Visionary Viewpoint

AN EXECUTIVE PUBLICATION FROM THE SCOTTSDALE INSTITUTE JUNE 2011

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Previously, he served at the New York City Department of Health and Mental Hygiene as Assistant Commissioner for the Primary Care Information Project, where he facilitated adoption of prevention-oriented health information technology by over 1,500 providers in underserved communities. Dr. Mostashari also led the Centers for Disease Control and Prevention (CDC) funded NYC Center of Excellence in Public Informatics and an Agency for Health Research and Quality funded project focused on quality measurement at the point of care. Prior to this he established the Bureau of Epidemiology Services at the NYC Dept. of Health, charged with providing epidemiologic and statistical expertise and data for decision making to the health department.

He did his graduate training at the Harvard School of Public Health and Yale Medical School, internal medicine residency at Massachusetts General Hospital and completed the CDC's Epidemic Intelligence Service. He was one of the lead investigators in the outbreaks of West Nile Virus and anthrax in New York City, and among the first developers of real-time electronic disease surveillance systems nationwide.

What would you tell a health system CEO to pursue today as organizational objectives in order to not only survive but thrive in the next three to five years?

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I'd say to them: Get meaningful using! This set of activities and processes that are instantiated in the Meaningful Use framework are basically not a checklist of hoops to qualify for incentives. They really are a roadmap for all the quality goals you want to achieve, a great guide for what you want your IS to have and your staff to do to thrive as you become accountable for the care you deliver. For example, let's assume there will be payment based on volume and quality of care. Most CEOs would say that's an eventuality. What can you do in terms of quality measures around people at high risk for heart attacks and strokes, which are the number one killers?

First, measure quality. Measure and monitor your improvement. We don't want measurement done to people. We want people to do measurement, to own it. Second, using registry functions make a list of those patients identified according to high blood pressure, on statins, been offered smoking cessation and so on. Third, you need to remind providers at the point of care when the patient presents. So you need clinical decision support to apply the right care at the right moment. You need CPOE. And all of these require structured data for lab values, problem list, medications. Guess what? They're all in Meaningful Use!

Then you bring in patient centeredness by giving patients an after-visit summary because most of them forget instructions. You provide them with a place where they can access their own medical records.

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Guess what? Meaningful Use! The same thing goes for safety around drug/drug or drug/allergy interactions. If you want to reduce readmissions and report to public health, you are a Meaningful User. It all makes sense if you work backwards from the objective and not as 25 obstacles. I'd say this is your roadmap—designed, deployed, implemented.

In addition to sharing success and lessons learned through Scottsdale Institute programs, how can SI support the ONC agenda for Meaningful Use and reform?

We think a lot about the diffusion of innovation. It's interesting to look at the role of early adopters. In some cases early adopters are incredibly effective at pulling behind them the rest of the industry. They can be active and effective agents. There are other instances when early adopters are wholly ineffective. It depends on who the early adopters are, how well they see the vision and how actively they take it to later adopters. So I'd urge you and your members to brag on yourselves, share best practices, share success and failures and highlight the way technology has been used effectively and efficiently. Tell compelling stories about real people, real doctors in real-life care and coordination.

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You've mentioned that listening to the many diverse stakeholders will be a first step in the new Office. How will you balance differing viewpoints?

I think listening is the first step for the new Office because it was the first step for the old Office. That is part of our identity and DNA. We'll continue to foster an approach that is inclusive, open and transparent. We'll also continue to seek out opportunities for open communication through tools like blogs, request for comment and the ONC website. We've held a public meeting on average every other day for the past two years. We talk to providers, academics, vendors, health insurers. So listening is what we do. But it's also not just taking the arithmetic mean of different points of view but really understanding what is in the public interest. That's our philosophy. And it's within the public interest to keep the momentum going—increasing the number of people to even higher usage. We'll continue to see ambitious but achievable balance. One real insight identified in last week's Policy Committee meeting was that it's not just a question of sooner or later, or easier or harder. How much can we align Meaningful Use with what they have to do. To the extent that Meaningful Use is in a virtuous cycle it will support the system changes needed for new models of payment, and the new payment models will create the business case for even greater Meaningful Use of health IT. Part of what we have to do is change the mindset of Meaningful Use. It's not just a set of requirements. It's an emblem of all that you need to do to be positioned for new payment frameworks like ACOs.

What do you see as opportunities for synergy between ONC's work and federal healthcare goals?

One thing is the excitement regarding the time we're living in and where we are heading. The release of the National Quality Strategy is really meant to be framework for public discussion. The goals of the Partnership for Patients website, include reducing HACs by 40 percent by the end of 2013 compared to 2010. That's something we're aligned with. Their target of a 20-percent reduction in preventable complications during a transition from one care setting to another—we're aligned with that. We need to coordinate with the National Quality Strategy whether it's concerned with patient safety issues like ADEs or preventive measures like aspirin, blood pressure and cholesterol.

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