of stress on depression, investigators did find a main effect for physical activity, such that those women with increased physical activity were less likely to develop high levels of depression symptoms 3 years later.

Data from the Women's Health Initiative (WHI) is available for review at the WHI website: http://www.whi.org. Ancillary study proposals, joining working groups, writing groups, and new paper proposals are actively supported by principal investigators at most of the 40 sites. Dr. Charles B. Eaton, senior author on the above paper, is the Principal Investigator at the Brown University, Pawtucket WHI site, and is glad to support any NAPCRG affiliated investigator interested in the WHI datasets. E-mail: charles_eaton@mhri.org.

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AAFP INTERVIEW WITH FARZAD MOSTASHARI, MD, MS, NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY

AAFP News Now recently sat down with Farzad Mostashari, MD, MS, head of the Office of the National Coordinator (ONC) for Health Information Technology (IT). This office is responsible for rolling out the various health IT incentives and penalties contained in the Health Information Technology for Economic and Clinical Health (HITECH) Act, which was enacted as part of the 2009 American Recovery and Reinvestment Act.

Many physicians who have adopted health IT in the form of electronic health records (EHRs) have expressed disappointment with the technology as it currently exists, so we asked Mostashari some of the questions family physicians have been asking the AAFP.

Q Physicians were told at the beginning of the EHR era that after the hard work of implementation, they would see the value of their investment in terms of gained productivity. How close are we to achieving that promise?

A If physicians just replicate the existing paper-based processes in a digital way, they probably are not going to get huge productivity gains. But if they redesign the care flow to designate what things are done by people versus what's done through the EHR technology, then that really adds to productivity. That's how I would summarize the experience of folks who have made EHR implementation a wonderful business decision.

It's important for physicians who have found productivity gains and value in their EHRs to share their stories. We know that successful implementation can be done, and is being done, by many excellent physicians who were able to—and I think this is the key—change their processes to take full advantage of their EHRs.

Q Many physicians are not seeing the expected financial return on investment after EHR implementation. Why is that?

A How you implement the technology has a lot to do with the results you achieve. But the bigger issue is how the compensation system is designed. If physicians are operating in a fee-for-service environment, then many of the gains of EHRs—for instance, in quality, safety and patient engagement—aren't reflected in revenue. Physicians are doing more work and delivering better care and service, but the added value is not reflected in the reimbursement.

We've been an advocate for making sure that when value is added, it's reflected in increased physician reimbursement whether it's through the patient-centered medical home (PCMH) setting, value-based purchasing or part of an accountable care structure. That's where the ability to manage information— not just for individual patients but for populations—becomes an absolute necessity, because in those models, it's not a question of whether there's a return on investment with electronic health records. A physician can't function in those models without an EHR.

Q Some recent research on EHRs has suggested that technology does not always improve patient care. Any ideas on what's holding back progress?

A If you look at different studies, you'll find some variance in terms of results. There are two things to pay attention to here. First, what does the *bulk* of the evidence say? If you actually do an evidence-based review of the literature—and we asked the RAND Corp. to do that for us—you find that upward of 80% of all studies on EHRs show positive results. So the evidence is there, but clearly there is a perception that the technology isn't helping physicians improve care.

That brings me to the second point. I think we have a natural tendency to focus on things that are counterintuitive. For instance, Kaiser (Family Foundation) published a study with 100,000 patients with diabetes and found that their care was dramatically improved with EHRs. That study didn't get much column space. But a small study (conducted by another researcher) that was focused on one setting with one particular EHR found there was no improvement in care quality. *That* study got a lot of ink.

Your readers believe in evidence and data, and I think we have to look at the data carefully. For instance, computerized provider order entry reduces (adverse) medication safety events by 48%, on average. That's not a hypothesis; there is no question about it. But we also have to recognize that it's not "auto magic." Implement this, and presto, you improve quality. Implementation is just the first step in gaining quality improvement. It's also important to learn from our failures and successes, identify the bright points and ask, "Why did technology work in this instance?"

Q Interoperability is one of the most important long-range goals of nationwide EHR implementation. How long will it take the country to get there?

A There is a sequencing issue, and we've got to operate first and then interoperate. If we don't collect data in standard ways, then when we share information, we're sharing garbage. So, the first step is to collect that information in standardized ways. Stage one of meaningful use was mostly about that. For stage two, we're going to move toward a single standard. We brought everyone together, and there over 100 organizations that participated in the process. It took 9 months, but we now have a consolidated clinical architecture file that is the standard that will be adopted by every EHR vendor that wants to get certified in 2014.

We all want interoperability, but it takes time to work through the very real technical issues because *this matters*. If we make a wrong decision here, it's literally life and death. There's not going to be a single date when everything is perfect. But during the next two years, there's going to be a palpable difference in terms of the ability to share information.

Q Stage two of meaningful use is very focused on patient engagement. How does this part of the rule benefit family physicians?

A One of the other things that happens in stage two is patient empowerment and an expectation that patients should be able to get a copy of their records. I know that many of your readers are going to be hesitant about this. I know there are concerns. But I'm also hearing from providers who say, "You know what? I'm going to take this as an opportunity to really engage patients as partners."

I'm asking physicians to embrace this as an opportunity and make it part of their workflows to educate and encourage patients to go to the practice website, download their records and view them. I think doing so will yield multiples (in terms of good outcomes) for our health care system.

Q Physicians make significant investments in technology, and yet, the systems they purchase today may not be adequate in 5 years. Will government money continue to flow to family physicians to purchase and implement EHRs?

A My best guess is that after 2015, the HITECH Act will provide incentive payments only to Medicaid providers through 2021.

Technology is just part of the cost of doing business. But if you look at health care in general, we spend about 2% of all revenue on information technology; in banking, the financial sector and information sectors, it's about 8%. The key in health care will be getting value out of those investments by improving quality and safety and by creating better patient experiences. Doing so should translate into higher incomes for physicians.

Q You talk to physicians all the time about health IT. Are doctors happy with their EHRs? What major concerns continue to surface in those conversations?

A The National Center for Health Statistics did a rigorous survey of office-based physicians in America and got a 68% response rate. Of those responders, about 15% said they were dissatisfied with their EHRs. I think that number may grow, because as we expand beyond the early adopters, the expectations for usable and intuitive technology are higher. I sure hope that the EHR vendors are hearing the same levels of dissatisfaction from their customers and their prospective customers that I'm hearing. I hope vendors are focusing on user-centered design in the next iterations of their software instead of adding more bells and whistles.

Q EHRs help physicians code more accurately for services provided. However, for some family physicians, an increase in the number of 99214 and 99215 evaluation and management (E/M) codes they billed has triggered a Medicare audit. Can you respond to physicians' frustration on this issue?

A Physicians have to be careful about using features that make it too easy to make a mistake and document something they didn't do. If an EHR speeds up documentation and makes it more convenient, that's fine. But it really is the obligation of the physician to accurately state what he or she did that was medically necessary for the visit. We've lived with that for a long time now with E/M coding, and it hasn't changed with electronic health records. The physician is still the one who is responsible for saying, "I did this, and I stand behind it."

If physicians accurately document all the care they provide and it justifies the higher level of payment, they will be fine. The audits will be fine.

Sheri Porter
AAFP News Now