



The Office of the National Coordinator for
Health Information Technology

Health IT, ONC, and Patient Safety

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Office of the National Coordinator for Health IT



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Paradise Lost



“The average physician wastes fifty to sixty per cent of his time in going from place to place or in the repetition of uninstructional details of practice.”

William Osler, M.D.
(1849 – 1919)

THE EARLY LIFE OF SIR WILLIAM OSLER.
Bulletin No. Ix of The International Association Of Medical Museums And Journal Of Technical Methods.
Montreal: Privately Printed, 1926:143

History of the Office of the National Coordinator for Health IT

- Established in 2004 by Executive Order from President Bush
- Codified in Statute in the HITECH Act 2009, part of ARA
 - » Coordinating & Convening Role across the Federal Government
 - » *Voluntary* Certification of EHRs
 - CMS partnership
 - Meaningful Use, MACRA
 - » Promote Adoption & Use of EHR's
- Priorities identified in 21st Century Cures Act

ONC: Activities and Actions

One Hundred Eleventh Congress
of the
United States of America

AT THE FIRST SESSION

*Begun and held at the City of Washington on Tuesday,
the sixth day of January, two thousand and nine*

An Act

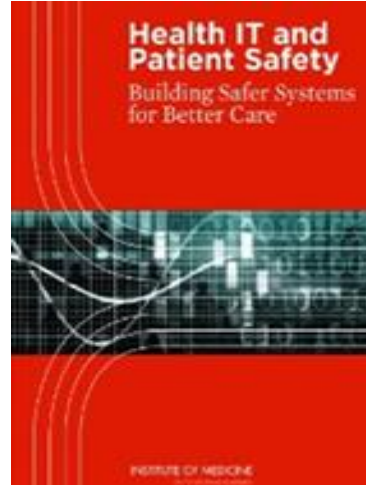
Health
Information
Technology for
Economic and
Clinical Health
Act.

42 USC 201 note.

TITLE XIII—HEALTH INFORMATION TECHNOLOGY

SEC. 13001. SHORT TITLE; TABLE OF CONTENTS OF TITLE.

(a) SHORT TITLE.—This title (and title IV of division B) may be cited as the “Health Information Technology for Economic and Clinical Health Act” or the “HITECH Act”.



Office of the
National
Coordinator for
Health
Information
Technology (ONC)

Health Information Technology
Patient Safety Action & Surveillance Plan

FY2013 - 2015



FEDERAL REGISTER

The Daily Journal of the United States Government

2015 Edition Health Information Technology (Health IT) Certification Criteria,
2015 Edition Base Electronic Health Record (EHR) Definition, and ONC Health
IT Certification Program Modifications

SHARPC
NCCD

ONC Certified HIT

HEALTH IT SAFETY CENTER ROADMAP

Collaborate on solutions, Informed by evidence

MISSION AND PRIORITIES



FEDERAL HEALTH IT MISSION

Improve the health and well-being of individuals and communities through the use of technology and health information that is accessible when and where it matters most.

2017-2018 ONC PRIORITIES

ONC will work to make health information more accessible, decrease the documentation burden, and support EHR usability under 21st Century Cures and MACRA.

ONC 2017-2018 PROJECTED OUTCOMES

	PATIENT	PROVIDER	COMPETITIVE MARKETPLACE
Interoperability 	Movable health records to shop for and coordinate care	Ability to efficiently to send, receive, and analyze data	Improved data flow standards Accessible API's
Usability 	Lower cost of care through greater provider efficiency More eye contact with providers	Burden reduction: <ul style="list-style-type: none"> • Less wasted time • Less hassle 	Ability to support new business models and software applications



INTEROPERABILITY GOAL

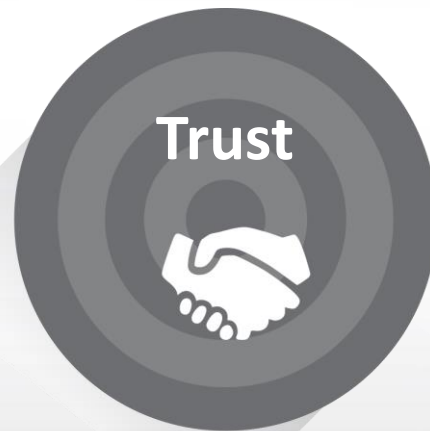
Reliable clinical information flows
to enable communication among services
that make use of health information.

