Good Morning. Thank you, members of the HIT Policy Committee, for inviting me to participate and share my experience with Meaningful Use -- and possibly improve it.

My name is Dr. Douglas Ashinsky, and I am a Board certified Internist, fellow in the American College of physicians, and a solo practitioner in Somerset County, NJ a suburb of NYC. You have my biography and you can see I am at the fore-front of technology in the medical field. Our office attested to Meaningful Use Stage 1 for 3 years, and we attempting to attest to Meaningful Use Stage 2 now. We are an NCQA Recognized Patient Centered Medical Home (Bridges to Excellence Level 3) and also NCQA recognized in Diabetes Care.

As a solo practitioner, my job is to be a physician, clinical coordinator, care coordinator, data imputer, quality coordinator, patient portal administrator, IT coordinator, etc. In other words, not only am I the physician provider but I am the front and back end user of the electronic medical record of my office and need to fully understand what the EMR can and cannot do.

Meaningful Use was designed to eliminate paper charts and digitalize patient data into an electronic health record. This increases data transparency. The hypothesis being if physicians met Meaningful Use, their quality of care would improve, and costs would be reduced.

Instead, physicians call it “Meaningless Use”. Reaching meaningful use guidelines has forced a computer, laptop, or tablet between the physician and his patient. This reduces the eye contact and interaction between patient and physician, because the physician is clicking, dictating or typing on his computer to meet actuarial and bureaucratic endpoints. These endpoints are not based on Evidence Based Medicine or any type of medical research and are quite arbitrary.

A recent article published in JAMA Internal Medicine examined these arbitrary endpoints. It was a first-of-its-kind, well-controlled study at clinics affiliated with Brigham and Women's Hospital in Boston. It compared the quality scores of 540 physicians who achieved MU with 318 physicians who did not. The study found "[MU] was associated with marginally better quality for 2 measures, worse quality for 2 measures, and not associated with better or worse quality for 3 measures.”

And this is what I want to discuss during the rest of time. My office attested to MU Stage 1 and is in the processes of attempting to attest to MU Stage 2. However, many of you, I would hope, know how difficult this is. CMS released data on May 1st and that at that time only 4 Eligible Hospitals had attested and 50 Eligible Professionals had attested to Stage 2. These statistics are "mind-blowing."

There are many reasons why these numbers are so low and will probably remain low this year. Beth Israel Deaconess Medical Center's CIO predicted 80% of hospitals will fail to successfully attest to Meaningful Use Stage 2 within the allotted time.

So I ask this committee: Was Meaningful Use implemented to improve the care given and reduce the cost of medical care? Or was it applied to penalize hospitals and physicians? I hope the answer is the former and this committee will realize what is happening in the medical field. Primary Care physicians are the "backbone" of medical care – but according to CMS only account for 2% of Medicare spending. Primary Care Providers are being driven out of medicine by all the rules and regulations thrust upon them. It is alphabet soup trying to meet MU Stage 1, MU Stage 2, PQRS, CPCI, PCMH, SNOMED CT coding, ICD-9, ICD-10, ACO's, etc. All of these have caused increased stress with severe mental, physical, emotional and financial burnout of primary care physicians.

The AMA wrote a letter last week to CMS with many valid points, including the observation "unless significant changes are made to both the current program and future stages then:

a) many physicians will drop out of the MU program -- and this is not what we want
b) patients will face disruptions and inefficiencies in their care because existing EMRs are unable to migrate data or facilitate more coordinated care
c) thousands of physicians will incur financial penalties that will hinder future technology purchases
d) and limit resources dedicated to advancing care
e) outcomes based on delivery models, which require data driven approaches, will be jeopardized

I agree with the recommendations and wish to enter the AMA's recommendations to this committee on Meaningful Use. They include:

a) Remove the existing program's "all or nothing" approach to items and replace it with a 75% met rates
b) Allow physicians who meet at least 50% of the MU requirements to avoid financial penalties
c) Add some flexibility to the threshold required to earn MU incentives
d) Remove the concept of "core" versus "menu" items
e) Remove any mandates that are outside the control of the physicians
    - The arbitrary numbers included in the requirements for MU Stage 2 -- such as patient secure messaging, patient use of VDT (view, download and transmit) and patient portal use -- are beyond the physician's control and are influenced by patient's preferences
f) Streamline the quality reporting programs; physicians who participate in PQRS successfully should be deemed as successfully meeting meaningful use measures
g) MU mandates should be evidence based
h) Costs to obtain MU mandates must be taken into account
    - Costs include cost for the multiple interfaces that needed, cost to have a "direct address" which unlike an e-mail address is not free, costs to establish relationships with cancer or specialty registries, etc.
i) Many of the problems with EMRs stem from the certification process, which is overly rigid and complex. It hinders vendors from delivering high quality - high performing products.
    - The process should promote and focus on the products ability to incorporate data and provide value to physicians and patients

I want this committee to listen to what a real physician has to say about meaningful use stage 2 before implementing MU stage 3. This committee should look back at what Meaningful Use was designed and supposed to accomplish - to improve the quality of care delivered in the USA.

We need to take into account the data and financial burdens Meaningful Use has put on physicians. We need to keep the positives from MU stage1 and Stage 2 and STOP the Meaningful Use calendar. Instead, with input from real physicians, redesign Meaningful Use so that physicians stop calling it "Meaningless Use."