Medication errors are on the “front burner” again, thanks to the latest report from an Institute of Medicine (IOM) committee. In July, the committee estimated that 1.5 million Americans are being harmed every year because they are being given the wrong drugs. The report drops a broad agenda in the laps of federal regulatory agencies and Congress. The report’s “to do” list includes improvements in clinical trial reporting, drug naming, labeling and packaging, electronic prescribing (e-prescribing) standards, and states’ surveillance of pharmacies, to name a few.

The IOM report reviews the past six years to see what progress has been made in reducing medication errors. This major national problem was first highlighted in its 1999 report, To Err is Human: Building a Safer Health System. The problems identified at that time included sloppy physician handwriting on prescriptions, the practice of drug companies using similar names for different drugs, hospital pharmacies sending the wrong drugs to patient beds, and bedside nurses failing to catch those mistakes.

Six years later, these problems still exist.

“The frequency of medication errors and preventable adverse drug events is cause for serious concern,” said Linda R. Cronenwett, co-chair of this latest IOM committee and Dean and Professor at University of North Carolina’s School of Nursing at Chapel Hill.

“We need a comprehensive approach to reducing these errors that involves not just health care organizations and federal agencies, but the industry and consumers as well.”

Although the report does not engage in finger-pointing, it is difficult to read any of the chapters without suspecting that the committee members felt that little significant progress has been made since the 1999 report. Certainly, the fact that the committee estimated that the 1.5 million people harmed every year has led to unnecessary medical costs—conservatively estimated at $3.5 billion—can be read as evidence of the failure to undertake a more systematic, aggressive effort to stamp out medication errors.

“It’s not as if nothing has been done. The 1999 report spurred the Food and Drug Administration (FDA) to require that most drugs sold to hospitals have bar codes on their labels. However, the report indicates that hospital pharmacies still make errors when they break those large bar-coded containers into smaller unit-dose packages—at an error rate of 17%. Moreover, hospitals, by and large, have not purchased the bar code scanners that would help eliminate bedside medication errors by allowing nurses to read unit-dose packages, which hospital pharmacies sometimes receive from manufacturers and sometimes make up themselves.

The report was particularly critical of the failure of physicians, hospitals, skilled nursing homes, and home health providers to purchase the kind of health information technology that would guarantee lower medication-error rates. The committee cited a 2005 study that looked ahead five years and predicted the use of electronic health records (EHRs) and centralized patient order entry (CPOE) systems by various providers. Those expected adoption rates were unimpressive and, in the committee’s words, “too slow.”

Alan Goldhammer, Associate Vice President, Pharmaceutical Research and Manufacturers of America, says that part of the problem with low adoption rates of EHRs is that drug companies have been restricted by federal law in donating hardware and software to physicians and hospitals. In July, Michael Leavitt, secretary of the Department of Health and Human Services, announced an expansion of so-called “safe harbors,” which delineate the kind of equipment and services that drug companies, pharmacy benefit managers (PBMs), and others can donate to physicians and hospitals without running afoul of federal anti-kickback and anti-self-referral laws. Both the House and Senate have passed separate health information technology (IT) bills aimed at speeding up the adoption of interoperable standards.

Adoption of technology is not the only roadblock to wider e-prescribing. State laws stand in the way, too. Forty-three states currently allow e-prescribing, but they have all sorts of provisions that complicate transition to a seamless, interoperable national EHR system. The Center for Medicare and Medicaid Services (CMS) pre-empts state laws when it comes to physicians using e-prescribing for Medicare patients taking advantage of the new Part D Medicare outpatient drug benefit. But that pre-emption does not affect health care providers who treat patients under the age of 65, and it even creates its own problems to the extent that physicians, for example, have to use one e-prescribing system for Part D Medicare-eligible patients and another system for all other patients. Only the states themselves can fix this problem.

The IOM report also highlights the potential value of medication therapy management, which again comes into play, particularly with the Part D Medicare drug benefit. Medicare patients who take multiple medications, who have several chronic conditions, and who have high drug bills are eligible for medication therapy management free of charge. But the value of these services, in terms of improved health outcomes and savings to insurers, is unproven, according to the IOM report. As a result, the IOM recommends that the CMS get moving in order to get a clearer picture of the value of medication therapy management.

REFERENCE