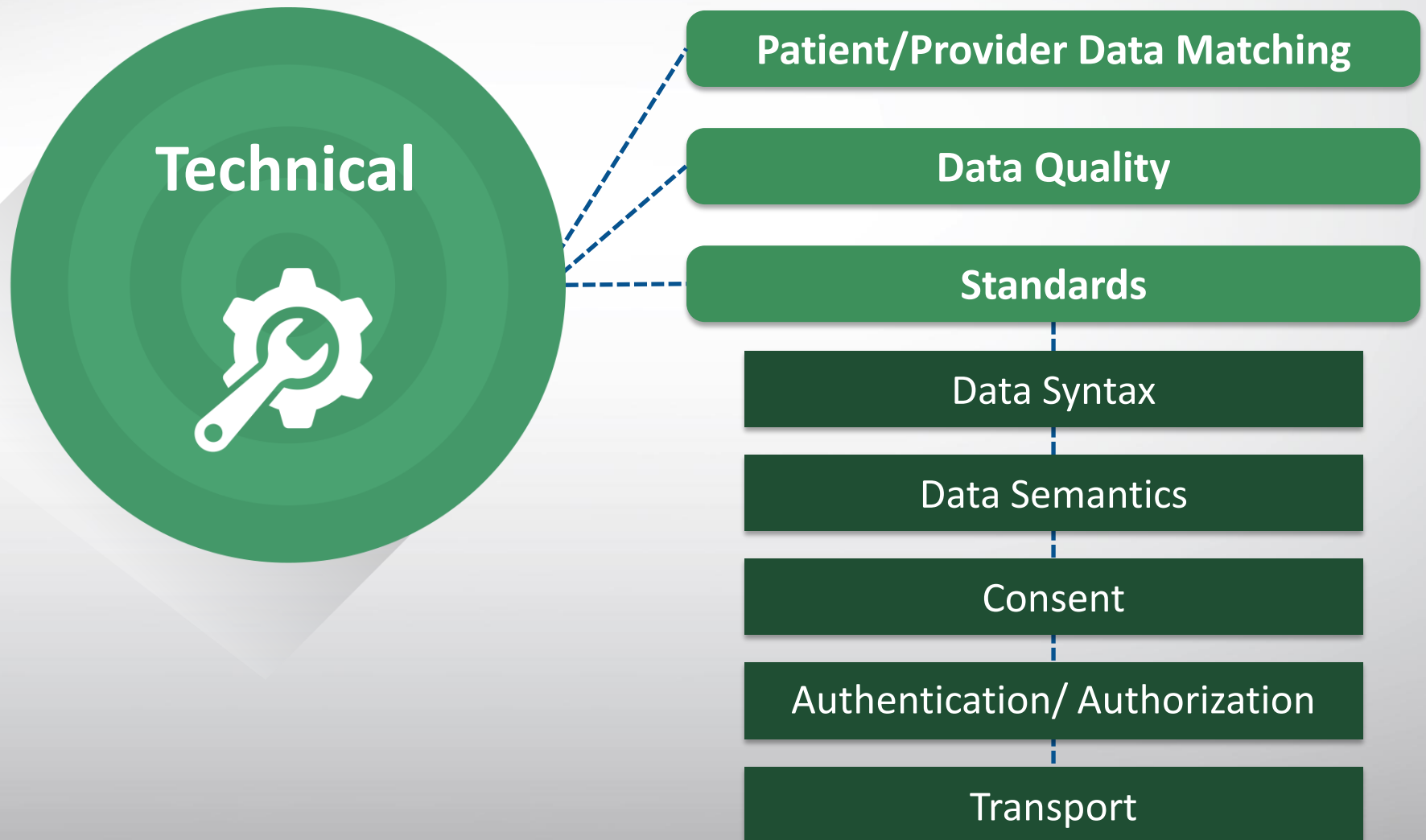
Achieving this goal will support a competitive market
that will give consumers and providers more choices.

