Chesapeake Regional Information System for our Patients
7160 Columbia Gateway Drive, Suite 230, Columbia, MD 21046

T: 877.952.7477 W: www.crisphealth.org E: info@crisphealth.org

Testimony for Implementation and Usability Hearing.

July 23, 2013

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. My colleague Scott Afzal is the Program Director for our HIE services.

1. Describe how you will address the meaningful use requirements for the inter-organizational transitions of care in Stage 2.

We believe this is a specific area of MU2 in which we can be helpful to our participating providers. Our Encounter Notification Service can enable a hospital to route structured clinical documents (CCDAs) to ambulatory providers who have subscribed to their patient panels in CRISP. We believe we could assist hospitals in meeting the 10% requirement for delivery of CCDA by receiving the document via Direct, "unpackaging them," then routing the document on to subscribed practices. While we do believe we are in a position to support this capability, we also see many organizations in Maryland planning to meet this measure independent of CRISP.

2. Will you use the Direct standards to meet interoperability requirements for Stage 2? Are your business partners prepared? Do you anticipate challenges because EHR vendors may require the use of a specific HISP? What new EHR capabilities required in Stage 3 or beyond would facilitate better exchange of health information (please identify the use case and the capability)?

As the statewide HIE in Maryland, CRISP currently offers HISP services and issues Direct accounts to providers, which they access through a web-mail-like portal. Almost all of the current usage of CRISP Direct services is in support of our Encounter Notification Services.

We expect that most providers are likely to use their EHR vendor's native HISP service or that vendor's exclusive HISP partner to meet their Direct-related MU objectives. Although CRISP is a HISP today, we are eager for the EHR vendors to implement Direct, so long as they are willing to invest in integrating HISP services into workflows in efficient and clinically relevant ways. CRISP's current Direct service, accessed through a separate portal, will never be easy enough to use in routine clinical workflows. Building Direct capabilities into the products is a step in the right direction, but it must be paired with workflow usability that will foster a willingness (through ease of use) to share clinical documents outside of the practice.

Although we are not necessarily looking for CRISP's HISP services to be supported by the EHR vendors, we do have a concern that EHR vendors who do not support other HISPs will complicate the rollout for larger organizations which are unlikely to be wed to a single EHR vendor, but will want a single Direct service for their employed or affiliated providers. We also see the broader challenge of HISP-to-HISP trust as existing service providers quickly on-board users.

3. What approaches will you use to meet the HIE requirements for Stage 2, and what challenges have you identified?

From an HIE perspective, we do not view meaningful use a critical driver in our service offerings or in our sustainability planning. Nor are we clear that there are requirements in MU2 that position HIE organizations well. We recognize the need to hedge MU requirements in a way that avoids reliance on an HIE organization, which is a major driver in our decision to not rely on MU as a justification for our value proposition to customers. Beyond the transition of care opportunity described above, we are currently working to support the public health reporting objectives. Generally speaking, we are working to align CIRSP services with hospital and provider reimbursement policy and the evolving incentives to coordinate care and avoid certain types of utilization. Coordination with our state health officials is important in that effort, as they are involved in setting the agenda for population health management initiatives and incentives.

4. What have vendors done to support interoperability between certified EHRs? What gaps remain to support exchange between certified systems?

We believe the focus on CCDA documents and Direct represents a significant opportunity from an interoperability perspective. While progress has been made on the various interoperability profiles, we have not yet found them to be of much consequence in our ability to integrate with EHR systems. If ambulatory EHR vendors could send and receive CCDA documents in efficient workflows leveraging the Direct protocol, significant progress could be made in our own ambulatory HIE efforts. (And significant progress could be made in many other important uses which won't necessarily require HIE support.)

To that end, a big gap which exists is that we are aware of very few clinicians in our state who are currently using EHR supplied or integrated Direct accounts. So progress from that standpoint is slow.

5. What HIE services are most important in meeting EHR use requirements?

As described above, our impression is that an HIE can be helpful in meeting a few requirements, but it is not necessary. Certain HIE functions are, nonetheless, helpful in our state. It may be that local incentives and regulation help us broadly enable such services in the future. For instance, making PDMP information more broadly available through integration with the HIE is being done through state law and regulation. Perhaps electronic publishing of MOLST/POLST will be similarly promoted.

6. Have you experienced any challenges with interoperability when both systems were purported to be certified for the intended purpose? Were there additional challenges to get the exchange to "really work"? What were the solutions you applied?

As noted above, we have seen some variation in how IHE profiles have been deployed as we have sought to make standards-based integrations between our HIE infrastructure and EHR systems. However, we believe that interoperability should be address where data originates and where data is consumed, rather than by a patch work of middleware that ultimately will be unsustainable over time. As an HIE we can facilitate the movement of information among disparate providers, but we believe progress on producing and consuming CCDA (which include standard clinical terminologies) and being able to communicate that document over Direct is a critically important step towards true interoperability.

7. Have you made or received electronic transitions of care to healthcare providers including skilled nursing facilities and home care agencies and if yes, have you encountered barriers and how have you converted the barriers into successes?

Our initial efforts to go live with transition of care information to skilled nursing facilities, pursued as part of a Challenge Grant, proved too costly to broadly replicate. Nor did we find much eagerness among the SNFs to enable the service. After inexpensive and easy to use Direct secure messaging becomes ubiquitous among ambulatory physicians and acute care hospitals, participation in exchange activities by groups that aren't now covered by MU2 should be an easier step to contemplate. It is also worth noting that workflows among skilled nursing facilities and home care agencies very often involve ambulatory physicians, generally employed elsewhere, who are reviewing information and writing orders. Automation will be difficult for these facilities until the ambulatory doctors can communicate electronically. In addition, our experience with the vendor community supporting skilled nursing and home health organizations has been that, in the absence of MU targets, these vendors are less focused on interoperability.

Other Thoughts:

- If the ability to generate and send a CCDA were ubiquitous, we as an HIE would be able to promote new services within our state. These might be supported by local incentives and regulation. Anything that can be done from a policy standpoint to make this a reality, most likely through an EHR integrated Direct account, should be a high priority.
- We are interested to see how methods of patient engagement will develop. While we haven't previously considered Direct patient engagement to be a good fit for the HIE, as it could tend to disintermediate clinicians, we are interested in whether MU2 requirements on this front, combined with Direct, spurs new thinking.