CTCTF Testimony: Doug Ashinsky
January 7, 2016

I would like to thank the ONC for asking and allowing me to give testimony for the Certified Technology Comparison Tool Task Force. Unfortunately, I am away today, January 7, 2016 and will only be able to give written testimony. I will not be able to give oral testimony or respond to any questions that the task force has in relation to my testimony or in order to help them gain a full understanding of the issues

My name is Dr Douglas Ashinsky. I am a board certified Internist who has been in practice to 28 years. I am a Fellow in the American College of Physician(FACP); As per the ABIM website, I am a participant in MOC(maintenance of certification); I am one of the original ONC Health IT Fellows chosen by the ONC; I am a Physician Vanguard as chosen by the REC of NJ(NJHITEC); I have given talks on EMRs and was one of the first physicians to attest the Meaningful Use in NJ in 2011 and I have attested to Meaningful Use each year afterwards and have just attested to Meaningful Use Stage 2 for 2015.

I am also a small practice physician; I am a solo internist in practice as part of a larger organization. My office consists of me (as the only physician); a nurse, a receptionist and a part time office manager. I am the solo provider of care for the patients of this practice and this a large practice of over 3500 patients. So as the solo physician, it is my responsibility to take care of all those patients, to see, talk and care for them. This is how medicine has been practiced for 100's of years; personalized care to the patients and the ability to speak to the physician. I am on call 24 hours/day; 7 days/week which gives patients absolute power to speak with me whenever needed and full engagement in their care

My office is part of an IPA and has participated with this IPA for more than 10 years successfully. My office is also part of an ACO which participates with many commercial payers as well as in the MSSP (Medicare shared saving plan). Over the past 2 years, this ACO has done well and has received Medicare Shared Saving as well as clinical coordination fees and shared savings from the Commercial Payers.

My office with me as the solo physician, is thus at the forefronts of Health IT and as a solo Internist can give opinions as to what allows a small practice to function well. I can inform this committee what is helpful for a small practice and what is harmful and hurts small practices. Small Primary Care practices have shown in several studies to be the most cost efficient in health care and recent studies even show that the preventable hospitalization rates for offices of 1-2 physicians is much less than that of larger practices: **(**http://www.aafp.org/news/practice-professional-issues/20140820smallpractstudy.html, http://www.healthcaredive.com/news/the-impact-of-practice-size-on-readmission-rates/299529/)

Medicine is a quickly evolving entity and it evolution has greatly increased over the past several years due to technology advances. What we thought could never be done in the past, can now be done. One such technology that was instituted, which many believed would help in these changes, was the advent of the EMR (Electronic Medical Record). The EMR was thought of as a method to "digitalize patient data"; in other words the elimination of the paper chart by digitalizing the data which would allow for the ability for a patient to have the portability of their records. This portability would give patients the ability to update and have accurate full patient charts available whenever and wherever a patient was.

This would thus enhance the quality of medical care, reduce the disparities in medical care and in thus reduce the costs.

However, this is not what happened. Instead of allowing the IT innovators and creators create and continue to allow the EMR to evolve (as most things do on the internet), the government through the ONC has handicapped the process. Rules, regulations, data capturing, quality measures, population management were established by "non-clinical bureaucrats" and these measures would be what physicians would be judged on. These "non-clinical bureaucrats" believe they and not the physicians know what quality care is and how to achieve it. In addition, physicians have felt that these "non-clinical bureaucrats" compel them to use a poorly functioning EMR by inflicting penalties on them for not using the EMR. Medicare is now penalizing those physicians who do not meet their guidelines for EMR and thus some primary care physicians are deciding to opt out and not accept Medicare for their elderly patients. Is this what we what to do when there is already a primary care shortage? And for those physicians who will continue to accept Medicare, should they be penalized for not meeting guidelines designed by "non-clinical bureaucrats" on a poorly designed EMR which has not shown that it improves care? (**http://www.kevinmd.com/blog/2014/08/love-old-people-will-accept-medicare.html, http://blogs.marketwatch.com/encore/2013/07/29/more-disgruntled-doctors-leave-medicare**)