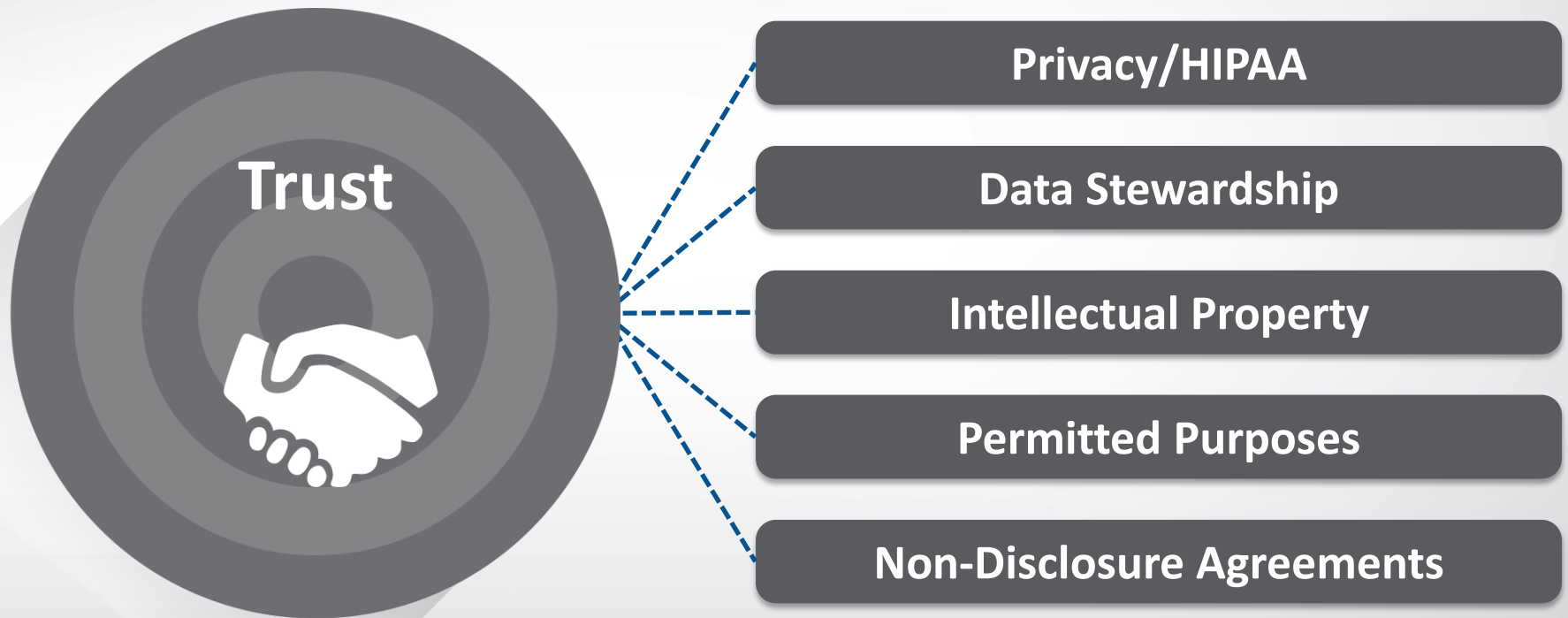
Consumers can more easily shop for
care by accessing and sharing their
electronic record as allowed under
HIPAA.

