

**Information Exchange Provider Directory Task Force**  
**Draft Transcript**  
**February 7, 2011**

**Presentation**

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Good morning, everybody, and welcome to the Information Exchange Workgroup Provider Directory Taskforce. This is a Federal Advisory Committee call, so the public will be able to comment at the end of the call. Just a reminder for workgroup members to please identify yourselves when speaking.

Let me do a quick roll call. Jonah Frohlich?

**Jonah Frohlich – Manatt**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Walter Suarez?

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Carl Dvorak?

**Carl Dvorak – Epic Systems – EVP**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Paul Egerman?

**Paul Egerman – Software Entrepreneur**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Seth Foldy? Jim Golden? Dave Goetz? Hunt Blair?

**Hunt Blair – OVHA – Deputy Director**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Steve Stack?

**Steven Stack – St. Joseph Hospital East – Chair, ER Dept**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Art Davidson? George Oestreich? Sorin Davis?

**Sorin Davis – CAQH – Managing Director, Universal Provider Datasource (UPD)**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Keith Hess? Sid Thornton?

**Sid Thornton – Intermountain Healthcare – Senior Medical Informaticist**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Lisa Robbin? JP Little? David Lansky? Micky Tripathi? Kory Mertz? Tim Andrews?

**Tim Andrews**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Connie Delaney? Did I leave anyone off?

**Gayle Harrell – Florida – Former State Legislator**

Gayle Harrell's here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Gayle, right, good morning. All right, I'll turn it over to Jonah and Walter.

**Jonah Frohlich – Manatt**

Good morning, everybody. We are very happy to be coming towards the end, though not quite finished, of the taskforce recommendations for the individual level provider directory. What we'd like to do today, Walter and I are going to tag team this, and I'll start us off and then Walter will wrap us up, is go through, what we've done is we've taken the discussions from the last six weeks or so and we've crafted a set of recommendations for most of the components of the ILPD. What we'd like to do is go through these and make sure that we've got them right, and if there's anything that folks believe we need to modify we'll do that here. Then we'll finish up with the recommendations.

There's a little bit of background noise. Does anybody else hear that?

**M**

It sounds like someone's playing Pong.

**Jonah Frohlich – Manatt**

Yes. Well, if it's not too distracting I'll just keep going.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

Should we go to the next slide, maybe, on the screen?

**Jonah Frohlich – Manatt**

Yes, that would be great, actually.

**Peter DeVault – Epic Systems – Project Manager**

Sorry, this is Peter DeVault. I just joined a minute late.

**Jonah Frohlich – Manatt**

Hi, Peter. So we're going to, again, look at the recommendations, review and finalize what's remaining, which are the operating requirements and business model recommendations and discuss those policy issues, and then we'll go through next steps. So with that, let's go to the next slide.

Our timeline is as follows. We are currently at the 7<sup>th</sup>, and on Friday the taskforce is scheduled to meet, I think one more time for this phase, perhaps for the last time, and finalize the policy issues and actions so that we'll make the final recommendations to the Information Exchange Workgroup, which will happen in about two weeks. So we have a bit of a break. Then the Information Exchange Workgroup, chaired by

Micky and David, will review them and then make a set of recommendations to the Policy Committee on March 2.

Just to remind us of our framework, we are making recommendations on the following functions that you see on slide four. When we do so we will be making recommendations around policy issues and actions that we will be proposing through our workgroup committees and ... to the Policy Committee through ONC.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

One quick question, Jonah, this is Walter, and this might be for Judy. I don't have this on my schedule for Friday, the 11<sup>th</sup>, so I just want to confirm it is Friday the 11<sup>th</sup> from the regular 10:00 to 12:00?

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Yes, it's Friday the 11<sup>th</sup> from 10:00 to 12:00, and I'll double check the calendar invite for everybody.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

Okay, thank you.

**Jonah Frohlich – Manatt**

This is a status of the ELPD recommendations. We want to make sure everyone is informed of how the recommendations are sort of wending their way through the process. So as you'll know, the Standards Committee received the recommendations on January 12<sup>th</sup> and they mentioned then that they'd likely assign project responsibility to the Security and Privacy Workgroup, which, Walter, is that your workgroup?

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

Yes, that is. We're starting already. We have a meeting on Wednesday with the leadership of the Health IT Standards Committee to finalize the focus of attention and locus of attention of this particular activity under the Standards Committee. So it is likely that the Security and Privacy Workgroup will begin to work on it. I am actually co-chair of that workgroup as well, so hopefully that will help do some of the linkages there between our two groups.

**Jonah Frohlich – Manatt**

Terrific. And it sounds like that workgroup is going to focus on digital certificates.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

We already started to work on the digital certificates. We're going to bring the two together, I think, as topics.

**Jonah Frohlich – Manatt**

Perfect. So we'll be hearing at subsequent meetings what the time frame is for developing those recommendations. Then, as Walter mentioned, given that he's co-chairing both this workgroup and the committee that we expect that there will be these ongoing exchanges between the two, I expect we'll hear or we'll receive questions requesting specific clarifications on some of our recommendations. Any thoughts before we move on? Okay, next slide, please.

