NEWS RELEASE

**FOR IMMEDIATE RELEASE CONTACT:**

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**ECRI and Health IT Safety Experts Team up to Tackle Alert Fatigue***ECRI’s Partnership for Health IT Patient Safety issues safe practice recommendations to reduce overrides, missed notifications, interruptions from Computerized Provider Order Entry (CPOE)*

**PLYMOUTH MEETING, PA—**A collaborative of national health IT safety experts has released new guidance aimed at improving patient safety by reducing the overwhelming number of alert notifications from computerized ordering systems in healthcare. While alerts can facilitate patient safety, they may also contribute to alert fatigue and clinician burden, says ECRI, the nation’s most trusted voice in healthcare.

ECRI’s *Partnership for Health IT Patient Safety,* a multi-stakeholder collaborative that sets priorities in health IT safety, established a six-month virtual workgroup last year focused on finding ways to reduce alert fatigue associated with Computerized Physician Order Entry (CPOE) systems. Their just-released white paper, [Safe Practices to Reduce CPOE Alert Fatigue through Monitoring, Analysis, and Optimization](https://d84vr99712pyz.cloudfront.net/p/pdf/hit-partnership/partnership_whitepaper_alertfatigue_final.pdf), outlines the workgroup’s processes and key recommendations that provider organizations can take to improve safety now and in the future.

“Alert fatigue is a common occurrence for physicians and healthcare professionals and in extreme cases, can be linked to unintended consequences,” says Marcus Schabacker, MD, PhD, president and chief executive officer, ECRI. “Clearly, clinicians are under enormous stress in this era of COVID-19 and we expect that these new safe practice recommendations will help keep patients safer.”

The [multi-stakeholder workgroup](https://www.ecri.org/hit/partnership-safe-practices-to-reduce-alert-fatigue), chaired by John D. McGreevey III, MD, at Penn Medicine and Adam Wright, PhD, at Vanderbilt University, set out to fulfill two goals: (1) Promote patient safety by optimizing necessary, clinically important alerts and (2) Promote clinician wellness and health IT safety.

“In order to narrow the scope of the project, we looked at alerts associated with CPOE because these are the most common alerts that clinicians experience. CPOE alerts can include drug interactions, drug dosing alerts, diagnostic and treatment alerts, and alerts based on disease or condition,” says Penn Medicine’s McGreevey. “These alerts serve as prompts or reminders that can advise clinicians about safety considerations in the care of the patient.”

The white paper outlines the workgroup’s **four safe practice recommendations**, strategies to address these recommendations, and actions for their implementation. The safe practices include the following:

* Governance—Identify, develop, and execute a Clinical Decision Support (CDS) and knowledge base governance plan
* Monitoring—Gather data and information using CDS-specific metrics and other tools to identify real-time or near real-time CDS alert functioning and impact
* Analysis—Regularly assess, evaluate, and interpret metrics, functionalities, usability, and impact to determine effectiveness and value while balancing and minimizing burden
* Optimization—Maximize the use of technology and various tools to create and promote effective, targeted, relevant, and routinely updated alerts

The [workgroup](https://www.ecri.org/hit/partnership-behavioral-health-workgroup) drew on the expertise of its members and external subject matter experts, an ECRI-conducted evidence-based literature review, and analysis of pertinent patient safety data submitted to the ECRI and the Institute for Safe Medication Practices Patient Safety Organization (PSO) and partner PSOs between January 2019 and February 2020.

“For a majority of the PSO events we analyzed, the alert did not function as expected,” says workgroup co-chair Robert Giannini, NHA, CHTS-IM/CP, patient safety analyst and consultant, ECRI. “An alert that isn’t as effective as intended puts patients at risk and contributes to clinician burden.”

ECRI’s *Partnership for Health IT Patient Safety,* funded in part with financial support from The Gordon and Betty Moore Foundation, was founded in 2013 and wrapped up in December 2020. All of the *Partnership’s* findings and safe practice recommendations and toolkits are available on [ECRI’s website](https://www.ecri.org) and at [www.hitsafety.org](http://www.hitsafety.org).

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## ECRI is the only organization worldwide to conduct independent medical device evaluations, with labs located in North America and Asia Pacific. ECRI is designated an Evidence-based Practice Center by the U.S. Agency for Healthcare Research and Quality. ECRI and the Institute for Safe Medication Practices PSO is a federally certified Patient Safety Organization as designated by the U.S. Department of Health and Human Services. The Institute for Safe Medication Practices (ISMP) formally became an ECRI Affiliate in 2020.

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