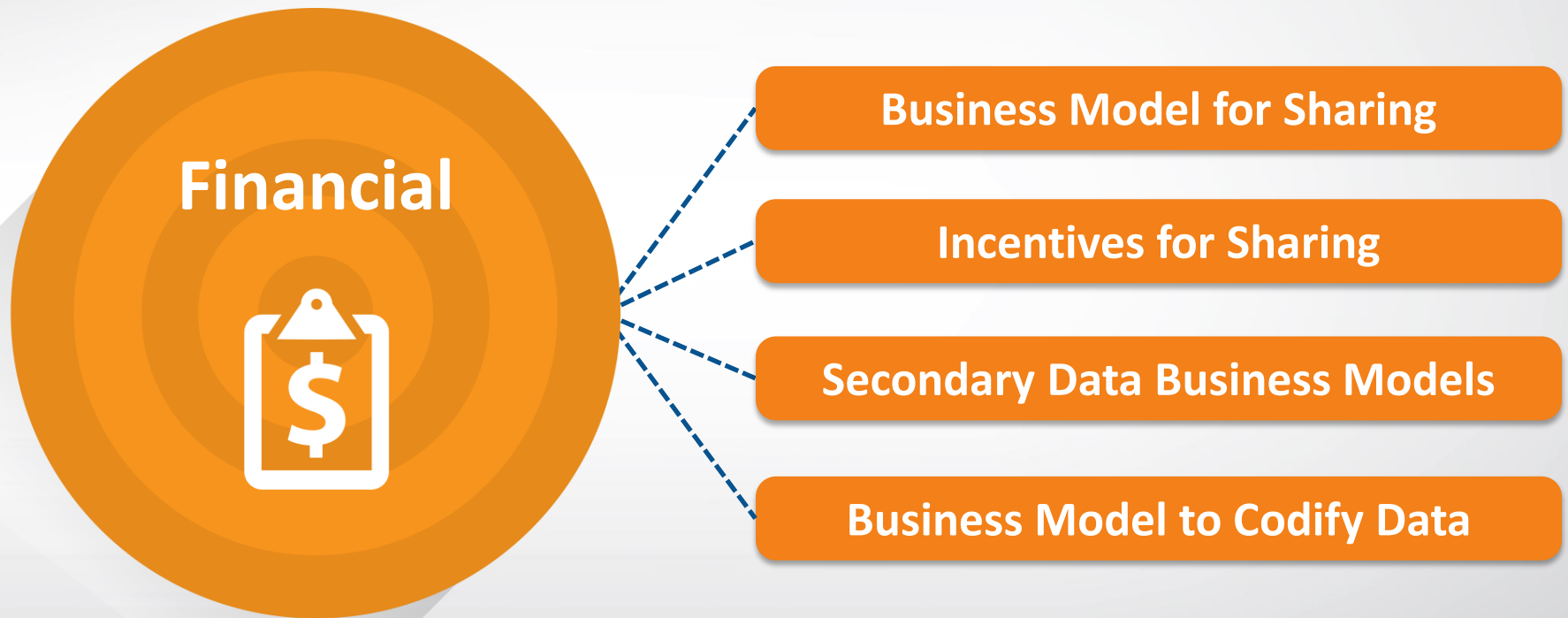
Providers will be able to choose the
products and tools that best meet
their needs.

