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# Testimony for HIT Policy Committee and HIT Standards Committee.

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My name is David Horrocks. I am the President of CRISP; the statewide HIE in Maryland. We are a non-profit public-private partnership, governed and advised by a wide range of healthcare stakeholders, and our mission is to improve the health of Marylanders through Health IT efforts which are pursued cooperatively.

Last week I attended our annual hearing on Health IT with the state legislature in Annapolis. We are reasonably proud of Maryland's efforts – all 46 of our hospitals participate in our HIE, we are doing innovative work with encounter notifications, and we are actively working with our public health leaders. And so we conveyed a generally positive report of progress to our lawmakers. Yet, our testimony was immediately followed by physicians and nurses who recounted disheartening stories about the growing frustration of time consuming EHR tasks, steep learning curves, and the continued difficulty laying hands on important clinical information. It struck me that they were describing, from the eyes of a provider, what remains an overarching lack of interoperability, punctuated by what are still very preliminary successes.

Our Maryland legislators asked us what they could do to promote or even compel improved interoperability. My take is that, as a single state, we are constrained in what we can do to promote interoperability among products used nationally. I am also of the opinion that our HIE strategies, by themselves, cannot achieve that deep interoperability for which the clinicians pine.

As one of the contributors to our state's HIE strategy, and an individual held accountable for implementation, I have made the following conclusions about the limitations and opportunities in our field:

1. The tie-in between adoption of health IT and near-term impact on provider reimbursement is strong. Tools which might help providers reduce readmissions, identify patients in need of follow-up care, or identify those at risk of adverse outcomes will receive a tentative reception when not tied to a payment reform or new CPT code. And if a new process takes extra time, the bar for when it should be used is high. Yet, when tied to a currently or very soon-to-be functioning payment reform, these same tools will command the attention of an institution's senior most leaders. I would suggest the committees do whatever possible to coordinate requirements and policy with payment reform efforts. Activities which may be a good idea and even improve patient care, but which can't be easily tied to reimbursement, should be put on

the back burner. Those will be easier to accomplish, or mandate, after the infrastructures for exchange are more fully built out. **Examples**: Tools to help LTPACs and hospitals better communicate a patient's health status are not well tied to reimbursement and are likely to be underused. Even for a doctor in an ACO sending a summary of care with a referral does not make an immediate impact on visit revenue, and a better motivation is required if it is to be used.

2. In Maryland, we have come to recognize that a data exchange solution does not need to be complex to be impactful. We are deploying a notification service which enables hospitals to communicate a patient encounter in real-time to a primary care provider or another entity with care coordination responsibility. This service is built using the most basic encounter data flowing from hospitals, basic rules to determine when and how to launch a notification, and simple secure messages sent via Direct. The announcement of new CPT codes for timely, post-discharge follow-up care are serving to create provider demand for these notifications. I encourage the committees to latch onto relatively simple uses such as this, in an effort to make their use widespread.

3. Meaningful Use, with its many parts, can be complicated for small practices. Some of the behavior I have observed to date can be characterized as taking just the steps necessary to meet minimums. If meaningful use were an algebra exam, many providers would be cramming for the test instead of learning the math concepts. Still, the foundations of EHR technology are being deployed, even when underutilized, and I am eager to see how requirements such as "you must do this for 10% of visits" will prove to work. I would encourage the committees to focus on fewer and simpler requirements, tying to other payment reforms where possible, and then insisting that those requirements are met in a thorough and meaningful way. **Examples**: The ability to calculate QI indicators is logically important, but it may be done only to meet a requirement and not used meaningfully. Perhaps mandating such capabilities in the EHR certification is appropriate at this moment, while compelling providers to use the capability outside of a clear business case is not.

4. Ease of workflow is critically important to providers, and standards must be implemented in a way which recognizes this reality. As a cautionary tale, we made IHE compliance central to the query HIE deployment in Maryland. Yet, we have found that our tools default to proprietary processes, and attempting to interface with other IHE compliant applications is very cumbersome for all involved. While products may check IHE box, that has thus far proven of no value to us whatsoever. I encourage the committees to insist that EHR certification be accomplished in a manner which is highly usable for the clinicians in the real world. **Example**: The "Blue Button" concept needs to be akin to the "Easy Button" in staples advertisements. Certification of an EHR should require generation and forwarding of a CCDA to be very easy from a provider workflow perspective, not just technically possible in the context of certification rules. While I have no specific suggestion as to how to incorporate a potentially subjective ease-

of-use requirement, perhaps evidence of a feature's broad use in production could be necessary for re-certification.

5. Of all the efforts being taken by ONC and the committees, the one for which I have the most hope and expectation is the Direct project – and more specifically the use of Direct combined with CCDA. An inexpensive, secure, and easy to use messaging platform which was ubiquitous for healthcare providers could unlock a panoply of innovation. I would encourage the committees to pursue, as a highest priority, efforts which will ensure that: a) Direct is easy to use, b) Direct is inexpensive, c) Direct is truly interoperable. These three priorities face risks in the current regulations. We are not confident that as HISP networks are established that they will diligently enable their participants to freely communicate across networks. And we are not confident the EHR interface will incorporate Direct into clinician workflows. Our best chance to accomplish these aims it to garner the full, true, and unflinching participation of the EHR vendors and to broadly establish at least one important use of Direct. (I do not believe the HIEs acting as HISPs will ever be able to make Direct a success on their own.) To create a demand for Direct, the committees should heavily promote an early use. Might the committees more tightly focus Meaningful Use criteria and EHR certification on making the production, transport via Direct, and consumption of CCDA documents a commonplace reality? Any purpose will do – results delivery, referrals, reporting – so long as the focused and straightforward requirements promote ubiquitous use. **Example**: The committee could work in conjunction with CMS to promote the use of Direct by PCPs to send referrals via CCDA, and to receive back visit notes electronically via CCDA. A PCP who did so could be reimbursed a small amount for making a follow up call, perhaps to a subset of her patients requiring more care. She would be motivated to use Direct and CCDA and motivated to refer to specialists also willing to do so, thus creating more demand. She would also pressure her EHR vendor to make sending and receiving very easy. This hypothetical example results in immediate reimbursement, rather than delayed rewards as received in Meaningful Use or end-of-year ACO payments.

**Other Thoughts:**

- The committees should not try to govern or shape query based HIE's, at least right now – focus on the foundation for secure messaging, or directed exchange, instead.
- Privacy and security become more difficult the more broadly a query based infrastructure is available and the greater the breadth of potentially sensitive information it encompasses. While it would be difficult to implement now, our long-term target should be direct patient control of most queryable information, through a model more like health record banks.
- After inexpensive and easy to use secure messaging becomes ubiquitous among ambulatory physicians and acute care hospitals, participation in exchange activities by groups that aren't now covered (labs, LTPAC, etc) should be an easier step to contemplate.

- Ubiquitous capability to generate and send a CCDA would allow states such as Maryland to use regulation to pursue various improvement activities for purposes such as public health reporting.