Integrating behavioral health records into EHRs

Electronic health records (EHRs) allow improved communication between primary care and other health care clinicians. However, exactly how the records of behavioral health providers should be included in the EHR has generated some debate.[1] One approach is to keep behavioral health records in restricted areas of the EHR or behind "break the glass" firewalls. The issue of whether and how to include behavioral health records in the EHR has become more salient as behavioral health services increasingly have become integrated into primary medical care services.[2,3] The collaborative behavioral health model, which has been described in this journal,[4] is an example of such integration. In the implementation of the model as described by Serrano and Monden, behavioral health records are integrated into the EHR and are fully accessible to other medical providers just as are the records of the primary care clinicians.

Over the period of a year, I had a natural experiment to study primary care patients' consent to inclusion of behavioral health records in the general EHR. I am a psychologist practicing part-time in a family medicine clinic that is a training site of a family medicine residency. In January 2010, my clinic affiliated with Access Community Health Centers, the same organization described by Serrano and Monden. In order to conform to the practice of their behavioral health consultation service, I began placing my notes in the EHR. Over the first year of the affiliation, I solicited written consent from each patient to allow me to do so. For those patients who did not consent, I dictated separate notes and placed the hardcopies in a locked drawer. During that year, I had 484 clinical encounters with 282 unique patients. Eleven patients (4%) withheld their consent to allow me to place notes in their EHRs.

My experience indicates that when properly explained, the great majority of primary care patients will consent to the placement of behavioral health records in the EHR. Further, many patients were enthusiastic that their primary care clinicians would have ready access to their behavioral health notes. My findings are similar to those of Flynn et al,[5] who found that 5% of patients in an outpatient psychiatric clinic declined allowing their records to be place in the EHR.

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Research doesn't support mandatory influenza vaccination

While the intent of Aurora's mandatory influenza vaccination[1] of health care workers might be noble, ie, patient protection, the research on the subject is lacking. Only 2 studies have tracked hospital-acquired worker-to-patient influenza (a relatively simple infection control metric) and both reported cases in the single digits for an average-sized hospital over multiple complete flu seasons.[2,3] In fact, the latter demonstrated that influenza made up only 23% of strains causing influenza-like illness (ILI), such that the rate for true worker-to-patient influenza infection for a 400-bed hospital is less than 1 case per year. Why? Influenza is a community-acquired disease, and standard infection control precautions (hand-washing, masking those with a cough, isolation, and visitor control) curb transmission in hospitals. Ironically, vaccination is possibly the least effective of these measures, and CDC data and at least 1 study cited below have demonstrated that over the recent past, influenza vaccine is between 40% and 63% effective, on average. Influenza is only one of a host of viruses that can sicken a hospitalized patient, but is the only one for which we have a vaccine. Yet the other control measures I mentioned are efficacious against ALL such organisms. Why don't we make those measures mandatory?

Last year at Mayo Clinic Rochester, we instituted mandatory compliance with an influenza control program for all employees with patient contact: get vaccinated or sign an electronic declination that included education. With over 25,000 such employees, everyone complied, no one lost a job, and 93% chose vaccine vs declination. We emphasized personal, family, and patient protection, and it was perceived as a benefit. We also emphasized other control measures, such as handwashing and staying home when ill, to control the ILIs for which we have no vaccine. Call it "Minnesota nice," but it can be done. Influenza vaccination is important but not worth terminating employment or disgracing a worker by forcing him or her to wear a mask the entire flu season (an alternative control at other medical centers) when there is no evidence that it will prevent infections.

In due time, possibly the next 5 years, we will have a better influenza vaccine that targets common antigens on all strains of influenza and that may not require annual vaccination. Employees who choose not to be vaccinated are not lunatics; they have endured the long lines to be vaccinated, they have been turned away during rationing, they (or co-workers) have gotten influenza despite vaccination. When we have a decent vaccine, like MMR or dT, we won't have to twist arms; everyone will get it. If we are going to regulate and scrutinize our dedicated health care workers any further, let's do it for the right reason. The American College of Occupational and Environmental Medicine's guidance statement[4] outlines a more balanced approach to this issue.

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