

Good morning, Chairman Gottfried and members of the Health Committee. I am Farzad Mostashari, Assistant Commissioner of the Primary Care Information Project at the New York City Health Department. I testify today on behalf of Commissioner Frieden. Thank you for the opportunity to discuss how we can ensure that New York State has a strong primary care system, capable of delivering quality health care to all New Yorkers.

We support statewide efforts to restructure and reform our health care delivery system to achieve universal health insurance and provide access to health care for all New Yorkers. We agree that these are very important goals. But if the goal of universal coverage is to make as much of a difference as it should in New Yorkers' health status, then we must simultaneously address the quality of care that is currently being delivered and it is toward that goal that my remarks are addressed.

Public health has traditionally focused on promoting structural changes to support healthy lifestyles and behaviors. And to be sure, this is the "sweet spot" of public health, to change the context in which people live through legislation, advocacy and policies such as fluoridated water, the Smoke-Free Air Act of 2002, eliminating trans fats from restaurants, or improving access to healthy fruits and vegetables. Yet, it is also true that tens of thousands of people in New York City and State could live longer and healthier lives with improved preventive care and better management of chronic conditions.

Recently, the Partnership for Prevention ranked the relative value of 25 clinical preventive services. They estimate that increasing the use of just 5 specific preventive services would save more than 100,000 lives each year in the U.S., including

- Increasing from 50% to 90% the number of adults who take aspirin daily to prevent heart disease;
- Increasing from 28% to 90% the number of smokers who receive medication or other support from their health care provider to quit;
- Increasing from less than 50% to 90% of adults who are up to date with colon cancer screening;
- Increasing from 37% to 90% the annual flu immunization rate for adults; and
- Increasing from 67% to 90% the number of women 40 and older who have been screened for breast cancer for the last five years.

And, the report goes on to point out the profound health disparities which are masked by these numbers. For example, Latino smokers are 55% less likely to get assistance to quit smoking from a health professional than white smokers; and Asian women aged 18 – 64 are 25% less likely to be screened for breast cancer than white women. These disparities are the not failure of communities of color but the result of a badly functioning health system which does not value prevention and primary care. This, in spite of annual national health care spending of \$2 trillion.

Similarly, surveys consistently show that New Yorkers are not receiving adequate primary care. This is particularly true among low income and uninsured New Yorkers.¹ In New York City alone, 1.5 million adults have hypertension, and only 31% of them have their blood pressure under control. More than 200,000 adult New Yorkers have diabetes but don't know it. More than half of New York City adults are overweight or obese. In 2005, 1,000 New York City adults learned that they had AIDS at the same time they found out they were HIV positive.²

The primary care system does not deliver health, efficiency or equity; it is filled with redundant, unnecessary, and sometimes harmful interventions, while evidence-based life-saving measures are delivered only about half of the time.³ Health disparities are not effectively addressed. We, at all levels of government, as purchasers of health care, and as guardians of the health and safety of the public, have a responsibility and an opportunity to create a new policy landscape for healthcare.

That is why the New York City Health Department is committed to working closely with you and other government and community partners throughout the City and

¹“Barriers to Care Among Racial/Ethnic Groups Under Managed Care,” Phillips, KA, Mayer, ML, And Aday, LA, Health Affairs, July/August 2000

“Patterns of Primary Care Utilization: A Survey of Community Residents in Bedford-Stuyvesant,” November 2002

“Managed Care in NYC: Low Income Consumers’ Experiences,” Community Service Society, February 2005

² New York City Department of Health and Mental Hygiene, 2004 Health and Nutrition Examination Survey.

³ New England Journal of Medicine by Elizabeth McGlynn et al, called “The Quality of Health Care Delivered to Adults in the United States,” June 2003.

State to promote a primary care system that is--as the Institute of Medicine called for in 2001--safe, effective, patient-centered, timely, efficient, and equitable.⁴

This is the type of primary care that physicians want to deliver – and what most people want to receive. But in order to live up to the promise of primary and preventive care, we need to take action today to reinforce our primary care infrastructure and begin planning for a system that has the capacity to deliver the outcomes we want.

Today, you're going to hear a range of approaches to building a high-performing, quality primary care system that include everything from improving access to care and addressing workforce shortages to ensuring the financial stability of our primary care safety net. The Health Department believes that electronic health records lie at the core of three key strategies to transforming our health care system. First, all providers – especially those serving patients with Medicaid and the uninsured – must be supported to adopt prevention-oriented health information technology. Second, financial incentives need to be aligned to support primary care, using quality measurement methods that utilize clinical data. Third, we need to rethink primary care service delivery--including who delivers the care, when it gets delivered, and how it is delivered--to support a business model that is flexible and patient-centered.

