



Agency of Human Services



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Division of Health Care Reform**

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Dear fellow Task Force & Work Group members:

My apologies for this late response to the questions posed for comment. I appreciate this opportunity to provide these written comments, as well as to speak to the hearing of ONC's HIT Policy Committee, Information Exchange Workgroup, Provider Directory Task Force on Thursday, September 30 as part of Panel 3: State / Regional / National Framing.

My comments focus on the governance, function, and value of a comprehensive approach to the creation of state-level Provider Directories and of the potential benefits for alignment of directories across state borders, regionally, and nationally. As importantly, I want to stress the value to the health care system as a whole (and to comprehensive health care delivery system reform) for taking an expansive approach to solving this problem. While Health Information Exchange (HIE) prompts the Task Force's inquiry, the opportunity to provide policy guidance to develop standards that could serve health care delivery and public health systems as a whole, and to align and augment resources, is substantial.

Our experience in Vermont points to the challenge of keeping provider data current, even in a small state with a relatively "knowable" universe of providers that numbers in the thousands. A disparate set of entities across each state and territory – both within government and in the private sector – have a need to keep current lists of health care professionals and institutions. With HIE and with other aspects of health care reform, the need for directories that can provide both electronic routing and "Yellow pages" services is highlighted. My most emphatic message is that this effort should extend well beyond the realm of HIE. This is an "and / both," not an "either / or" situation. ONC has the opportunity to advance the policies and standards of both routing and of "Yellow pages" Provider Directories for HIE, and also to offer a vision for the application of Provider Directory governance and technical standards more broadly across the health and health care landscapes.

In most if not all jurisdictions, there is neither a common unique identifier nor a process for comparing, aligning, and de-duplicating lists across applications and entities. However, this current gap also illustrates the opportunity. Having struggled with how to meet this challenge on the comparatively small scale of Vermont, we have concluded that it would be of substantial value to have a common, centralized directory that is refreshed and authenticated (ideally daily but at the least weekly) from disparate state and non-governmental sources and integrally linked to the state HIE network's directory, messaging, and record locator services.

Vermont has co-located HIT policy coordination with the state's Medicaid agency, which highlighted the natural opportunity to have Medicaid play a lead role in this effort, but whether it is done by the public health, insurance regulatory, or other state agencies, our experience and recommendation points to the value of having maintenance of a core Provider Directory repository as a public function.

A common Provider Directory can feed to (and be fed by) state-level, regional / multi-state, and interstate / national HIE network services. Below that expansive vision, there needs to be an authoritative source of current, validated data, and our experience suggests that function can and should be done at a state or sub-state level first, where the directory can be "closest" to its data elements. State governments already perform this function in different domains (medical licensure, Medicaid provider enrollment, public health functions such as emergency preparedness and response registry systems). The opportunity is to amplify and aggregate those public functions to align disparate data sources to make maintenance of the core Provider Directory data set more efficient while simultaneously providing HIE networks with an authoritative source of record.

Uses and sources of Provider Directory data include but are not limited to: public and private insurance provider enrollment records, multi-payer claims databases, boards of medical licensure and professional registration and certification, volunteer emergency responder and other public health registries and directories, commercial HIE, EHR, and other identity service vendors, professional and membership organizations, federally maintained or funded sources including the CMS NPI and NLR data bases, the VA, DoD, and the ONC's REC grantees – in short, any entity or organization that touches or has a need for "provider" demographic and other identifying data. It is worth noting that uses may be outside the realm of the usual health care context. For instance, having provider data geo-coded is of importance in relation to mapping and ensuring broadband connectivity, so both a provider's physical address (or addresses, for many individual providers practice in multiple locales) and billing / administrative address should be indexed.

Defining "Provider"

We understand and support the HITPC's continued use of the HIPAA definition of provider, but the context of Provider Directories point to the need for development of a more nuanced ontology or hierarchical structure of objects (for differentiation of types of providers that include individuals and institutions) and their attributes (roles, types, etc.). A particularly useful outcome of the Task Force's work could include a list of the questions Provider Directories are trying to answer ("What place does a provider practice? What insurance does a provider accept? What organization(s) employ the provider?") that could be developed for the HIT Standards Committee to consider in development of a Provider Directory ontology.

A broader set of use case questions will produce more broadly applicable, durable Provider Directory standards. Recognizing the "mission creep" risks of "boiling the ocean" in this quest, our Vermont experience nonetheless points to taking an expansive view. Otherwise, we risk needing to rework and revisit the underlying structural assumptions about Provider Directories' core architecture. This again points to the value ONC could add to the national discussion about and need for Provider Directory standards.

Multi-state efforts

In New England, as in most if not all regions of the country, health care providers and consumers routinely cross borders to deliver and receive care. The challenge of interstate HIE foregrounds the need to develop common standards, architecture and attributes of Provider Directories that will support and enhance such

exchange. Through the New England States Consortium Systems Organization (NESCSO), we – along with New York – have developed an MOU for development of a common Provider Directory architecture. In discussions with our colleagues in the Southeast, we understand similar efforts have been organized there.

