



**American Hospital
Association**

Six Children, No Theories

Nancy Foster, VP for Quality and
Safety Policy



John Wilmot
1647 – 1680
Second Earl of
Rochester

“Before I got married I had six theories about raising children; now, I have six children and no theories.”



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Six Theories (circa 2010)

1. Improve caregiver decisions
 - Use EHRs to enter orders
2. Improve patient outcomes
 - Patients will demand clinicians use EHRs
3. HITECH Act will lead others to achieve the improvements boasted about in journal articles



D Blumenthal, M Tavenner
NEJM May 2010

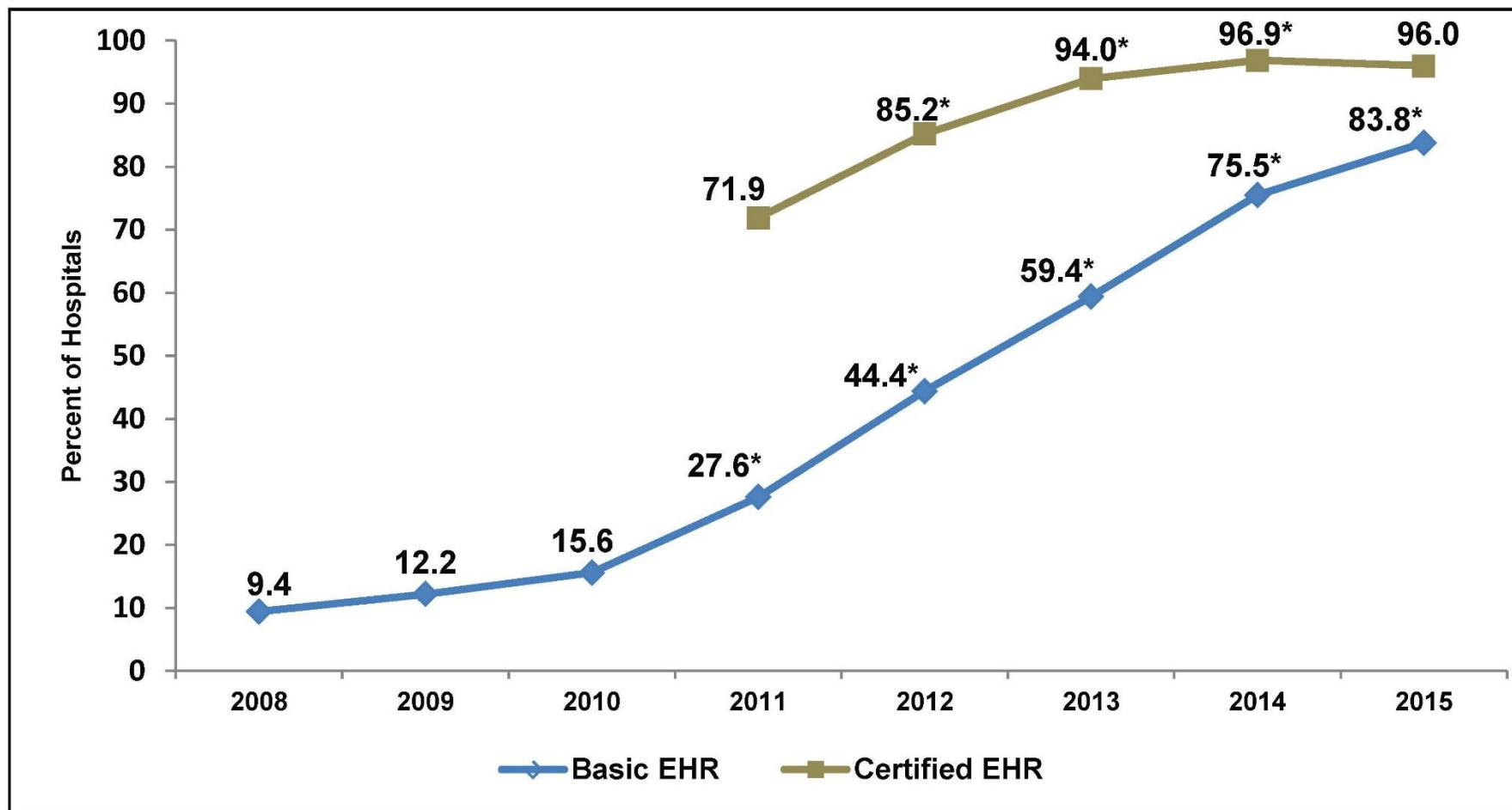
Six Theories (cont)

4. A “nationwide” system of EHRs
 - Interoperability that facilitates care
 - Interoperability that helps track public health concerns
5. “Meaningful Use,” as defined by public policy goals, will lead to better patient outcomes
6. Data will be kept private and secure



