An Argument for the Enforcement of Electronic Health Record Cross-Communication

Haig Aintablian, MD — AAEM/RSA President

A 77-year-old patient comes into the ED for a complaint of shortness of breath x 6 months. This is the first time the patient has come to this hospital and there are no medical records in the EHR. The patient doesn't remember what problems they have, but they know they're on some sort of medication for their heart. They deny any kidney problems. You optimize the patient in the ED, see no acute ECG changes, no troponin elevations, but a creatinine of 2.3 and a BNP that is mildly elevated. You admit for heart failure and AKI. Multiple renal and cardiac studies are done in house because his records can't be retrieved. Once they are retrieved you see that his BNP and Cr are within baseline and the patient did not require admission.

EMS brings in an obtunded, short of breath 86-year-old patient from a SNF. You have documents that are limited to a PCP note from one year ago, and a barely legible medication list, as well as some transfer paperwork from the SNF. No POLST or code status can be found. They are teetering toward intubation and you have no family or MPOA to contact regarding medical decision making. You try to call the SNF, but they are not helpful with determining code status. You intubate and resuscitate the patient and they are admitted to the ICU. Two days later a POLST is found with a DNR/DNI status from an OSH. The ICU team must now determine their course of action with this patient.

A 32-year-old female comes in due to abnormal uterine bleeding x 3 weeks. Her bleeding has not changed and she went to the hospital across the city yesterday for similar complaints but was discharged. She doesn't recall what they did, and does not have her paperwork with her. You order a pelvic ultrasound, urine and serum studies, and ultimately find no signs of anemia, pregnancy, and an ultrasound that shows a fibroid. You discharge her with instructions to follow-up with her OB/GYN. Her OSH did the same workup yesterday and had the same recommendations.

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A 24-year-old girl comes to the ED with her dad due to severe headaches x 4 weeks that are associated with morning nausea and vomiting. Neither her nor her father have a lot of medical literacy and are very concerned as her headaches have not gone away. She has a story that concerns you for pseudotumor cerebri versus an intracranial mass. Her dad says that she was just discharged from an OSH last week, and that they did studies but he's not sure what exactly they were. You order a CT scan and perform an LP. Everything is within normal limits. You discharge the patient with neurology follow-up. Her OSH had already done this workup and her inpatient neurology notes showed concern for atypical migraines.

A 43-year-old female comes to your ED with a complaint of severe chest pain radiating to the back. She is asking for pain medications as her pain is extremely severe. She denies having had this before and states that it had just started an hour prior. Her state-mandated opiate screen reveals concern for opiate seeking behavior. However given your concern for both medicolegal and patient risk, you order multiple lab studies, a CTA of her aorta, and give her more than one dose of morphine for what seems to be real pain. You find that her heart and lungs have no significant findings on any of the studies and before you give her the

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results the nurse informs you that she has eloped. In the last day, two outside hospitals had performed similar high contrast and radiation studies after which she also eloped.

These aren't uncommon cases found in the ED – many of them are based on cases I and others have witnessed personally. Multiple times every shift, we are dealt with ordering labs and imaging studies, calling consults, and admitting patients that may not have required these interventions should we have had better access to their complete medical records. I suspect that every specialty has similar grievances regarding the lack of proper communication between EHRs. In one way or another, this topic should be a non-issue, but I also understand why it is.

Sharing large amounts of personal data between EHRs is a massive and burdensome task. It has multiple legal and HIPAA potholes that would need to be paved out. How far back should EHRs share? Should a physician or non-physician provider be allowed to access every single HER record on a patient? What implications will this have on HIPAA? Do you share across city or state lines? What if a patient's records were accessed from a facility in no relation to a patient? How easily could all this data get breached if one facility's EHR were compromised? Should this be an opt-in option for patients? Should we only share the immediate last two weeks of data?

In many ways, sharing between EHRs could be one of the most successful cost-saving measures in modern medicine. It could avoid expensive studies that were done by other physicians, unnecessary consults that stretch our healthcare thin, and costly admissions for chronic problems masked as acute ones. Above all though, it would be an incredible save for our patients, not only by decreasing their healthcare costs significantly, but also by saving them massive doses of radiation and complications from interventions.

American healthcare is complex in many ways, and this issue is definitely not without its entanglements. However, if we, as the next generation of physicians, would like to take back control of our healthcare and optimize it for what's best for the patient, this wouldn't be a bad place to start. ●

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