Transformational Impact of Health Information Technology on the Clinical Practice of Child and Adolescent Psychiatry

Todd E. Peters, MD

KEYWORDS

- Health information technology • Child and adolescent psychiatry
- Medical informatics • Health IT • Pediatric behavioral health care
- Clinical decision support

KEY POINTS

- Child and adolescent psychiatrists are faced with many challenges in implementing health information technology strategies, such as electronic health records, into clinical practice. These challenges have likely contributed to a delay in implementation within psychiatry.
- Several strategies can be implemented to improve patient care using health information technology, including clinical decision support strategies integrated with electronic health record systems.
- Future growth within behavioral health information technology will be imperative to align with other medical specialties in the multidisciplinary care of youth. Reaching a balance between privacy and increased transparency of care will be imperative.

INTRODUCTION

This is an exciting but difficult time for treating mental health needs in youth. In treating the pediatric population, no child or adolescent now knows of a time without cellular phones or widespread Internet use. According to Pew Research Center data from 2015, 92% of teenagers access the Internet daily and 73% have regular access to smartphone devices. Most teenagers also regularly access social media sites, which have become a major source of news and information for teens. In some ways, this movement has likely assisted with destigmatization of mental health issues in in the

United States, giving millions of youth and their families a platform to share struggles with psychiatric symptoms and treatment. However, children's use of social media can give them access to millions of people at their fingertips, which offers significant risk, including the inherent risk of more widespread bullying, sexual exploitation, and discussion of self-injury or suicide strategies.

Although children have been quick to adopt the latest technological advances in treatment, many child and adolescent behavioral health practitioners have been slow to adopt health information technology (IT) in their clinical practice. Studies have shown that psychiatrists are the least likely to adopt use of electronic health records (EHRs) in clinical practice. Although previously many providers questioned whether to have a Web site for their practice or accept emails from patients, now providers are faced with pressures to respond to negative Yelp or Google ratings by frustrated patients or to have their own social media presence. Given these advances in health information and the expansive use of the Internet by most patients and families, practitioners are faced with a challenge unlike those faced in preceding generations. How do practitioners discuss the use of electronic communication between providers/institutions and electronic medical records with patients, recognizing that the patients/families are the true owners of their medical records?

Although it is sometimes easier to focus on the potential pitfalls of practicing in the Internet/digital age, this article takes a more balanced approach in focusing on the transformational nature of health IT, including:

1. Optimizing use of EHRs for clinical practice, including documentation strategies to improve care
2. Leveraging health IT to improve quality of care, especially through clinical decision support (CDS) strategies and electronic standardized assessments
3. Focusing on potential for future growth in the realm of health IT in child and adolescent psychiatric practice

BACKGROUND FOR HEALTH INFORMATION TECHNOLOGY IN CHILD PSYCHIATRIC PRACTICE

The area of clinical documentation is not a new challenge in psychiatry. Historically, issues surrounding information that should be documented in the legal medical record, including the personal and private details of each patient's personal history, have challenged providers. Documentation of practitioners' work continues to serve many purposes: to serve as an internal record of patient care; to detail evaluations and assessments for other providers within a health care team; to justify the work that is performed for billing/insurance; and to serve as an external record for families, especially in times of litigation. Historically, many providers have incorrectly thought that a patient's medical chart is the property of the practice or provider, creating barriers to open access by the patients. Over time, most practitioners have come to understand that, although providers are the legal creators of the record, the patient remains the true owner. In child and adolescent practice, this delineation is unclear and depends on the state laws where each clinician practices.

Safety and confidentiality issues are also not new to the digital age. However, this has become exacerbated with the advent of remotely accessible EHR systems, especially in mental health. Because of these concerns for confidentiality, the Health Insurance Portability and Accountability Act (HIPAA) was created in 1996 to provide additional regulations for so-called covered entities, which are any practices or institutions that perform electronic transfer of clinical information. After this development, signed disclosure statements releasing electronic dissemination of documents