EHR – “ERRORS HAPPEN REGULARLY” (Cont.)

Interviews conducted by KHN with physicians, patients, IT experts, health policy leaders, government officials, attorneys and EHR vendors revealed “a tragic missed opportunity: rather than an electronic ecosystem of information, the nation’s thousands of EHRs largely remain a sprawling, disconnected patchwork.”

Raj Ratwani, who directs MedStar, has used eye-tracking technology to demonstrate how easy it is to make mistakes when performing basic tasks using two leading EHR systems. Ratwani has identified the repetitious box-ticking and endless pulldown menus as leading to “cognitive burden” for providers. In a 2017 study in the Annals of Family Medicine, it was noted that doctors spend 5.9 hours (out of an 11.4-hour workday) on EHRs, compared to 5.1 hours spent with patients. 44% of the time spent on the EHR is focused on clerical and administrative tasks, like billing and coding. An American Journal of Emergency Medicine study estimated that an ER doctor makes 4,000 computer clicks over the course of a single shift.

What can be done to improve the current situation? Raj Ratwani is pushing for a central database to track errors and adverse events related to EHRs. Seema Verma, the administrator for the Centers for Medicare and Medicaid Services, has promised to reduce the documentation burden on physicians and end the gag clauses that have been used to protect the EHR industry from full disclosure of EHR-related adverse events. The Pew Charitable Trust, the American Medical Association and Medstar have developed a resource document, “Ways to Improve Electronic Health Record Safety,” which includes recommendations on how to advance usability and safety throughout the EHR software life cycle. It can be used as the foundation of a voluntary certification process for EHR developers and implementers and includes criteria
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detailing what constitutes a rigorous safety test case and the creation of sample test case scenarios based on reported EHR safety challenges. https://ehrseewhatwemean.org/

Researchers examined usability of the two major EHR systems—Cerner and Epic—which account for a large percent of the U.S. market. Their goal was to identify adherence to basic usability principles by examining the two systems in use. They found large variability by clinical site in time, clicks, and error rates, with some error rates reaching 50 percent. Improved usability and safety require shared responsibility and action from stakeholders, including patients, providers, vendors, and policymakers.

The site has videos of real and simulated EHR usability challenges. The videos demonstrate the wide variation in usability across different EHRs, as well as the challenges observed while using the EHRs in practice. Some videos are screen recordings of an actual EHR, and other videos are fictional representations of an EHR that demonstrate the usability challenges observed during the study. https://ehrseewhatwemean.org/videos/

DIAGNOSTIC OVERSHADOWING (Cont.)
referred to, pejoratively, as “frequent fliers.” Individuals who frequently seek care from emergency departments often have underlying co-occurring mental health and/or substance use disorder diagnoses, yet typically their chief complaint is not related to these conditions, but rather to nonbehavioral medical problems. These individuals are vulnerable to diagnostic errors and provider biases that negatively impact their care.

Patients who have severe mental illness or who are actively using substances can often be labeled as “poor historians,” particularly if there is no one to advocate for them or validate their medical/social history. Providers may rely on documentation from previous visits, copying and pasting previous history into a current note, which may or may not be accurate or relevant. Underlying suspicions or malingering or drug-seeking behaviors can result in a failure to conduct adequate diagnostic testing and treatment. Diagnostic overshadowing can prevent or delay making an accurate and complete diagnosis, even if such conclusions would be obvious in patients without behavioral health conditions.

In the case presented in the Commentary, a 72-year-old woman, with a history of opioid use disorder, presented at an emergency department complaining of epigastric pain. She had abnormal vital signs and an elevated troponin but did not receive further diagnostic cardiac testing or intensive monitoring. The author attributes this lack of vigilance on the part of the treating providers to the patient’s former opioid use overshadowing the correct diagnosis of ST-elevation cardiac infarction.

In a busy emergency department, it is easy to see how this could happen. Harried providers are dealing with conflicting priorities, and a patient with a past history that implies malingering or drug-seeking can easily have his/her presenting complaint minimized in an effort to keep up with production pressure. There are ways to assist providers to side-step diagnostic overshadowing. The Commentary lists three types of interventions:

- Include in health professional training how to care for individuals affected by mental illness and substance use disorders, with an emphasis on this population’s increased risk of co-morbid medical illness and mortality.
Over the ten-year period, nearly two-thirds of obstetrics-related cases and 63% of cases involving a diagnostic error involved high-severity injuries. Conversely, 72% of surgery-related cases involved medium or low severity injuries. Death-related cases accounted for the largest amount of total indemnity, but severely-injured patients under age 40 received the highest payments.

CBS identifies high-severity injuries, with examples, as follows:

- Permanent, significant – sub-optimal management of a non-English speaking patient’s compliance with consults delayed diagnosis of a brain tumor resulting in permanent vision loss
- Permanent, major – patient with vascular occlusions required bilateral leg amputations after a vascular consult was delayed
- Permanent, grave – mismanagement of anticoagulants after a heart attack resulted in patient suffering a stroke
- Death – patient with a history of aortic dissection complained to PCP of chest pain. After an x-ray, patient died at home. Posthumous reading of the x-ray showed an enlarged aorta, which ultimately ruptured.

Patients with severe, permanent (non-fatal) injuries seek compensation – in addition to pain and suffering – to cover the health care costs and lost income of their remaining years (sometimes decades).

CBS points out that high-severity outcomes and a greater likelihood of high payments make these cases focal points for both claims management and risk management. Effective risk-reduction efforts targeting the root causes of high-severity cases should also help reduce less severe events.
CHANGES WITH THE SENTINEL EVENT PROGRAM

We are very pleased to announce that Michelle Caldwell will be joining the Sentinel Event Program. Michelle has direct experience in identification of sentinel events and conducting root cause analyses in her previous work with Maine General Medical Center. Michelle has 27 years of experience in healthcare and has a master's degree in Healthcare Administration. Michelle will begin her work with the SET on July 8th.

We are also announcing the promotion of Joe Katchick to Assistant Director of Compliance and Operations for the Division of Licensing and Certification. Joe will continue to have oversight of the SE Program, and will be an ongoing resource for the SET. Until the SE Manager position is filled, Joe will continue to provide management and direction for the SE Program.