

Viewpoint

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Dr. Karen DeSalvo is a physician whose 20-year career has focused on improving access to affordable, high quality care for all people, especially vulnerable populations. She has pursued this goal through direct patient care, medical education, policy and administrative roles and as a researcher. As the National Coordinator for Health Information Technology, she is leading the nation's charge to promote, adopt, and meaningfully use health information technology in order to achieve better care, lower costs and improve overall health nationally.

Prior to joining the U.S. Dept. of Health and Human Services, she was Health Commissioner for the City of New Orleans, and New Orleans Mayor Mitchell Landrieu's Senior Health Policy Advisor. While there she transformed the outmoded health department into a modern and effective one, and restored healthcare to devastated areas of the city, including leading establishment of a public hospital. Dr. DeSalvo also served as a professor of medicine and vice dean for community affairs and health policy at Tulane University School of Medicine.

Trained in internal medicine and public health, following Hurricane Katrina she was a leader in building an innovative and award-winning model of neighborhood-based primary care and mental health services for low-income, uninsured and other vulnerable individuals linked by a sophisticated health IT infrastructure.

Dr. DeSalvo earned her Medical Doctorate and Master's in Public Health from Tulane University, and Master's in Clinical Epidemiology from Harvard School of Public Health.

You have published a "10-year Vision to Achieve an Interoperable Health IT Infrastructure" on the HealthIT.gov website. What's driving this initiative and how confident are you that we can realize this goal?

The country is at a pivotal point. We've successfully adopted EHRs, but we need comprehensive information to do patient-centered, coordinated care. That requires interoperability, which is a technical, political and governance issue. Interoperability is achievable in this country. We know the web is ready. We know consumers expect that care is seamless and that the information is there. I'm optimistic.

What are the biggest barriers to interoperability and how can we overcome them? What of initiatives like the Healthcare Services Platform Consortium (HSPC) led by Dr. Stan Huff, CMIO at Intermountain Healthcare?

It depends on who you ask. Most folks would say it's largely about the culture, business and regulatory environment as opposed to technical issues. The number of innovators in the healthcare marketplace environment seeking interoper-



KAREN DESALVO, MD, MPH, MSC, NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY, US DEPARTMENT OF HEALTH AND HUMAN SERVICES

ability on behalf of consumers and doctors is increasing. We are ready for it.

While the private sector has successfully created interoperability in some areas, it has not succeeded nationwide. That's why we need to approach interoperability on multiple fronts including governance, regulatory and culture. We must build upon best practices irrespective of vendor, data source or geographical location. This is less about connecting EHRs than bringing together a broader set of data-trading partners. Interoperability must be flexible and sustainable enough to accommodate genomic, proteomic, patient-generated and public-health data.

You have a strong interest in the interplay of social and environmental factors that affect health and the fact that these factors need to be incorporated into the electronic medical record. How important are these factors in health and how do we make sure they become part of an EMR?

The healthcare portion of an individual's overall well-being--that generated by the inpatient and physician office

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experience—accounts for only about 10% to 20%. On the other hand, there's rich data from the social and non-medical spheres where we live, learn, work and play as well as from sciences like genomics. It's clear we're missing critical information about the health and well-being of a person.

You can't intervene where you can't measure. I don't think this is a short-term issue, nor is it about IT infrastructure. It's information about the environment that surrounds the person, including relationships with trading partners. It's a huge culture change, but it's necessary in order to achieve better clinical and financial outcomes. And it's very intuitive. For example, do low-income seniors have meals on wheels or need transportation support? All of that information should be more seamless.

Patient engagement is obviously a hot issue in healthcare. How do you define it and how valid are metrics like Patient Activation Measurement (PAM) scores?

My first goal for patient engagement is to think about folks as individuals and consumers, and to move them out of the "patient" box. Second, in my academic years I conducted research on self-rated health tools. How would you rate your own health? is a question that turns out to be a powerful predictor of not just current state but future state as well.

People's minds can account for past medical history, family history and a deep intuition about their own condition. You can roll all this up into a single question that's about as good as big data. I am a believer in giving a strong voice to the individual.

Project Blue Button was launched a few years ago as an initiative to standardize patient access to his or her own clinical information. What's the status of Blue Button and how successful do you believe it will be in fostering such access?

Blue Button is a really important part of our platform. It's a pull to get consumers and caregivers to demand more

seamless information, but also to improve care and build a bridge to value.

Blue Button is incredibly successful at the VA, where millions of patients use it. Pharmacies like Walgreens want to share information through Blue Button. We're launching a number

of PSAs for consumer marketing this fall. What I see in the marketplace is the desire for more of a person-centered architecture, cloud-based but private—kind of a B2B on steroids.

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You bring a strong background in public health to the ONC. How will we integrate public health and private medical care?

Public health and medicine—Hygieia and Panacea—are sisters in Greek mythology. However, public health became more marginalized as we focused on things like antibiotics after public water systems were built. We have hit the ceiling with medicine as life expectancy has plateaued. That's why public health is in ascendancy now. It deals with more environmental factors and social determinants of health. The Ebola outbreak demonstrates more than ever how medicine and public health need each other.

Before coming to Washington to take the job as National Coordinator for Health IT, you spent much of your career in Louisiana. What lifelong lessons did you learn from Hurricane Katrina and its aftermath, which not only destroyed hospitals but ultimately left a completely new community than what existed before?

What I learned was that with a shared vision people can accomplish anything. And if you put people first, it's easy to leave baggage or agendas at the door. So, whenever we run into obstacles at the ONC, we remind ourselves that we're coming to work every day to make lives better. I became very optimistic about people after we gathered together following Katrina.

*~ Chuck Appleby
Director of Publications & Communications
cappleby@scottsdaleinstitute.org*



STANLEY R. NELSON, Founder & Chairman Emeritus (1926–2012)
Donald C. Wegmiller, Chairman • Shelli Williamson, Executive Director
1660 Highway 100 South, Suite 306 • Minneapolis, MN 55416
Phone: 952.545.5880 • Fax: 952.545.6116
scottsdale@scottsdaleinstitute.org • www.scottsdaleinstitute.org