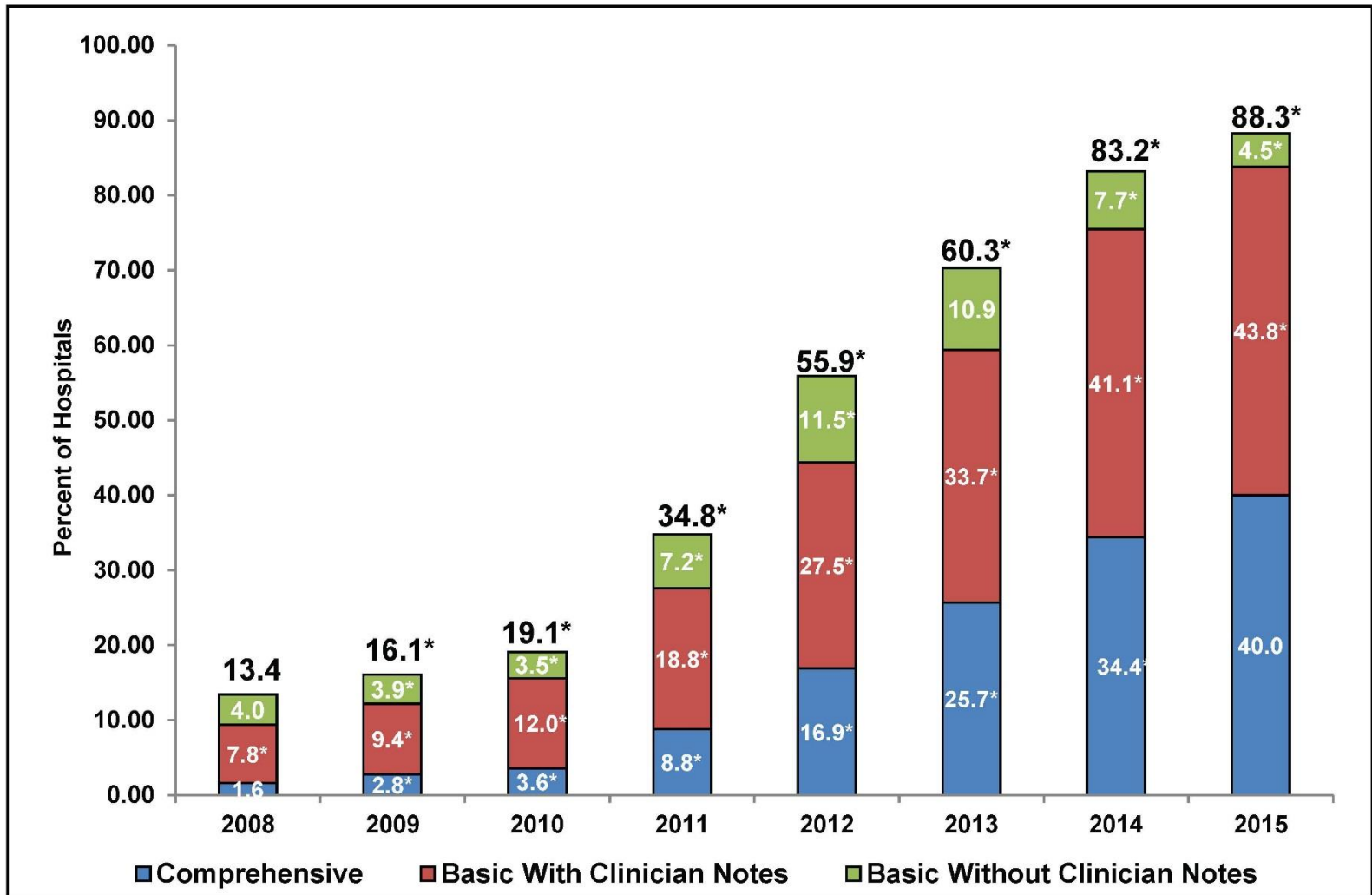
Experience - The Good

Hospitals with EHRs – ONC Data Brief No. 35, May 2016



Experience – The Good

Improvements in functionality - ONC Data Brief No. 35, May 2016



Experience - The Good

- Reliance on EHRs as part of care delivery has increased
- Catches for drug/drug interactions, wrong doses
- Alerts for abnormal lab values, significant findings
- Some using EHR data to predict risk for better management of patients
- Able to support decision-making around test ordering



Experience – Challenges

- Substantial risks from EHR implementation
 - Compounded by the pace of implementation
 - Mismatch between “normal” implementation and MU driven implementation
- Variability in EHRs/implementation leads to variability in risks
 - Daylight between MU requirements on providers and certification requirements for EHRs



Expeirence - Challenges

- Risks from technology itself
 - Device failures – data lost, programming errors
 - Communication failures
- Risks from faulty use of technology
 - Data entry errors, transmission errors = loss of information integrity
 - Impediment to patient relationships



Experience - Challenges

- Risks from mismatch of care functions to device functions
 - Usability challenges
 - Less reliance on incident reports, but are signals clear and accurate?
 - Hard stops and work arounds
 - Copy and paste errors
 - Inadequate updating of clinical support systems
- Risks from lack of interoperability



Reducing Patient Risks – Some Ideas

- Slow the policy-driven imperatives, focus on the clinical imperatives
- Focus on standards that assist interoperability within a facility, between providers
- Align requirements for EHR vendors and providers
- Collect, analyze, and share information on EHR-related errors
- Alter guidelines/ meta-analyses reports to be specific about implications for decision-support programming





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Vice President for Quality and Patient Safety
Policy

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