We're going to start off with where we are making our first set of recommendations; first, is participants. Just to be clear, we've got three different sets of definitions here. One is participants and the others are users, and then we've got something in the lines of content, with who will be included in the ILPD. So we're going to start with participants, those who can actually engage and use an ILPD, or who should be able to participate in ILPD services. Our recommendation is that all individual healthcare providers, those being physicians, clinicians, dentists, etc., that are involved in any Health Information Exchange transactions, whether receivers or seekers of information, should be considered as a participant and that there needs to be identified at the individual level for purposes of receiving or requesting health information. So that means we're talking about not entities again, we want to be very clear that these are talking about we're making recommendations for individual clinicians. That's our first recommendation.

I'm going to pause and make sure that no one has any specific comments, and if you do we need to discuss.

**Peter DeVault – Epic Systems – Project Manager**

I just want to make sure, is that what we're talking about here are the individuals who will be in the directory. Is that correct?

**Jonah Frohlich – Manatt**

Yes.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

Yes. I think from a definitional perspective or a legal definition, we talked about a couple of references. I think Kory sent us an e-mail with a couple of suggested references. Of course the first one is the HIPAA definition of healthcare provider, but that's much more encompassing, including both individual healthcare providers, as well as organization providers or entity providers, so it's much more encompassing. But there are other definitions that point to more specific individual healthcare providers, like the definitions used in the National Physician Practitioner Database just as a reference for physicians, but it's not only for physicians that we're looking at. So any individual that is licensed or otherwise authorized by a state to provide healthcare services is what is using that definition. So that kind of reference might be something we want to consider, including as a reference point for who do we think should be included in this ILPD.

**Hunt Blair – OVHA – Deputy Director**

Walter, just building on that point, I think it would be good to include that kind of definition to make it clear that we're saying any individual provider, so it could be a mental health provider, it could be a pharmacist potentially, right?

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

Absolutely, yes.

**Hunt Blair – OVHA – Deputy Director**

It could be a clinical social worker.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

Yes.

**Hunt Blair – OVHA – Deputy Director**

I like that any licensed or certified health professional kind of direction illustrates that it's that broad.

**Steven Stack – St. Joseph Hospital East – Chair, ER Dept**

I think Tim tried to address this in a previous call. But if I don't know that the person's name is Dr. Robert Jones but I know that he's at Pulmonary Associates, would it be that we might require as a field that you give the name of your practice and even though only individuals get into the directory it's still searchable by practice name?

**Jonah Frohlich – Manatt**

Yes, absolutely. In fact, we'll talk about content in a couple of slides, but that's exactly one of the things we want to make sure that is included in the recommendations.

**Steven Stack – St. Joseph Hospital East – Chair, ER Dept**

It might be useful at some point as we go through the slides just to clarify somewhere that only individuals who are in the directory will be searchable by multiple types of fields.

**Jonah Frohlich – Manatt**

Okay ....

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

Yes, to be included in the functional capabilities.

**M**

Yes.

**M**

Right.

**Jonah Frohlich – Manatt**

I like the notion of shared including and making it more specific around license and certified health professionals. I think that will certainly help sharpen the recommendations, so let's do that. Okay, next slide, please.

Users, so we have three specific recommendations on users at this point. The first is that users with access to an ILPD's content should include clinicians and both front and back office staff. We don't want to limit this. The suggestion that we're talking about for the physician practices, which is sometimes ... but we wanted when we discussed this last time, we wanted to make sure we're not just limiting it to administrators and managers. So we're talking about people who are both helping to administer organizations and the clinicians within them.

The second is that we would recommend that there be defined roles and role-based access policies for access to and use of the ILPD services and that these policies should be set at the local level and consider federal, state, and local statute regulations and accepted practices.

The third is that some sensitive content, such as state license numbers, DEA numbers, etc., that are likely required or should be required to populate an ILPD, that content needs to be restricted, or should be restricted and the user access to this information needs to be specifically limited to those who absolutely need to access it. So again this is a definition of the use based access or the rules based access. We want to make sure that there are some restrictions on some of that content because of considerations around fraud and potentially identity theft.

Any thoughts on these recommendations? Have we got this right?

**Paul Egerman – Software Entrepreneur Hunt Blair – OVHA – Deputy Director**

I have a very minor wordsmithing thing. You referred to "front" and "back" office staff, and it occurs to me that some HIM professionals might not feel that they are front office or back office staff. So maybe you want to say something else like "and support staff" or "and administrative staff" or something like that as opposed to front and back office.

**Jonah Frohlich – Manatt**

Yes, I like that actually. So we call them "support" and "administrative" staff?

**Peter DeVault – Epic Systems – Project Manager**

... upgraded a little bit, yes.

