Testimony to ONC Panel 2: **Exchange Service Providers**

By David Horrocks

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My name is David Horrocks. I am the President of CRISP, an HIE with 53 participating hospitals serving Maryland and the District of Columbia. We are a non-profit governed by our member organizations, and operating as a public-private partnership. We were chartered to improve health and wellness by deploying health IT projects which are best done cooperatively.

CRISP has three primary service offerings: a query portal which facilitates pull transactions by clinicians and is used 1,500 times a day; an encounter notification service which alerts PCPs and care coordinators about hospital or ED admissions and discharges and sends 7,000 notifications a day; and analytics and reporting services which we operate in partnership with public health agencies in Maryland.

Regarding the role of exchange service providers in a JASON like architecture, I have a few thoughts about the concept of a new architecture.

First, it would be accurate to say that the services CRISP provides have been built in pragmatic, incremental, and even opportunistic ways. Our approach to gathering medical records for query is not particularly elegant. The records are not captured in a consistent format, many records are not stored as discrete data, and mechanisms for patient engagement and control are limited. Our approach was chosen simply because it's what we thought we could pull off at the time. But the approach has proven to be a successful, incremental improvement over the prior method of faxing paper records. While we think what we have was the right choice at the time, we recognize our current approach should eventually be superseded – made obsolete. If a JASON like architecture does not do that, something else should and will. Maybe it would be something non-Jason like, such as health record banking.

On the secondary use and research front, most of the work CRISP does today is based on records collected by regulation of state agencies – records which resemble an APCD, in that

they are coded and structured like claims data. We find such data is useful for population health management efforts. In contrast, because the discharge summaries, labs, and radiology reports we receive through the HIE are not structured, they are harder to use for secondary purposes. It is a weakness to our current architecture.

A second brought thought is that when members of our community ask us to become involved in an effort, we generally go back to our mission statement and ask ourselves whether it is something that is best done cooperatively. If an initiative can be accomplished through a private investment or will be spurred by competition, then it probably isn't a good fit for CRISP. If the JASON authors are correct, and APIs built into EMRs can facilitate much of the exchange activity which currently flows through CRISP, and the business drivers to spur private investment to make this happen can be marshalled without a community-governed entity such as CRISP, then so be it. Perhaps the role of CRISP would be narrowed away from technology operation to facilitating trust relationships, facilitating uses of information for research, or other things.

Having said this, I must confess to having doubts about the ease of getting from here to there. We've seen the difficulty of rolling out secure messaging, with is probably straightforward compared to building open APIs to access granular data.

As to the role of an organization like CRISP if a JASON like architecture were successfully deployed, I tend to think the community would still have use for an organization to facilitate cooperation, but that it would be doing less technology operation.

As I imagine how the world would operate with ubiquitous, well-documented, and functional APIs in every medical records system, I think that would be similar in some ways to a world in which a single vendor's system was being used by every healthcare provider. The basic interoperability challenges would be off the table. I do have some experience watching single-vendor solutions used to facilitate health information exchange. I'm struck that even after the interoperability is solved, participating organizations still struggle to establish rules of the road. It doesn't automatically solve questions of allowable data use, patient consent and control of data, and patient matching. You may still have tensions between competitors who need confidence about how the information they provide is used. And the privacy and security of such an architecture must still be managed – someone needs to audit access and provide accountability for bad behavior. A similar set of issues exist when it comes to use of data for research. I suspect the community will still need trusted entities to consolidate, hold, and then manage access to such data, even in a world where gathering the data in the first place becomes much easier.

Perhaps in a JASON like architecture those are the things which would be done by organizations such as CRISP. So in closing, if policy makers think a push towards JASON is pragmatic, and incremental, and that it can be pulled off, then I'd say go for it. If the policy makers conclude it is too ambitious, I'd suggest more incremental approaches for now, such as steps to make Direct secure messaging truly ubiquitous and easy to use.