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From: [redacted]
Sent: Thursday, May 16, 2013 2:09 PM
To: CommentPeriod, HealthIT (Thune)
Subject: REBOOT - HIT feedback

Dear Senators, Thune, Alexander, Roberts, Burr, Coburn and Enzi,

My feedback on federal progress promoting HIT adoption and standards is relatively short because it would take hours to intelligently craft words to detail this massive and complex HIT train wreck.

My comments are also anonymous because I was part of an HIT implementation team at my place of employment starting in early 2010. The entire project, from the unproven and unsafe technology to the leaders focused ***only*** on receiving the ARRA incentives, scared me into sleep deprivation and stress like I have never experienced before.

I am not an IT expert. I am a healthcare provider. What I realized over a short period of time was that this massive project was going to jeopardize patient safety and patients would suffer death or injury because of it. Sadly, realizing that I was not in a position of leadership or government to make a difference or to tear down the silos that existed, I gave up and decided to take a job that had absolutely nothing to do with HIT. I was powerless to make a change and I feared for my job and family reputation in the community as I voiced my serious concerns for HIT implementation.

My focus is now defense. I have armed my family with information about HIT and potential dangers. Anytime a family member receives healthcare, we are careful to double/triple check the physician orders written, double/triple check information that is passed from one HIT system to another and double/triple check all treatments and implementation of care. Despite our measures to protect the family member we still experienced numerous and serious medication reconciliation errors within one hospital system while crossing three (3) disparate HIT systems.

You mention five key implementation deficiencies.

- Lack of Clear Path Toward Interoperability.
This is a biggie gentleman! Building interfaces with all of the different software within a typical hospital system is a nightmare. And when changes are made to one interface, the risk is great to disrupt another interface which has great potential to cause patient HARM. In my experience, the different HIT companies do not want to work together for interoperability and the constant building of interfaces is dangerous. True interoperability means getting rid of all the disparate system and having ONE SYSTEM for the entire healthcare experience. And please don't refer to this as socialism or communism. It is for PATIENT SAFETY, which would be "meaningful".

-Increased Costs
My experience is that the HIT implementation at my healthcare system has doubled from the original projected cost! And the project is not yet completed. Much of the cost of HIT implementation is devoted to building and maintaining interfaces. No one had a clue what a project of this magnitude would cost.

-Lack of Oversight
Self-attestation is a joke. I sat in on Meaningful Use meetings, where project leaders only focused on the measures for attestation and the easiest path to meet the measure. No regard for the patient. Is that truly meaningful use? And from the news releases I read, Meaningful Use Stage 2 measures have been watered down. Again, is that meaningful use?

-Patient Privacy at Risk
Data breeches are numerous and a common occurrence. Shouldn't this be corrected or at least minimized before HIT is mandated and implemented?

-Program Sustainability.
Sustainability will be tough and I agree with your comments. Compliance and maintenance costs are unreasonably burdensome, not to mention the time taken from truly providing good care of the patients because the providers are too busy navigating these systems.

The word safety is mentioned just a few times throughout your REBOOT document and "Potential to jeopardize patient care" is mentioned within the five key

implementation deficiencies at the beginning of the document. I am afraid that you are missing thee biggest deficiency of HIT implementation. This technology is not tested and has not been vetted by the FDA. Would you let your mother have a hip replacement with a medical device that has not been clinically tested or a new medication that has not been clinically tested? This technology is complex and is unproven! There is an irrational exuberance that the technology will be the answer to healthcare problems when in fact it has created a nightmare for many healthcare facilities.

I speak only from my experience, but I assure you that the more I have read and researched about HIT implementation nightmares, I took some comfort in knowing that I was not alone in my worries and fears for safe patient care in an HIT environment.

Answers? I regret that I have no clue other than to scrap the entire HIT implementation project until a safer and proven plan can be developed. So many healthcare providers have so much money invested that stopping the project could cause serious financial distress. But in the name of patient safety, stopping implementation would likely be the best answer.

The concept of having a secure network in which providers can share patient data nationwide is a good one. But it is only a dream. It can't possibly be done with the many HIT vendors competing for all the dollars to be had and absolutely no cooperation with each other for interoperability.

I don’t trust HIT. It not innovative, it is experimental. It is a myth that HIT offers productivity, efficiency, reliability, and safety. I have personally experienced the pitfalls as a provider and as a patient family member.

Please read the sites below for well-written and documented concerns regarding HIT implementation that I can’t even begin to address in this feedback you have requested.

http://www8.nationalacademies.org/onpinews/newsitem.aspx?RecordID=12572
So, it was known that HIT effectiveness was poor, had safety issues and usability was poor, but incentives and Meaningful Use criteria were still developed?

http://hcrenewal.blogspot.com

Countless references and documentation of bad HIT.

http://www.ctlab.org/Cook.cfm
Dr. Richard Cook, the lone dissenter in the IOM report that studied health IT safety, ("Health IT and Patient Safety: Building Safer Systems for Better Care").

http://www.ischool.drexel.edu/faculty/ssilverstein/cases/
Scot Silverstein, Veteran physician informaticist. His own mother died from bad HIT. Very Very Sad.

I hope you are able to find answers that will potentially save patients from HIT related injuries and death.

Regards,
Anonymous and Scared for Patient Safety