**Jonah Frohlich – Manatt**

Good. Okay, other thoughts? Terrific. Let's move on, please. Next slide. These are the use cases, slide eight. We are recommending that there are six scenarios. I think we want to also be a little explicit here that these are not the only scenarios in which the ILPD could be used, but these are the scenarios that we have drawn out and defined. They include clinic to clinic exchange push and pull scenarios; they include hospital to clinic exchange, both push and pull scenarios; lab to clinic exchange, a push scenario; and then a public health alert, which is again a push scenario.

A few comments ... across these scenarios is if a submitter needs to send a message to an individual level provider, the submitter has some information on the individual but does not have the individual's

location information, the ILPD is used to identify all possible locations on the individual himself or herself. With additional information, the submitter identifies and selects the appropriate location and the ILPD provides some form of linkage to the ELPD so that the appropriate security credentials and certificates may be obtained and used by the machines to actually establish a secure connection. And that the submitter sends to the individual provider at the identified location, so the transaction is actually carried forth. ..., let me finish and then I'll take some questions.

And the privacy and security considerations really across the scenarios, first is that all use cases are contingent on following all federal and state privacy laws and rules, and that the full use case adds an extra layer of complexity that requires a stronger focus on following relevant privacy and security rules, things like ..., for example. I'm going to stop there for a moment and take any questions or comments here. ....

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

Jonah, the public health alert case I see is a push scenario. Where would the public health review of or investigation of a disease to pull data fit? Is it not in this at all?

**Jonah Frohlich – Manatt**

I don't see why it couldn't. For example, you could—and I think we talked a little bit about this with Seth a couple of calls ago, that we could certainly envision a scenario whereby a public health agency uses a geospatial querying capability, or at least wants to query clinicians within a certain geography. And might have the names of the clinicians and needs to identify the practice sites specifically and start pulling information from the relevant EHRs. And that the ILPD could be used to identify the clinicians and then link it to the ELPD certificate. But I think when we discussed this we said that we certainly could envision this. We just didn't articulate that specific scenario.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

Is that something that we should consider for the future, or is it going to be picked up somewhere else?

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

I just wanted to jump in. I think we didn't exhaust all the possible scenarios that the ILPD would support, so we could certainly create another one example of public health, a pull scenario for public health, just to complete the documentation, if you will. But, again, that doesn't mean that these are all the possible scenarios, there are many more scenarios, and really the principle is what's the functionality of the ILPD to support different types of exchanges. But it would be helpful probably to actually have an additional public health scenario that shows how the pull will work.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

Thanks.

**Jonah Frohlich – Manatt**

Follow up item, can we have someone draft that specific scenario who is steeped in public health?

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

I can give you an easy use case with hepatitis C report that's positive, and it's a chronic case rather than an acute occurrence of hepatitis C. You get it from a lab and you don't know anything more about the case than if it's a positive test and then you find that the guy's had hepatitis C for several years and you can find that from a query. If you like, I could help you with that.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

Yes, Art, at the end of the slides there is a description of the various scenarios, so if you could use one of those slides and provide an example of that—

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

I'll send it along. Thank you.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

... that would be great. We can exchange via e-mail with Seth as well, because I know he has some thoughts about that too.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

Sure.

**Jonah Frohlich – Manatt**

Terrific. Thank you. Other considerations for the use cases? All right, terrific. Let's move on to slide nine. We have a few recommendations around the ILPD content, this came from our last discussion of just over a week ago, four recommendations thus far. The first, and this is based on again the participants' recommendations that we made at the onset of this call, that individual providers and not entities or organizations should be listed in the ILPD. I think we need to refine this to say that the individual provider ... should conform to HIPAA definitions specifically and they should include licensed or certified health professionals. I think we need to be also very specific that we're not talking about ... entities because the definition includes organizations. So we'll do that.

The second is that the information needed for an individual provider listed in the ILPD should include the following, and this goes to some of Steve Stack's comments. The demographics should include last and first name, provider types, specialty name and address of practicing locations, practice telephone, e-mail address and hospital affiliation, and that it should also include, and we split these out on purpose, potentially sensitive identifiers like the NPI, DEA number, or state license number.

Third is that there should be limited access to and tight policies regarding access to potentially sensitive identifiers, such as those license numbers, to minimize the risk of fraud and identity theft. We have a concomitant recommendation on the functional side, that you'll see in a minute, in that the existing sources of content, like the state licensing boards, health plan vendors, etc., should be considered as content providers to ILPD operators. And we've heard from a number of those during the hearings, from Wisconsin, ..., etc., and WellPoint.

Those are the four recommendations we have on content. Are we missing anything, first of all, that we should be including for our final set of recommendations to the Policy Committee Information Exchange Workgroup?

**Hunt Blair – OVHA – Deputy Director**

Jonah, I guess the question that I have relates to one and two, in that the instance where individual providers are affiliated with multiple entities, it seems as though we need to be able to account for at the ILPD level that the individual might be linked to those multiple entities. First of all, I don't know how the rest of the taskforce feels about that. And secondly, I'm not sure we're capturing, in this recommendation, how we propose to deal with that.

