Despite $30 billion spent to improve it, health information technology rated a top patient safety issue

BY JOSEPH BURNS | APRIL 14, 2016

Just seven years after the federal government announced plans to invest in health information technology (HIT) for physicians and hospitals, those new systems are listed in a report Wednesday as the number one cause of patient safety concerns.

In the report, Top 10 Patient Safety Concerns for 2016, the ECRI Institute said HIT configurations that do not support each other were the number one patient safety issue for hospitals and other health care provider organizations.

Since 2009, the federal government has spent an estimated $30 billion to get hospitals and physicians to adopt HIT and electronic health record (EHR) systems to comply with meaningful use standards, according to Robert M. Wachter, MD, a professor and interim chair of the Department of Medicine at the University of California, San Francisco. Wachter is the author of The Digital Doctor: Hope, Hype, and Harm at the Dawn of Medicine's Computer Age.

That investment in HIT and EHRs moved doctors and hospitals away from burdensome and impractical paper charts, but the new systems have failed to meet the expectations of doctors, hospitals and federal officials. Even second largest safety issue in ECRI’s third annual report—patient identification errors—is related to HIT. EHRs, at least in part, result from HIT and EHR system failures, said William Marella, executive director of PSO operations and analytics in ECRI’s Patient Safety, Risk, and Quality Group.

Number three on this year’s list is inadequate management of behavioral health issues outside of behavioral-health settings, such as emergency rooms and hospitals. That’s followed by inadequate
cleaning and disinfection of flexible endoscopes (reported widely here and here), and inadequate reporting and follow-up of diagnostic and imaging tests.

ECRI is an evidence-based practice center and patient service organization (PSO) as designated by the federal Agency for Healthcare Research and Quality. As a nonprofit organization based in Plymouth Meeting, Pennsylvania, it produced the top 10 patient safety list and guidance from with assistance from patient safety experts to help hospitals, physicians and other provider organizations set priorities and improve patient safety.

HIT and EHR systems have failed to meet expectations for several reasons. “Part of the problem was the rapid adoption of the EHRs that we’ve seen over the past several years to take advantage of the economic incentives for hospitals and physician practices,” Marella said. “Now that we’ve built this fantastic infrastructure, a lot of the systems wind up being interruptive or more of a detraction to patient care.”

Many HIT and EHR systems do not match how physicians how work in clinical settings. “A lot of clinical organizations went into this expecting that IT would solve all of their problems, when in fact IT applications have to be configured to match the clinical workflow,” Marella said. “But the clinical workflow also has to adapt somewhat to be make it manageable within this new environment that we created.”

HIT systems also can exacerbate existing problems involving patient identification. Medical records often contain incorrect patient information, and most hospitals and physician groups have duplicate patient records. HIT and EHR systems have the potential to solve these problems but only if the data being entered is accurate in the first place.

“In that case, you’re basically putting garbage into the system and then you should expect to get garbage out as well,” Marella noted.

On the issue of inadequate management of behavioral health problems, many ER patients with a medical illness also have an underlying behavioral health issue, said Catherine Pusey, ECRI's manager of clinical analysts, patient safety, risk and quality.

“These patients often end up on medical or surgical floors of the hospital where there is a gap in the expertise needed to recognize behavioral health issues,” she said. “This also happens when people are admitted as inpatients, even if they don’t come in through the ER.”

Recognizing that many of the top 10 patient safety problems are well known, ECRI lists the number 10 issue as, “Failure to embrace a culture of safety.” To address these failures, Josi Wergan, a risk management analyst for ECRI, said hospitals and physician organizations need to focus more attention on patient safety.

“You need a great culture of safety in the operating room, but you also need it everywhere else. You need it in all of your clinical areas. It has to be everywhere. It can’t just be in one spot,” she said.