The ONC has allowed the vendors to use the old technology of a billing system, add an EMR of poor quality onto it and call it a "certified EMR". These EMRs put a poorly designed systems into the exam room. These poorly designed EMRs do not enhance the relationship between the patient and the physician. These EMRs force the physician or physician extender to click and tab on a computer in order to meet ONC or CMS guidelines instead of addressing the patient who is in front of the physician. How would you feel to be the patient in front of a physician who is pouring their heart out and see the physician with their head buried in the computer? Is that how we enhance and improve Healthcare? Shouldn't the physician be looking directly at that patient who is talking to them? In addition, none of these guidelines set forth by these "non-clinical bureaucrats" have been established to have clinical validity or achieve better medical care. In fact, a recent study shows minimal correlation of Meaningful Use with improved clinical quality and in some cases, there was actually poorer quality (**http://medicaleconomics.modernmedicine.com/medical-economics/news/does-ehr-meaningful-use-lead-better-care-quality**)

Due to the burdens of these rules, regulation, quality measures, and other data gathering measures set forth by the ONC and CMS, the small independent practice is no longer financially viable. It forces the small practice or the independent practice to give up their autonomy and join a larger group in order to remain financially viable. This change of small practices being taken over by large groups does not help the quality of patient care. Several studies have shown that small practices have lower rates of preventable hospitalizations than of larger groups. Other studies show that when the small practice is bought by the large group, the cost to the patient for the same visit, procedure or test increases in price: (**http://www.nytimes.com/2015/02/07/upshot/medicare-proposal-would-even-out-doctors-pay.html?_r=0, http://www.latimes.com/business/healthcare/la-fi-hospital-physician-costs-20141021-story.html**)

So how does this translate into the questions that the Certified Technology Task Force is asking? Well, let's go back to the beginning of the establishment of EMRs and Meaningful Use. In 2009, Certified EMRs and Meaningful Use was established. In the year 2009, this "Certified Technology Comparison tool (see attached Excel Spreadsheet)" would have been very useful. At that time, most physicians were independent and when they were told should consider obtaining an EMR to digitalize and improve the portability and accessibility of patient's data and charts, this "tool" would have been of great value. Most of us knew little about what an EMR was, could do, what certification meant, what population management was, what data blocking was and what "interoperability" was. This tool would have been of great value prior to going to the conferences and exhibits where EMRs were displayed and physicians needed the knowledge about the EMRs before buying the technology.

However, we are now in the year 2016; since 2009 the percentage of physicians who are independent has been greatly reduced and some have estimated it to be less than 20%: (**http://www.physiciansfoundation.org/uploads/default/Health_Reform_and_the_Decline_of_Physician_Private_Practice.pdf**)

And the ONC statistics show that at the present time the rates of physician offices and hospitals having a certified EMR is greater than 73% (**https://www.healthit.gov/sites/default/files/data-brief/2014HospitalAdoptionDataBrief.pdf**)

So my question to the Certified Technology Task Force is why we are spending so much time, effort and healthcare dollars on a tool of little significance. At the present time there are not many physicians who remain independent. There is even a smaller percentage of those independent physicians who have not purchased or currently use a certified EMR. The time, effort and healthcare dollars that are being spent on this Certified Technology Comparison Tool should be spent on something that will improve healthcare. It would be better spent on stopping "data blocking by the vendors" changing the "10 year Roadmap to Healthcare Interoperability" to a 1-2 year roadmap and make "interoperability" happen quickly. If we really want to improve the care to patients and reduce costs to the patient, we need immediate "interoperability" of the EMRs and the ONC should force the vendors of the EMR to cooperate in achieving this goal.

