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National Committee on Vital and Health Statistics
Hearing on Meaningful Use of EHRs
April 28, 2009

Good afternoon, thank you for the opportunity to testify

I am Dr Farzad Mostashari, Assistant Commissioner with the NYC Department of Health. Congress was wise to offer funding in the HITECH Act for the “meaningful use” of electronic health records. By doing so, Congress created a mechanism to safeguard their intent that this unprecedented public investment not treat technology as an end to itself, but rather result in concrete progress towards policy objectives-- measurable improvements in health, and reduction in costs.

To fulfill this intent, we must work backwards from the desired outcomes in order to determine meaningful use metrics and the scope of work for regional extension centers. Implementation of the HITECH provisions can then proceed along a consistent pathway from product development, to EHR implementation, to practice redesign, quality monitoring, and ultimately, reimbursement reform that will both benefit from, and sustain, these activities.

This is the "glide path" we seek.

Virtually every health reform strategy under serious discussion includes encouraging more organized systems of care, and increasing accountability for health care quality and cost outcomes. The transformative potential of health IT is to provide the information necessary for organized care delivery, and drive transparency in health quality outcomes. This is the end-point for meaningful use- incentive payments tied to "measures that matter" that will sustain improved clinical outcomes (e.g., blood pressure control), evidence-based care (e.g., smoking cessation therapy and aspirin use), patient safety (e.g., potential adverse drug events), continuity of care, patient satisfaction, and compliance with public health reporting.

Meeting these end-points will require practices to engage in new processes (e.g., electronic prescribing, patient outreach), to embrace health information exchange (e.g., medication histories, clinical summaries, notifiable disease reports), and quality reporting. The mid-point criteria for “meaningful use” must be strong enough to spur these real changes in care processes, but focused enough to be feasible for motivated practices in all settings to achieve.

What fuels these processes is information; electronic data that can be queried and collated. This is the beginning of meaningful use- collecting and documenting the critical data elements needed for organized care processes, continuity of care, and quality reporting. Smoking status must be asked, blood pressure must be measured, electronic problem lists maintained, and allergies and medications documented, and laboratory interfaces established.

There is reasonable concern that even such a stepwise escalation of ‘meaningful use criteria,’ could overwhelm many small private practices that lack ready access to IT expertise. What I can add to this discussion is our experiences at the NYC Primary Care Information Project.

With spending authority from public funding, we established a master contract with a commercial EHR vendor, eClinicalWorks, a little more than two years ago. As we detailed in a recent Health Affairs publication¹, we worked closely with the vendor to develop new functionality that supports prevention and population management, including integrated registry functions, point of care decision supports for providers, and automated quality measurement.

We have reached out to primary care practices that serve Medicaid patients, and have signed agreements with over 1700 providers in small practices, community health centers, and hospital outpatient departments. In the city’s three most underserved communities over 53% of small practices are in our program. In a little more than one year, over 1,000 providers in over 150 of these independent medical practices were brought live with a 99% implementation success rate.

We provide boots on the ground project management support for implementation, and post-implementation technical assistance around effective use of the EHR to protect patient privacy, and improve practice efficiency, safety, and quality of care. We have used our scale and technical expertise to convince commercial laboratories to grant electronic interfaces to even small practices, worked with NY State Medicaid to provide 90 day medication fill histories back to providers, and created a clinical hub that could link our practices to local RHIOs or personally controlled health repositories when they are operational.

Without creating a massive centralized data warehouse, we are receiving monthly utilization reports that enable us to identify and help practices use the record more effectively (e.g., documenting allergies in structured format that can be used to provide alerts). Developed through funding from AHRQ, standardized quality reports on a small set of key clinical outcomes (like blood pressure control among patients with diabetes) are visible to providers and reported to the department. Quality data from these practices as well as NYC practices using two other popular commercial EHR products are being used in an innovative and robust trial of pay for quality, and will be shared back with practices for benchmarking purposes. Developed through funding from our CDC Center

¹ Mostashari, F., M. Tripathi, et al. (2009). "A Tale Of Two Large Community Electronic Health Record Extension Projects." *Health Affairs* 28(2): 345-356.

of Excellence in Public Health Informatics, the Health Department is also receiving electronic reports of immunizations, and daily reports on trends in respiratory febrile and gastrointestinal diseases that are helping us monitor the swine flu outbreak in NYC today.

I know there is much work to be done before we reach our goal of improved community health, but at a cost to government of about \$20,000 per provider, our regional extension center has ensured that our practices, including the solo practitioner in a storefront in Harlem will qualify for the physician payments in 2011 and forward, by any likely metric of meaningful use.

Some will say that the difficulty of changing physician practice means that we should set low goals for meaningful use, perhaps simply adoption of certified records in the early years. But providers don't want to implement technology. They want to improve care for their patients. Any effort, however well intentioned, to "help" them by reducing meaningful use to simply adopting technology will not only fail to improve care or costs, but is also likely to fail at engaging most small practices in EHR adoption.

Setting a standard for meaningful use that is consonant with the mission of health care providers, and supporting them through robust and empowered regional extension centers is our best bet.