**Jonah Frohlich – Manatt**

Hunt, as I understand it, you're talking about the link between if a provider is in two or more locations but they suggest that there are two or more EHRs that are distinct, that we need to, first of all, have them all listed here, and second of all, have a mechanism to link to their ELPDs?

**Hunt Blair – OVHA – Deputy Director**

Yes, I guess the way I'm thinking about it—and I apologize to those of you, well, I sent a very schematic drawing after our last call trying to express this. I haven't had the opportunity to get back to everybody about it or to share with the whole taskforce, but what I'm thinking is that, yes, what you said, Jonah. And that maybe the way to accomplish that is that each part of what we say is that, and again, I don't know what the right computer technology term is, but that each individual has two keys. One that is the individual and the second is their link to an entity. We talked about lots of use cases where providers are operating at different times, in different spots, with different EHRs and sometimes even within a larger entity a provider could be operating at two different locations of that same entity. So somehow that level

of, and Sorin talked about this a little bit last time, that level of complexity is something that we need to be able to address systemically. I don't know what others think about that.

**Steven Stack – St. Joseph Hospital East – Chair, ER Dept**

Hunt, I think you raise a very valid point. That's what I was trying to conceptualize. If there's a Dr. Jones, but Dr. Jones works at hospital A and hospital B with different EMRs, I would think you'd probably have one discrete entry, but there would be an opportunity to have multiple entries for a practice site. So if you search "Dr. Jones, Pulmonologist," then in the query if you put in enough search fields to find the right person so that you got it down to one individual, there would actually be two entries with two locations. Then each location would probably have to be keyed to the appropriate ELPD entry so that routing happened properly. So somehow, you'd have to have ways to distinguish where you're sending information for Dr. Jones at the ILPD level even though it would be done behind the scenes as to which entry in the ELPD it was routed to.

**Tim Andrews**

I'm not so sure it can be behind the scenes, but I think it certainly has been my understanding since we did the ELPD work that those would be the only real addresses, if you will, external addresses. So if a provider in this directory, the ILPD, the information that's in this directory isn't really electronic addressing information it's information that would get passed to an ELPD entity, and then they would figure out how to get it to the right Dr. Garcia, or whoever it is, within their ELPD. That means you do have to have some way to link one entry to multiple ELPD entries. I'm not sure it can be totally transparent because whoever wants to send a message has to figure out which practice, which location, which ELPD ultimately. Maybe the ELPD isn't directly visible, there's some more friendly name for it, but it has to have some name and that the user or a machine if it's a machine, has to figure out which one of those to send it to. That was my understanding. Then behind the scenes all the detailed stuff, yes, can be sort of transparent, but somebody's got to ultimately figure out which ELPD ... provider the message is going to go to. Is that correct?

**Steven Stack – St. Joseph Hospital East – Chair, ER Dept**

Tim, is this feasible, and I'm sorry, it's hard to describe some of these complex processes, so say Dr. Jones works at three different office locations but it's all in one integrated, multi-specialty group and it all has one EMR. For Dr. Jones then, he really only needs to list the clinic's name once, and he may have multiple locations but it's irrelevant because it's all going to route to the same EMR. Then that EMR when it gets it will have to deliver it to him directly or however they do that. But if Dr. Jones works at hospital A and hospital B, and so you pull up Dr. Jones in the ILPD and then it says, okay, Good Samaritan and University of Kentucky are his two options and they have two different EMRs. Then I'm thinking of if the physician is creating their entry in the ILPD you'd say, okay, I'm Dr. Jones, I work at hospital A, and hospital A has this entry in the ELPD. Then I also work at hospital B, and hospital B has this entry in the ELPD. So maybe the practice location is what determines where to go and someone who only has one EMR there's only one entry, but for multiple locations that would be linked to the practice site, which raises one other question I still have that I'm not sure we fully addressed.

What if I'm a primary care doctor and I'm referring someone to an allergy practice and I know the allergy practice has four doctors, and my normal referral pattern is I refer to the practice and they assign the first available doctor in the group, so I don't really know which specific name. And what ends up happening in those instances then is that in order to route information, because the ILPD does not include just entity or practice names as opposed to individual doctors you end up routing information using a specific doctor's name and then does that create a liability chain. Let me give you one example of how that happens.

In an emergency department for a hospital in order for the facility to bill Medicare a Medicare eligible physician has to be associated with each visit. So when we have multiple doctors working in an emergency department, because their registration staff have no way of knowing which caregiver will ultimately see the patient, if I'm the day doctor, even if there are two other physicians on duty 100% of the patients are registered under my name. Where that creates problems is if a second doctor gets sued because all the orders look like they came out under my name in the computer system, I get pulled into that and then I've got to be defended to get dropped off of a case. So it makes a big difference that

you're routing things to the appropriate person as many times as possible so as not to create downstream confusion. Was that too much to process?