The Certified Technology Task Force must also know that when a small or independent practice joins a large group, they don't have the choice of what their EMR they will be using. Usually part of their contract includes that they will adopt the EMR of the large group. Thus the independent practice which is joining a larger group does not need this tool nor will use the tool. They will simply adopt the new EMR

Additionally; the Certified Technology Task Force must also know how expensive it is to change EMRs. If a small, midsize or large practice wants to change EMRs they to spend a tremendous amount of money to do this. The practice will need to pay the cost of obtaining their patient data from the old EMR vendor, pay for the new EMR, pay for the new EMR set up and training, and then pay the new EMR vendor to take the old EM data and upload it to the new EMR. These costs are extremely high (much higher than estimated by the EMR Vendors) and limit the ability for many practices to change their EMR and the EMR vendors know this. There have been reports of EMR Vendor "data hostage" when a

practice wants to change EMRs: (**http://www.bsminfo.com/doc/ehr-vendor-holding-patient-data-hostage-0001**)

So I ask the Certified Technology Task Force the following; I understand that as part of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Congress requested a study to "examine the feasibility of establishing one or more mechanisms to assist providers in comparing and selecting certified EHR technology products". However, I implore the task force that instead of wasting the time, efforts and money necessary to put this tool into place, that they ask Congress not to spend this time, effort and healthcare dollars on something that is not of much use.
(http://thehealthcareblog.com/blog/2015/12/28/why-meaningful-use-has-to-go)

I implore this task force to see that the time, effort and dollars could be spent better to improve healthcare by using it to improve the currently available EMRs and improve the portability of the patient data by speeding up the process of "interoperability". In my office, even though we have a "certified EMR" and have been using the same EMR for 6 years and have attested to Meaningful Use for 5 years, my nurse and receptionist spend up to 50% of their days scanning documents as "pdf files" into the patient's chart and then figuring out how to manually add it to the chart so it becomes "structured data". This is an absolute waste of healthcare resources. This is NOT HOW WE IMPROVE HEALTHCARE. Use this time and effort to create an EMR which is not intrusive in the doctor/patient relationship and actually enhances the visit. If this cannot be done then I implore this task force to recommend "Mothballing the current EMR/MU system". Let's learn from our mistakes and create a better system using IT innovators, with physician and patient input, and eliminate the excess rules and regulations. Use this time to make a certified EMR system which is "interoperable" between physician offices, hospitals, labs, nursing homes. Such a system will improve patient healthcare and reduce the costs of healthcare. . As per recent AMA survey, physicians want and have embraced adapting new technologies at a blistering rate. An AAPS survey found that 80 percent of the physicians surveyed felt EHRs impede patient care and almost half say patient safety is at risk. (**http://www.healthcareitnews.com/news/ehr-use-frustrating-time-suck-physicians-tell-american-medical-association**)

Now that I have given the background to what would be useful to the US Healthcare IT system and improvement in patient care, I will answer the questions put out by the Certified Technology Task Force for a small primary care practice.

First, what should the "tool" look like and in what formats should it be in. I have enclosed a tool which was provided to me by my Certified EMR vendor which includes most of the valuable assets needed by physicians in small practices. I like it in the Excel format but would also want it available in a Word, Adobe Acrobat pdf and Power Point Format. This way, physicians can use whatever format they prefer. If such a tool existed in 2009, I would have used it to help make the decision as to which EMR I would want. Once again, though, in 2016, when most small practices are being bought out by larger organizations and are being told which EMR they will be converted to, this tool is of little value. And for those small practices that have not started using an EMR, this tool could possibly help them make a decision on choosing and EMR. It can also help them make the decision to remain as is and not adopt an EMR.

Secondly, how important is it that the EMR is fully integrated into the hospital or healthcare environment. This is a question which has many answers based on what the practice is, how it operates and what its future plans are. Most small primary care practice physicians want an EMR that is "interoperable" between it and all of its hospitals. Thus, when a patient is admitted, all data will automatically interfaced into the patient's charts as structured data. My office has an interface and uses the same EMR as one of the hospitals that I have privileges with. This improves patient care and reduces the burdens of my practice since the data from the hospital data does not have to be "manually added into the chart so that it becomes structured data". However, even though we use the same EMR and have an interface, a large percentage of the data does not flow directly into the patient's charts and still has to be "manually added". Again, the lack of "interoperability" is the problem. If my EMR could actually talk with and send and receive actual data from other systems, this would greatly enhance patient care and in turn reduce healthcare disparities and cost. The current systems don't do this and the "transition of care documents" are an actual waste of time and effort and do not enhance the care of the patient. Thus having the same EMR as one's hospital is helpful but it is not the most important aspect in choosing the EMR for a small office.