However, the difficulty with the state and regional level approach is that each state is so busy implementing the many aspects of HIT and HIE policy, progress on the Provider Directory effort has been slower than ideal, despite the desire to find a common solution.

Our experience points to the value of a national solution constructed in collaboration with the states. States would benefit from the development of common standards for both Provider Directory architecture and governance, and speaking on behalf of a state that has struggled with solving this problem for the last half decade, we would welcome ONC and CMS leadership in development of a common standard and vision for Provider Directory development and deployment.

Short answers to the Task Force’s specific questions follow on the next pages. Thank you again for this opportunity to comment.

Sincerely,

A handwritten signature in black ink, appearing to read "H. Blair". The signature is stylized and cursive.

Hunt Blair
Director, Division of Health Care Reform
& State HIT Coordinator

1. What use cases do you or your stakeholders have for provider directories? Who would use them and for what?

Point-to-point communication between providers and between patients and providers; provider should be inclusively defined.

2. What set of clinicians and entities need to be included to enable your use cases?
 - a. Would it need to include individual clinicians, or is the entity sufficient?

Needs to be at the individual clinician level (but include the entity). Clinical messaging is to the individual.

- b. Does it need to be authoritative and complete, for instance containing all licensed physicians in a state?

Ideally, yes. However the perfect shouldn't be the enemy of the good.

3. How will provider directories support providers in meeting MU requirements?

Critical to secure clinical exchange.

4. Which type of provider directory are you focusing on and why?

- a. Yellow pages: An authoritative resource listing clinicians and entities that is used to "look up" providers and point to the routing directory

- b. Routing directory: routing registrar to provide addressing hierarchy/service to enable machine-to-machine routing in context of health information exchange activities

We are focused on both. The former is a State function, the latter is the HIE focus. Both need to facilitate interstate look-up and routing as well as in-state.

5. What information about clinicians and entities needs to go into the provider directory in order to make it useful for you?

- a. For example, provider type, specialties, credentials, demographics and service locations.

As much as is possible and practical; contact information, referral expectations, licensure, credentialing, specialty and sub-specialties, the multiple roles played by providers (volunteer emergency responder? faculty? researcher?), the multiple physical locations in which they practice, the organizations at which they practice, billing relationships for each location and organization, mailing addresses where different from physical addresses.

6. What level of data accuracy is needed for your purposes?

Sufficiently accurate to prevent machine routing of PHI to wrong destination.

7. Given your use cases how would you recommend a directory be structured? At what level should the directory be established (e.g. state, regional or national)? What concerns do you have?

Common exchange components nationally/regionally to enable interstate communication. Internal architecture that is state- or region-specific will work as long as access handshakes are standardized nationally, but model architecture and a minimum set of standard data elements would go a long way toward enhancing interstate exchange.

8. What is your approach to building or enabling provider directories?

a. How will your approach support information exchange for stage one meaningful use?

It should permit securely routed clinical summaries

b. What data sources are you considering to populate a provider directory?

Medicaid and commercial carrier provider enrollment data, State medical and professional licensure and certification records, REC outreach data (especially valuable for validation because they are physically visiting practices), CMS NPI data files, Area Health Education Center survey data, CAQH records, really any and all reasonable sources from which we can automate feeds or otherwise routinely refresh.

c. What are the key challenges you are facing?

The key challenge is designing the right object hierarchy or ontology.

d. How will your approach maintain data accuracy, completeness?

By cross-referencing and validating the data across and among the multiple data sources. Once the core Directory data set is built, the principal challenge is keeping up with changes, which will require a dedicated staff resource able to resolve questions not able to be handled in an automated MPI environment.

10. How can ONC and states work to ensure interoperability and access across provider directories being created under the State HIE Cooperative Agreement Program?

a. What steps could be taken to encourage regional collaboration in establishing provider directories?

Focus requirements on the communication between directories and minimum necessary to ensure accurate, secure, point-to-point communication

11. Would you consider working with other States and federal partners to establish a consistent set of business and technical requirements? If so, would you consider a joint procurement process and/or establishing a service that others (States, public or private organizations, etc.) could use? If so, what can ONC, CMS and states do to support this process?

Yes. ONC, CMS, and the states should implement the recommendations of the Task Force through a similarly rapid-cycle set of standards developments which can be shared with the states in the near term and formally adopted in the longer term.

- 12.** What are the opportunities and challenges to creating provider directories that are openly available and usable by multiple information exchange entities and participants? Who should be permitted to participate in such a model? How would this work at a technical level?

Governance and maintenance should be structured for sustained functionality and interoperability. The details of this work constitute the next near-term phase of work.

- 13.** What policy levers can state governments or the federal government use to assist in the establishment of provider directories and maintaining data accuracy and quality?

Standards, standards, standards; many elements of HIE – and HIT more broadly – will evolve through marketplace innovation, but clear definition and expectations for structure, governance, and routing for this core functional component of HIE will support and enhance innovation and ensure successful implementation of the broader vision of state and national exchange.