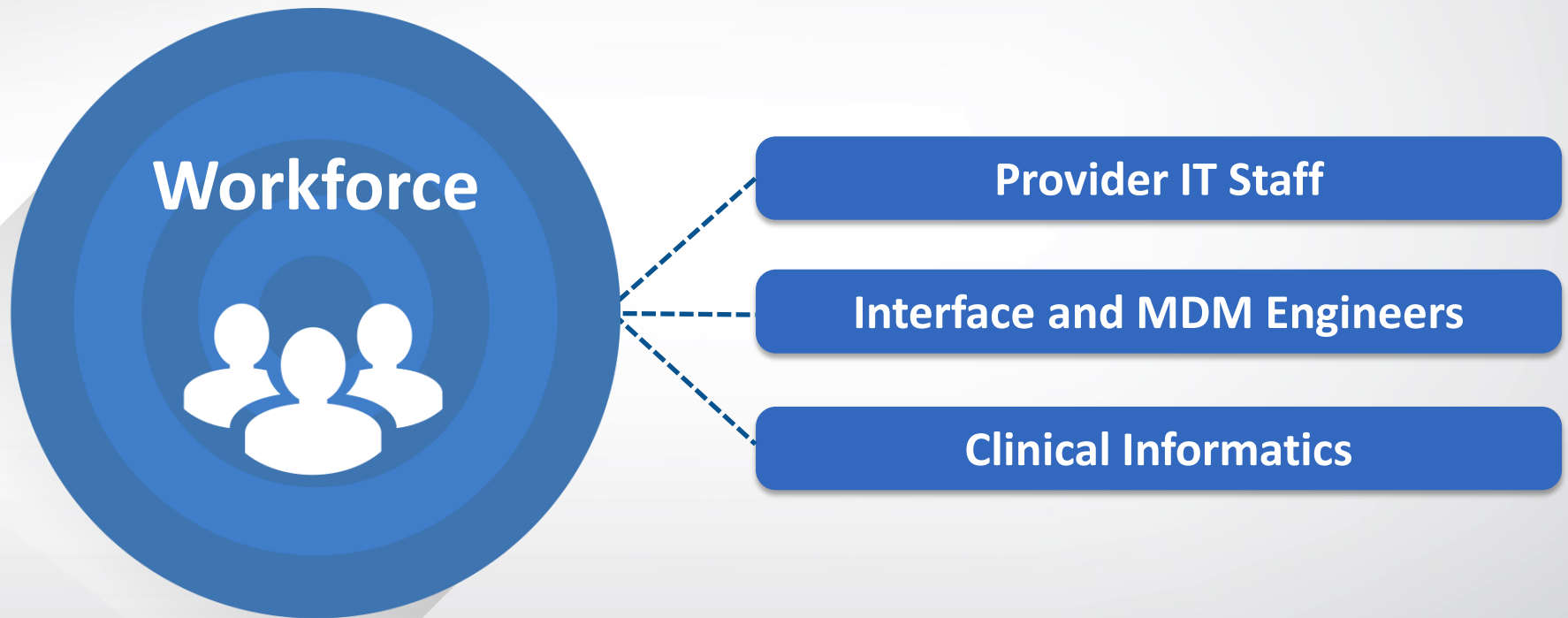
INTEROPERABILITY TARGETS











USABILITY DEFINITION

The extent to which health IT tools are intuitive and easy to use, allowing consumers and clinicians to interact effectively, efficiently, and with a high level of satisfaction. Usability is primarily focused on how easily information can be recorded and used in a health IT tool, rather than the amount of documentation that must be recorded.



USABILITY GOAL

Health IT tools are intuitive and functional so that consumers and clinicians can perform the activities they want and need to perform.