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

No, I think you're highlighting some of the complexities of the functionality of ILPDs and ELPDs as well. In many instances when I'm referring a patient if I know that the actual provider I will be sending to, the individual physician I'll send it to, so okay I'll be able to send a message to that physician with the clinical information of the patient. If I don't know then I might not be in a position to send a message to a particular physician. I might be in a position to send it to a particular clinic or facility and the facility will then allocate the information to the physician once the specialist, let's say, is identified and the appointment is made. There are a number of other interesting elements of this relationship. In some cases I'm referring a new patient or a patient that is with me, but I'm referring it for the first time to this other clinic. And they don't have an EHR of that person in that other clinic, let's say, so if I send it there that EHR connection is not going to happen yet because they haven't opened yet an EHR or a paper chart. But let's say an EHR for that patient until the patient makes the appointment and then the patient comes in and they create the patient record and then the referral information about that patient shows up. That's an interesting situation because, yes, in many cases the patient that is being referred to a new clinic, they don't have a record of that patient there the first time they go there.

**Steven Stack – St. Joseph Hospital East – Chair, ER Dept**

A perfect example of that, Walter, is fracture care. If you slip on the ice at 8:00 at night and you break your ankle, you go to an ER, and we have a doctor who's listed as on call, and we say call this person's office the next morning for your fracture care. But they're in a practice with 12 other orthopedic doctors and their group has each day a different doctor does the fracture care follow up from the previous day. So we have no idea which doctor they're going to see and that practice has also never seen that patient before because they're only going to see them for that one episode of care.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

My view of things, I guess, and I'm sure there are other perspectives there too, is I think the push scenario might not work in there. The pull scenario will be the one needed, whereby the specialists that have been assigned this patient will be able to query and pull the information about the patient for the referral.

**Steven Stack – St. Joseph Hospital East – Chair, ER Dept**

That's one way to solve it, I guess.

**Peter DeVault – Epic Systems – Project Manager**

I think that's exactly right. I sometimes think that we lose the importance of the pull use cases in a lot of our discussions about directed exchange and that kind of thing, but pull is exactly the right thing for that.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

So I think we need to document, and I've been taking notes here, because this is a very important point, I think we will need to add that clarification about the functionality and the kind of scenario situation for those cases. Yes, I think we'll document that here too.

**Jonah Frohlich – Manatt**

Okay, very good.

**Steven Stack – St. Joseph Hospital East – Chair, ER Dept**

Then, Walter, the real work will happen in your Standards Committee Workgroup on how to actually make this work.

**Tim Andrews**

Actually, one other thing I would add is that at least in my recollection of the ELPD discussions was we talked through this very issue and the notion that there could be more or less inboxes for the ELPDs. So there could be more than one entry point. I don't know, we didn't really specify, because again the ELPD

is sort of a general entry point anyway, but we had the idea that there could be special addresses, because we had things like lab providers as well where it wouldn't make any sense to address a specific person. So at least in my mind the idea of these kinds of references where you don't know exactly which physician in the practice or provider is going to end up with it, there isn't a rule. It would have to be style, if you will, since we haven't specified it by policy.

But I think the idea was you could use a push mechanism directly to the ELPD and to an inbox, or in this case a fracture follow up care to an orthopedic practice or something like that, where they would set up a special thing. It sounds like, from your description, Steve, that would probably be better in many ways because you would not be assuming an assignment. Essentially you're working around the system now by assigning it to a specific provider and this would give you a way not to do that so that the practice can assign it to the right provider right from the beginning. But maybe I misinterpreted the earlier conversations.

**Steven Stack – St. Joseph Hospital East – Chair, ER Dept**

I think you've got it. But ... for most of these care is local, right, so the one instance I can think of, and this is again the tail wagging the dog, but I guess we should try to account for it, is when we have this over the holidays where a person comes up to Kentucky to visit for Christmas but they live in Florida. They break their ankle, and three days later they get on a plane and fly home and that's where they get their final fracture care. So now we need a way for the doctor in Florida, they won't know my name, it depends on what the patient knows or is aware of, but the patient may be able to say, yes, I went to St. Joe East in Lexington. Can you just get it from them? I don't possess the medical records, the hospital does, and so they can reach into the hospital, but there's no directory as we've conceived of it for them to look up St. Joe East.

**M**

Right. You know we—

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

....

**M**

Exactly. When we were discussing the ELPD making recommendations we were very specific and said that the ELPD itself would be searchable, discoverable. That would allow for either in a push or pull scenario an exchange happening directly with the EHR itself and not necessarily specifying the individual level provider that it would be going through, the inbox, so to speak, of the individual.

**M**

That's where you envision maybe these two directories being the engine under the hood, but there's a skin overlaying it. So it's an interface that kind of blinds the user to which directory they're pulling off of.

**Jonah Frohlich – Manatt**

Yes, I think it does help with that ... analogy.

**M**

Okay, thanks.