The small practice needs a versatile EMR that is "interoperable" with all the hospitals, facilities, labs and organizations that it interacts with. It needs to be low cost. It needs to have low maintenance costs and low IT costs. IT needs to have minimal needed add-ons since most vendors charge extra for any add-ons requested by the small practice. In other words, it needs to be a "complete EMR". It needs the ability to be easily upgraded at no additional costs. It needs to have low educational and training cost on learning how to use it or whenever there is an upgrade or addition. It needs to have a "training team" that actually has had experience in a small office; training in a small office is much different than training in a large office. Most importantly, though, it needs to enhance the doctor/patient relationship and not just be a conduit for obtaining structured data on the physician's practice which will be used by CMS or insurance companies. It needs to be a nonintrusive in the doctor/ patient encounter. For the doctor or patient, it needs to be virtually invisible during their encounter.

I hope that the Technology Comparison Task Force reads and thinks about what is expressed in my testimony. I would have wanted the opportunity to have given this as oral testimony and to be able to answer any questions that the Task Force has for a small practice. If needed, or if the Task Force wants more information, they can easily contact me at a convenient time and we could discuss the above. I really hope that the Task Force understands what is currently happening in the Medical Field. I hope it uses its expertise to enhance the patient experience and the doctor/patient relationship. By doing this, we can improve the quality of healthcare through the use of Health IT and by enhancing the quality we will have patient engagement, reduction his healthcare disparities and reduction in Healthcare Costs.

CERTIFIED TECHNOLOGY COMPARISON TOOL

Instructions: The intent behind reviewing these categories and identifying metrics is to identify gaps in the existing marketplace, and what the barriers to providing this information might be. The spreadsheet below includes the categories discussed during the meeting, as well as some questions that were raised during the meeting. Please respond to the questions using the drop-down options provided. Feel free to provide additional context in the "other comments" cell (column J).

Comparison Categories: *(column A)* these are high-level categories that will permit an environmental scan of the existing comparison tool marketplace and identify gaps in key areas within which providers may want to compare CHIT modules. The descriptions provided under the category headers are examples and are not meant to be an exhaustive list of category content.

Metrics for Comparison: within each comparison category, there may need to be some consistent metrics that providers need and/or want to see in order to compare CHIT modules. For the purposes of identifying gaps or barriers in the existing marketplace, please consider what these metrics could or should be. These metrics could include functionality, cost, usability & accessibility, and/or user reviews. There is currently some overlap between comparison categories and comparison metrics. That overlap is highlighted by an *.

Comparison Category	Does this category include CHIT functionality?	Are there data sources that provide information that is comparable across products?	How important is usability/ease of use to the user for this category?	How useful would a tool be without usability/ease of use information for this category?	How important is cost to the user for this category?	How useful would a tool be without cost information for this category?	Do you feel this category is in scope for the comparison tool?	Should this be a comparison category, or a metric by which CHIT is compared?	What aspects of this category are most important in a comparison tool?	Other feedback
Regulatory Requirements (Identifies which certified health IT modules meet federal program requirements)										
Practice management/ financial system integration (Scheduling, billing, payment processing, financials, integration of these platforms with certified health IT)										
Privacy and security (Certification criterion mapping, ease of use)										
Usability & Accessibility* (User experiences as related to workflow and patient safety; Identifies products that provide accessibility-centered design)										
Data migration (Data portability, functionality to support effective migration, support payer audits and court-ordered documentation)										
Population health management (analytic functionalities, panel management, case management)										
Patient engagement (Patient access to health information, API, secure messaging, bill pay, scheduling, patient generated health data)										
Interoperability services* (HISP connectivity, e-prescribing, public health interfaces, ability to connect to other EHRs, other interfaces (lab, radiology, etc.))										
Transition to Alternative Payment Models (APMs) (Provides guidance on selection of modules to support APM activities)										
Quality improvement (Availability of practice-relevant clinical quality metrics, ability to track performance over time, reporting architecture, audit accountability, data storage)										
Total cost of ownership* (Information is provided on the base cost of the product, service charges, maintenance and support, interface for labortory and other ancillary services, hardware costs, and any other recurrent fees)										