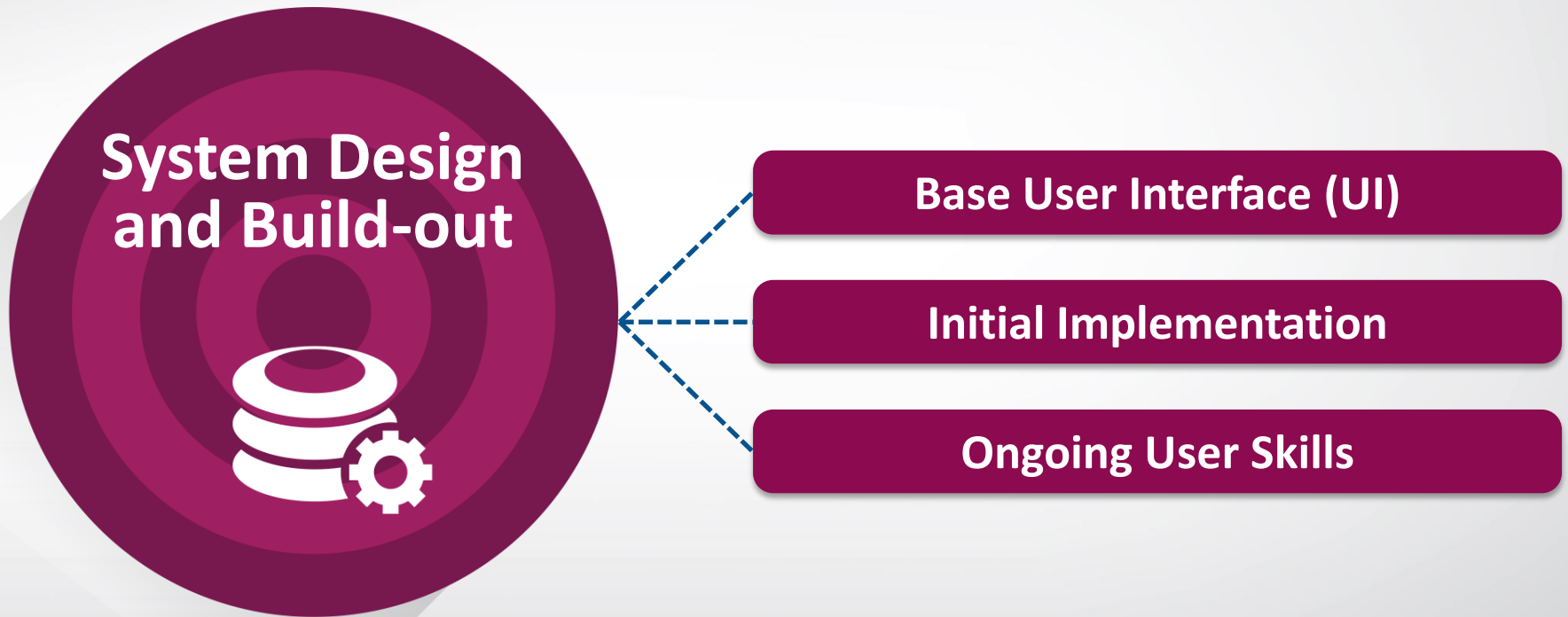
USABILITY TARGETS

**System Design
and Build-out**



**EHR Burdens
and Requirements**





EHR Burdens and Requirements



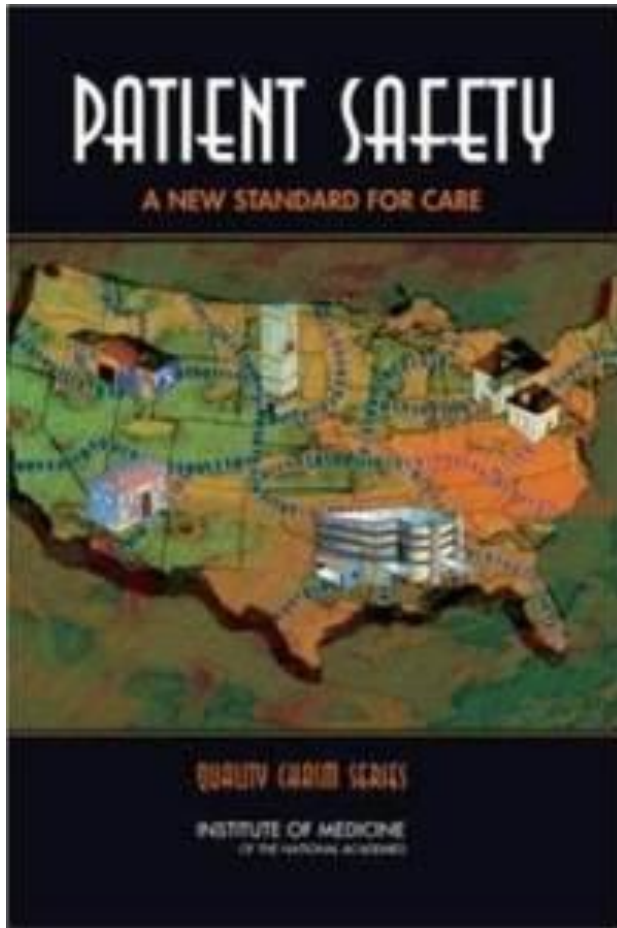
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graph LR; A((EHR Burdens and Requirements)) -.- B[Institutional Mandates]; A -.- C[Third-party Billing/Coding]; A -.- D[E&M Documentation]; A -.- E[Quality Reporting]
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Institutional Mandates

Third-party Billing/Coding

E&M Documentation

Quality Reporting



“The committee strongly believes that patient safety is indistinguishable from the delivery of quality care.”

Paul Tang, MD, Committee Chair
Patient Safety: Achieving a New Standard for Care: November 2003, pg. 6

Sir Cyril Chantler

Medicine used to be simple,
ineffective and relatively safe.

Now it is complex, effective and
potentially dangerous.

The role and education of doctors in the delivery of healthcare.

Hollister Lecture delivered at the Institute of Health Services Research, Northwestern University, Illinois, USA. October 1998. *Lancet* 1999;353:1178–81.

Safety Culture

“...the **core values and behaviors resulting from a collective commitment by leaders and individuals to emphasize safety over competing goals to ensure protection of people and the environment.**”

US Nuclear Regulatory Commission

<http://www.nrc.gov/about-nrc/safety-culture.html>

- **Designed to help healthcare providers & organizations optimize the safety and safe use of electronic health records (EHRs)**
- **Each of the nine SAFER Guides identifies recommended practices, which healthcare organizations can use to self-assess practices associated with safe EHR use.**



Self Assessment

Test Results Reporting and Follow-Up

General Instructions for the SAFER Self Assessment Guides

Perceptions of Hospital Safety Climate and Incidence of Readmission

Luke O. Hansen, Mark V. Williams, and Sara J. Singer

HSR

Health Services Research

© Health Research and Educational Trust

DOI: 10.1111/j.1475-6773.2010.01204.x

RESEARCH ARTICLE

Conclusions: Our findings indicate that hospital patient safety climate is associated with readmission outcomes for AMI and HF and those associations were management level and discipline specific.

climate and higher readmission rates for AMI and HF ($p \leq .05$ for both models). Frontline staff perceptions of safety climate were associated with readmission rates ($p \leq .01$), but senior management perceptions were not. Physician and nurse perceptions related to AMI and HF readmissions, respectively.

Conclusions. Our findings indicate that hospital patient safety climate is associated with readmission outcomes for AMI and HF and those associations were management level and discipline specific.

Key Words. Safety culture, safety climate, hospital readmission



The Office of the National Coordinator for
Health Information Technology

Thank-you & Questions

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