**Hunt Blair – OVHA – Deputy Director**

Just one more thing on this, I think that part of the confusion is that there's a difference between the ELPD and provider entities. So in the example, Steve, that you just gave, the provider would go, whatever the mechanism it is, ... how it all looks like in the end, effectively to the ILPD to search for the— Anyway, I just think that by making the distinction between ELPD and ILPD we've allied the day to day relationship between the provider entities and the provider individuals that have confused our conversation about it a little bit.

**M**

I agree. I think we're beginning to understand it better as a group, but if it took us this long to describe it well, we probably need to ... a few words on a slide when this presented so it's clear.

#### **Hunt Blair – OVHA – Deputy Director**

I've just been sitting here tinkering with a picture that some of you all have seen and some of you have provided feedback to, and it's probably still overly simplistic but I'll just go ahead and send it all out to the group and people can have at it some more. Thanks.

**M**

Thanks, Hunt.

#### **Jonah Frohlich – Manatt**

Okay, let's move on to slide ten, functional capabilities. So what does a directory ..., what are the functions that it needs to support? We've made a series of recommendations here. One is that the ILPD should support directed exchange, and when we say directed exchange, again, we're talking about both push and pull scenarios. It doesn't mean it can't be used for other scenarios involving third party ... or other third parties that are manipulating data, but we're talking specifically about some directed exchange here push and pull. But there would be again some basic discoverability of individual providers in their practice locations. Again this goes to the discussion we just had, that discoverability means searchability, so we're talking about names. We're talking about practice locations, name of practices, and we're recommending that there is discoverability of individuals in the ILPD, that it provides some discoverability and linkage to an individual level provider's ELPD listing.

So again I think it's hard for us to articulate effectively what that linkage truly is, but that there does need to be a really tight association, and maybe we can refine this a little bit if anybody has some suggestions, but there needs to be linkages or some interaction with the ELPD for basic information regarding exchange capabilities. So I think the scenario that's envisioned here is that ... you have the name of a provider you want to send a record to, but you don't necessarily know that that provider supports a CCD, you can look them up in the ILPD, you associate the ELPD and somehow that ELPD can attest the receiving EHR's capability. And it might be that that's what this recommendation is suggesting. I don't think we're suggesting that the ILPD replicate this functionality, just that it can convey that information. But we might need to refine this because it could add to some confusion here.

#### **Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

I think that these last two bullets really are part of the same concept, of the fact that we expect that the ILPD will be linked with the ELPD. And by virtue of that connection or that interaction or link of the information of the individual provider through the ILPD can be linked to the entity level entries in the ELPD where that individual provider practice is. And basic information about the location, the entity, can be accessed that way, I suppose, through the interaction, including that kind of information about the capabilities of exchange and things like that. But I think these two bullets are talking about the same concept of the interaction between the ILPD and the ELPD and the ability that if I'm searching an individual and now I need to know what are the practices. So I see the practices in the ILPD, and now I find that this is the practice I want, and I need to be able to pull in from the ELPD the characteristics of that practice, that's the kind of concept that I think these two bullets are trying to transmit. We can re-word and combine the two perhaps.

#### **Jonah Frohlich – Manatt**

Okay. The last bullet here, the last recommendation is that we recommend a mechanism for individual providers listed in the ILPD or their delegated staff to correct or update listed information. So again that's a functional recommendation of the ILPD service. I'm going to pause there for a minute and check if there are questions.

#### **Seth Foldy – Wisconsin – State Health Officer**

One question, Seth Foldy joining the call, there are certainly situations where the enterprise might want to be in charge of how individuals – so I'm curious to know if there was much thought given as to when and

what an individual can change, since in some ways they are nested now, per the most recent comments, in the ELPD.

**Jonah Frohlich – Manatt**

That's a really good question. I think what you're talking about is sort of a delegated function for updating listings.

**Seth Foldy – Wisconsin – State Health Officer**

Yes. It seems to me that we will probably encounter a demand potentially for restrictions on the ability of individuals to change their listing inside their enterprise relationship.

**Jonah Frohlich – Manatt**

Right. And I think ... if there would be in many instances that the entity or the enterprise itself would be the organization that is updating ILPD listings for the clinicians that are practicing within its four walls. Walter, you can probably envision this for Kaiser, you're not going to be the one updating your listing.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

Yes. There's a personal component of it and then there's a business relationship component of it where a practice—those kinds of things.

**Seth Foldy – Wisconsin – State Health Officer**

So is there a second bullet that relates to the enterprise updating an individual's listing? If not, we may need to incorporate both concepts.

**Claudia Williams – ONC – Acting Director, Office State & Community Programs**

I'm wondering, this is one of these domains where there's going to be some variability, so if you imagine the CAQH QPD, which its first incarnation was to support credentialing, a lot of those individual docs are updating their own information in order to get credentialing so that it can support other purposes. Alternatively, you can imagine a scenario where the entity is really downloading the information, so I think maybe as we think about recommendations we're going to have to remain open to different pathways, depending on what things are built on locally. But maybe it's really helpful to acknowledge both, or acknowledge what needs to be thought through for both, so that we can reach the goal that we need, that individual map to the entity, and that regardless of what way we do it needs to happen. This is an example where this ILPD discussion is a little different because there might be three or four ways to do it. But any way you do it we're going to have to have a pathway that maps the two together.

