their institution.

Much of the apprehension about EMR and unrestricted access to psychiatric records originates – correctly – from concern for confidentiality of records [2]. In response, it has become common practice to exclude details from psychiatric evaluations from a patient's medical charts [15,16]. This endeavor, however, counters any efforts to bridge the gap between medicine and psychiatry. Instead, the separation of psychiatric records from other medical records reinforces that

medical professionals see a distinct difference between psychiatry and other healthcare specialties. Furthermore, it fails to address the importance of an interaction between the two fields. In one study, all psychiatric patients with repeat visits to the emergency department had prior mental health records that were unavailable to ED clinicians at the time of the patient crisis [17].

The need to balance patient confidentiality with the provision of optimal quality of care requires careful consideration of the competing concerns of a variety of stakeholders. Because of factors that include stigma regarding psychiatric illness, the application of Health Information Technology to psychiatric care has lagged significantly behind somatic medical care.

There remains – and should remain – debate about how psychiatric medical records should be stored, and whether or not they should be made accessible to non-psychiatric physicians. Much of the debate centers on the issue of confidentiality [2,18]. We know of no prior exploratory investigation that has studied this issue systematically and descriptively. We further know of no prior examination of the impact of these decisions on the quality of psychiatric patient care (e.g., readmission rates, length of stay, etc.). Lastly, we are not aware of any published studies on the prevalence and availability of EMR in psychiatry.

In 2007 there were 18 hospitals listed on US News and World Report's ranking of Best Hospitals in the United States. We surveyed all of these hospitals to determine if these centers have psychiatric EMR and whether unrestricted access is given to non-psychiatric practitioners. We then analyzed whether access to electronic psychiatric records correlated with improved patient care outcomes.

2. Method

We identified the nation's top hospitals as those ranked on US News and World Report's Best Hospitals list (2007). After initially conducting phone surveys asking about the psychiatric record keeping practices at these hospitals, we developed a forced-choice questionnaire on surveymonkey.com to confirm and standardize the results.

The survey focused on whether inpatient psychiatric admission and discharge summaries, psychiatric Emergency Department evaluations, and psychiatric consultation notes were paper or electronic and whether psychiatric records were “able to be viewed by non-psychiatric physicians while working on a medicine floor” (and, if so, whether access was “unrestricted”). We obtained responses from 100% of the hospitals from which we requested information through a two-step process. We identified an initial group of psychiatrists, generally the director of psychiatry residency training or the head of consultation-liaison psychiatry, to whom we emailed our survey (Supplementary Document). We obtained initial responses from psychiatrists at 14/18 (77.8%) hospitals. Additional psychiatrists were identified at the remaining four sites, and a second query returned results from the remaining four hospitals, hence data was collected from all sites by the end of 2008 (100%).

Hospital-level patient outcomes data were acquired through the University Health System Consortium (UHC)

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