First, as Mayor Bloomberg said in February of 2007, let's set this goal: Five years from today, every doctor's office, clinic, and hospital in America that accepts Medicaid and Medicare must be using prevention-oriented electronic health records. Today, less

⁴ Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century*. March 2001.

than 5-10% of medical providers nationally are using electronic health records. Most of the systems developed to date have focused on in-patient, not ambulatory care and on documenting and billing for the patient visit, not on using electronic systems to improve the quality of care or focus on prevention.

Using city, state, and federal funding, the Health Department's Primary Care Information Project is distributing a prevention-enabled electronic health record to primary care providers who care for Medicaid and uninsured patients. This EHR is interoperable with regional health information exchanges and other electronic health records, and incorporates clinical decision supports and quality measurements based upon Take Care New York's 10 priority preventive services. While this effort will cover about 1400 New York City providers with a high proportion of Medicaid and uninsured patients, more is needed locally and statewide. Payers, providers, health insurance plans and government must all make a commitment to invest in EHR systems.

Second, the financial incentives for medical providers are misaligned. Reimbursement is often based on the quantity of services provided rather than quality; is skewed towards payment for costly interventions rather than prevention measures, and favors procedures over primary care. Yet it is cheaper by far to pay for someone to receive a flu vaccine than a hospitalization for a serious case of influenza. Asthma hospitalizations are reimbursed, yet time spent teaching a patient to use their inhaler correctly is not. Reimbursement rates for prevention activities such as blood pressure checks, vaccinations, smoking cessation counseling are often low or non-existent.

Telephone consultations to help keep someone out of the emergency room may not be reimbursable, yet the emergency room visit would be.

We need automated collection of clinical quality measurement data from EHR-enabled providers that would be used as the basis for physician benchmarking, recognition programs, and a “pay for prevention” incentive structure that rewards primary care doctors who succeed in keeping people healthy. That means not focusing on processes, but rather on clinical outcomes, including the key preventive services that would improve population health.

The State and City should greatly expand prevention through programs that recognize physicians and provide enhanced reimbursement to primary care providers who offer care according to the best practice clinical guidelines, and for quality outcomes. Current quality measurement methods and data rely on the use of aggregated administrative claims data for quality measurement. However, if quality measurements are going to be used for significant incentives or recognition programs that will change physician behavior and improve outcomes, the data has to be timely, and tied to clinical measures. For example a prevention program would focus on blood pressure and cholesterol measurement and control rather than number of visits for hypertension or ordering a cholesterol blood test. Most significantly, however, EHRs can give practices the tools they need at the point of service. Rather than receiving a report card which tells them about their failures after the fact, during a patient visit, they could receive an alert that says, “this patient needs a flu shot, click here to order.”

Third, by deploying trained professionals into new and expanded roles, such as patient navigation, case management, care coordination, and teaching patients self-management skills, the primary care system will be able to provide care that is more efficient and will have better outcomes for patients. This system improvement will require ensuring that the services of non-physician health care workforce, such as nurse practitioners, physician assistants, care managers, and nutritionists, be adequately reimbursed. It is unrealistic to expect physicians to deliver high quality, patient-centered care on their own. Physician recognition and incentive programs could potentially sustain physician practice improvements including EHR implementation, practice redesign and care management and coordination necessary to improve outcomes.

Fully implementing EHRs and changing to a team approach to manage patient care, requires a commitment to payment reforms that compensate providers for this enhanced level of care. Physician teams should be reimbursed for patient outcomes with rates that reflect time spent coordinating care, and not just for face-to-face encounters. These reimbursements could come in the form of an additional case management fee that is per member per month for capitated programs, or a fee added to service and procedure rates.

Now, let's imagine combining the power of EHRs with a team approach to care management. For example, an electronic health record will allow a provider to quickly and easily print out a registry report on all patients with uncontrolled hypertension, so that a nurse can call them to encourage them to fill their prescriptions, to find out if they are taking the medication according to the physician's directions, or if they have

increased their exercise or improved their eating habits, and to provide assistance in accomplishing any of these activities.

In summary, a modern and effective primary care sector that is well resourced and meets the needs of New Yorkers, will require the following reforms:

- **Help medical providers and institution adopt prevention-oriented electronic health records**
- **Implement a system of care that “pays-for-prevention”**
- **Promote the development of an adequate primary care workforce in New York**

Thank you again for the opportunity to speak to you today.