**Sorin Davis – CAQH – Managing Director, Universal Provider Datasource (UPD)**

I would totally agree with you. I can tell you at CAQH that's sort of one of our big struggles right now, because I think we've got the individuals who are willing to work as individuals, but there is the large groups, the faculty practices, that really the providers rarely interact. The updates all come from those groups, and they're going to need a pathway to be able to do it.

**Jonah Frohlich – Manatt**

It sounds like we should, and maybe it's in this last bullet of recommendations that there's a mechanism for individuals or their delegated staff, it sounds like we need to refine that and describe how there might be this sort of delegated function of the entity or enterprise to update individual provider listings. Is that right?

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

Yes, I think that's right.

**Jonah Frohlich – Manatt**

Okay. Other thoughts on this? Let's move to slide 11, and Walter, I'm going to have to turn it over to you in just a moment. I think I've got about five minutes. In this we're talking about the recommendations on slide 11 for operational requirements, and we have four recommendations here, and we'll turn these bullets into numbers. The first is that we are recommending an audit trail function to determine

appropriate use and access of ILPD services and content. The second is that the ILPD content should be updated regularly, at least quarterly, as we've heard in many of our hearings, and more frequently if possible or specifically as providers change practice locations and affiliations. The third is that update in resolution processes should be put into place to allow ILPD users to request changes to content when errors are encountered. You may want to refine that again based on what we just mentioned and say users and/or enterprises that are responsible for updating ILPD information. Then finally, if a provider in the ILPD is affiliated with an ELPD entry, that there should be a tight link between the ILPD and the ELPD entries. I don't know if we want to get more specific on that recommendation.

**Sorin Davis – CAQH – Managing Director, Universal Provider Datasource (UPD)**

On bullet number two, I think if you leave it at regularly, this notion of at least quarterly I can tell you can be quite a burden on the provider community. You will discover that you're going to have difficulty with compliance with that kind of a frequency. We do it three times a year, every 120 days, and I can tell you that it can sometimes be a struggle for providers to do it that often. We chase them regularly to remind them to do it, and we often get the feedback of, nothing has changed in the last 120 days, why are you bothering me?

**Jonah Frohlich – Manatt**

Okay.

**W**

Have you done any sensitivity analysis for what data quality is gained or lost with different intervals?

**Sorin Davis – CAQH – Managing Director, Universal Provider Datasource (UPD)**

We have not done it at the interval level. We have completed a data quality study in general to see how providers, the compliance. The good news there, and I'll be happy to share that with the group as well, is that providers for the most part are willing to give us the data. How you ask questions is critical because they can make mistakes, and it's real important. We did not see any variation on the frequency but we know from a customer service perspective anecdotally that we do get commentary on three times a year for some providers seems like a lot. So it's just a point. A part of me likes quarterly because I think Medicaid in some states has quarterly reporting requirements so some people have to collect data that way, but the providers are not going to be happy having to maintain quarterly as a rule.

**Hunt Blair – OVHA – Deputy Director**

I think the point about this second bullet ties back to the last bullet on slide ten and the whole notion of some kind of governance agreement potentially among contributors to ILPDs, if it's a federated structure that feeds into the ILPDs like in some states we're talking about. I'm not sure how to reduce that to the bullet, but maybe the thing to say in this second bullet on 11 is to somehow or another reference the fact that it could be not just the provider but again the delegated staff or delegated authority.

**Jonah Frohlich – Manatt**

Yes, I think that's a good point and we can make that change. The real emphasis should be updated as changes in information occur, making the point that there should be diligence on the part of the providers that when something happens this should be embedded in their process, that they should communicate the change.

**Hunt Blair – OVHA – Deputy Director**

Right. And I'd expand that point, this is Hunt again, not to just the individual providers but to the entities, hearing some stories from my colleagues in Indiana about massive changes that health systems make, not even really thinking about what the implications will be down the road and all kinds of system implications, like even just changing a phone number. So we need to be setting the bar that everybody who's a player in this has the responsibility to update on all changes.

**Jonah Frohlich – Manatt**

Yes, I would agree with that. I think we could take a lesson from Wikipedia and other Wiki collaborative components where you really have a joint shared responsibility to update the ILPD listings and that there

does need to be a mechanism, which is why we put it in, for anyone to be able to request the change, not just those who are listed.

**Hunt Blair – OVHA – Deputy Director**

But it has to be tied back to the governance structure so that only authoritative sources can make the changes. As in the Wikipedia example, anybody can log on and –

**M**

Right, that's a good point.

