American College of Physicians
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September 23, 2014

Chairman Ron Wyden
Senate Finance Committee
221 Dirksen Senate Office Building
Washington, D.C. 20510

Ranking Member Orrin G. Hatch
Senate Finance Committee
104 Hart Senate Office Building
Washington, D.C. 20510

Chairman Tom Harkin
Senate Committee on Health, Education, Labor and Pensions
731 Hart Senate Office Building
Washington, D.C. 20510

Ranking Member Lamar Alexander
Senate Committee on Health, Education, Labor and Pensions
455 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Marilyn Tavenner, RN
Administrator
Centers for Medicare & Medicaid Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

Karen DeSalvo, MD, MPH, MSc
The Office of the National Coordinator for Health Information Technology
U.S. Department of Health and Human Services
200 Independence Avenue S.W. Suite 729-D
Washington, D.C. 20201

Dear Senators Wyden, Hatch, Harkin, Alexander, Administrator Tavenner, and Dr. DeSalvo:

Up until this year (2014), the Meaningful Use (MU) program has been successful, where success is defined as:

1. Accelerating EMR adoption, which had previously been moving at a snail's pace, to one of rapid adoption;
2. Quickly bringing doctors, other clinicians, and staff to a modest degree of competency in EHR and health IT use; and
3. Making personal health information more broadly available to patients, families, and consumers.

The MU program was thoughtfully drafted and, at least initially, executed in iterative stages – acknowledging the hard work of learning new workflows such that care provided during and after the learning processes was safe and effective. Early in the MU program there were many supporters in the provider community – where idealistic providers and technology enthusiasts saw the potential for health IT to be wedded with care delivery redesign – sustained by new payment models – such that the technology, its adoption, and its use were optimized in the interests of better patient care.

That said, MU has few friends now, and few clinicians have faith that MU will help to make care better. In fact, we are concerned that MU has a greater chance now of stifling rather than stimulating innovation. We have seen this sentiment expressed by EHR vendors, where enhancements that are not driven by regulatory requirements seem to be on hold until after the MU program is sunset.

While we appreciate the call for more robust interoperability, we believe, in contrast to some, that the MU program is actually moving this forward at about the right tempo. It appears that much of the early magical thinking about the power of health IT to improve care is not gone. Instead, the magical thinking has shifted its sights from EHRs as the totem to interoperability. As doctors who manage patients with chronic diseases, where our responsibility to these patients is continuous and not episodic, we are concerned that technical interoperability will not move forward judiciously. Without the existence of filters and other management tools, as well as workflows to control and manage the data flows, clinicians are likely to drown in unhelpful and unusable electronic data. Without the rich context that allows information to be thoughtfully used, the result is a flood of data that is not manageable and not in the interest of patients. This notion is supported by surveys, where clinicians want interoperability but caution that information without sufficient context can just as likely overwhelm or mislead, as to solve a clinical puzzle. As we have all learned with great disappointment, pushing care summaries around the system has been a failure. Seven pages of repetitious facts in no particular order and with no headline or synopsis only leave a receiving doctor asking the sending doctor, "So what do you really think?"

MU was structured as a one-size fits all program, where all providers work under the same set of requirements. This concept allows for easier administration, but makes no sense to anyone. David Brailer, the first national coordinator for health IT, in attempting to describe the potential value of EHRs, likened them to MRIs; but MRIs of information, not of body parts. This is a very apt analogy. MRIs are enormous value to certain types of doctors with certain scopes of practice. However, for other types of doctors and other scopes of practice, MRIs are useless. We would never require doctors to order MRIs of patients if the MRIs were of no use. This should hold true for the EHR as an MRI of information. For doctors whose scope of practice includes the use of information over time to improve care, the EHR has a particular purpose. And for doctors who are primarily proceduralists, attempting to shoe-horn the EHR into the role of an MRI of information is not only unwanted, it adds time and burden, and leads to frustration and anger. Rather, we should be engaging providers in particular scopes of practice to contribute to the many ways that health IT, other than traditional EHRs, can make care better.

While we appreciate the flexibility proposed by CMS for Stage 2 reporting, and appreciate the requests by our colleagues at the AMA and MGMA for even more flexibility and time, we believe that adding more time without fixing what is broken only postpones what we believe is an inevitable conclusion. While Stage 1 could be relatively easily fit into the workflow and scope of practice of most doctors, that cannot be said for Stage 2. Overly described requirements which poorly fit certain specialties will not be made better over time. For example, 10% of all patients seen during a measure period need reminders for preventive or chronic care. While this may be an easy requirement for internists, who practice preventive and chronic care management, it is certainly not the case for all doctors. And where that question has been asked, we have heard CMS and their contractors say, "So just remind patients about cancer screenings or flu shots." And to be sure, that can be done, but it is nonsensical for these doctors and their patients. This sort of nonsense measure has led many doctors to take what could be something critically important in improving care, and made it into a game – a box to check. And this is just one small example. We have to stop ordering doctors to perform irrelevant activities just to avoid a penalty. Even if the activities seem simple and easy to regulators, the very notion of considering this acceptable behavior prevents many from fully supporting this program.

More importantly, there are requirements for overly defined workflows, some of which are (in our opinion) poorly thought through. At this stage in MU, doctors should be starting to move from their basic use of EHRs to more advanced processes – setting the stage for use of the EHR to improve care, Instead we see doctors spending their time now trying to figure out workflows to "pass the test" – as doing the right thing for patients does not equate to passing MU. A similar situation exists for EHR vendors, which are now spending less time and resources on non-regulatory requirements development than they did prior to MU.

To make matters worse, MU has only addressed what providers do, and not what other stakeholders in the healthcare ecosystem, or healthcare process improvement do. The quality and accuracy of information supplied electronically to doctors and patients for formulary benefits is poor – and in many cases, the online formularies are less accurate than the paper formularies that were used decades ago. Further, while there are never ending requirements for data collection, there are no requirements on either public or private payers such that the information gathered and stored in EHRs can be easily re-used to enhance the efficiency of healthcare operations. Prior authorizations are a key example. Rather than developing new exercises for providers to master, MU should focus on what is already in place but is either not working or not optimized.

The bottom line – EHRs and other health IT hold great promise to make care better, safer, and perhaps even more cost effective, and the MU program started with the best of intentions and has achieved remarkable results in a short period of time. We respectfully submit, however, that what is needed is not just a few months longer attestation deadline, but a reboot such that MU again can be a catalyst for appropriate change, and not a roadblock to innovation. We call for sober analysis of what has been done, such that we are informed by this information, rather than continue an inexorable climb in requirements and complexity. This may mean not only delaying attestation requirements; it may mean removing some; or perhaps even determining that the most effective approach for MU is to largely move out of the way. And one way to "move out of the way" of scope of practice optimization and innovation is to re-conceptualize ONC and MU – where the federal role is largely rolled back to standards and utility functions – and we instead ask our medical professional and specialty societies to become active partners in this process, such that they own scope of practice innovation and requirements.

The Medical Informatics Committee of the American College of Physicians respectfully submits this letter in the hope that it will assist the Senate Committee Members, working with HHS administrators, in removing obstacles to physicians and other health care providers created by the development and implementation of the MU program. Should you have any questions, please contact Thomson Kuhn, Sr. Systems Architect, tkuhn@acponline.org

Sincerely,

Peter Basch, MD, FACP
Chair, Medical Informatics Committee
American College of Physicians