**Claudia Williams – ONC – Acting Director, Office State & Community Programs**

Sorin can speak to UPD, but I think it's a very interesting case because you have two things. One, the individual provider is accountable for their profile and you have a really clear accountability link. And two, it's linked to credentialing, so you have a high motivation to keep it updated. I think we're going to have challenges on both fronts, so who is the ultimate accountable entity, and maybe there's a way to delegate that to the entity, not the individual, but maybe the individual provider has to authorize that. I don't know. And secondly, I think we certainly don't want to create ILPDs with no business case around why anyone should want to update the information. And like I think, Jonah, in California what you guys did was said you can't participate in any of the services the state's helping to launch unless you also participate in a provider directory, so that was one mechanism. Maybe you link back to credentialing, maybe there are other ways, but that's going to be really important to figure out.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

Jonah, I have a question that relates to this last comment by Claudia. Entities will likely want to have this link to their credentialing process and providers may leave and then they would no longer be credentialed in that institution and someone's now pushing to that ILPD that's been changed or that provider who's left the agency. How will you get the push to a non-affiliated ILPD to the right ELPD, someone who once was associated, but now is gone? Do you want that information to go to their new site?

**Jonah Frohlich – Manatt**

Yes, I think that's a really good and important point and a question we need to address. I think it calls for what Hunt calls ... governance here, where there needs to be both a mechanism and an established process whereby any change made, there needs to be an agreed upon set of rules that ... specific change. Especially if it's like removing an individual provider from a listing that affiliates it with an entity and links it to another, so I don't think we necessarily need to get specific with how that's done, just that that's a part of the functional requirement that we're recommending needs to include that process.

**Sorin Davis – CAQH – Managing Director, Universal Provider Datasource (UPD)**

Does anyone envision the need for maintaining historical data like this? Because typically the way you deal with that is an end date to, if you will, that relationship. The question is, does that relationship carry over into the future? Is it relevant for something like this? Do you need that historical data? If you do then you deal with it through an end date kind of relationship.

**Hunt Blair – OVHA – Deputy Director**

I think Linda from Wisconsin in her testimony talked about the importance of keeping the data forever, right? So the end date for a provider in a specific context would be an important field to have in this, you're right.

**Sorin Davis – CAQH – Managing Director, Universal Provider Datasource (UPD)**

Yes. I mean that's how we do it in the UPD because we need the work history going back ten, fifteen years.

**Hunt Blair – OVHA – Deputy Director**

Right. I think that's where Linda was coming from also.

**Steven Stack – St. Joseph Hospital East – Chair, ER Dept**

Can I ask, Claudia, when you use the term, and others on the call, “credentialing,” what do you mean by that? Credentialing has a lot of meanings and it has more stronger meanings for me as a doctor. So what do you mean by that?

**Claudia Williams – ONC – Acting Director, Office State & Community Programs**

Well, I was just using the UPD example, where that directory has served plan credentialing purposes.

**Steven Stack – St. Joseph Hospital East – Chair, ER Dept**

Oh—

**Claudia Williams – ONC – Acting Director, Office State & Community Programs**

... and that’s only one. All I was trying to do is make the point that that is a really strong hook because I need to get credentials.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

Steve, I was referring to it as “privileged” at an institution.

**Claudia Williams – ONC – Acting Director, Office State & Community Programs**

Okay.

**Steven Stack – St. Joseph Hospital East – Chair, ER Dept**

Right.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

So general to credentialing aspects, I guess, ... the health plan credentialing of providers and then the hospital privilege credentialing process.

**Steven Stack – St. Joseph Hospital East – Chair, ER Dept**

And as much as I’d like to have new things serve multiple purposes, I guess I’d be very careful how that gets inserted into this particular discussion, because credentialing, I think we have other levers and ways to assure compliance other than using that particular term, because it can be charged at times. Credentialing gets just one step away near to licensure and things like that. As far as people participating in this, I think you might have to just have that if you haven’t validated that your entries are correct on a periodic basis, perhaps your activity in the directories ceases until such time as you verify. So I think for us to have to do 3 times a year if you haven’t moved for 15 years and nothing’s changing, it gets frustrating unless it’s easy and automated. So perhaps there’s an e-mail notification to the designated compliance officer for a practice, and it’s probably the practice manager or the doctor themselves that says is your entry up to date, please click on the link below, and you either say yes, or you say no and then it prompts you to update your entry. But I’d be careful with the credentialing part and also careful, as I mentioned on a call a long time ago, about making this directory into something that everybody goes to to get all this information. It’s principally a routing tool.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

I think that’s a very important point to make as a definition of scope, if you will, and understanding what this is not supposed to be used for, perhaps. I find that the real main primary purpose is for routing for exchange of health information that it might provide some other information but that it’s not its intent really to do that. At some point, and at the very early part of the discussions we had several calls ago we had thought about maybe this could support some other types of transactions, including this core credentialing process. But clearly the credentialing process is a legal process, in the first place, and it’s a process that requires a lot more validation and verification and things like that. So in my mind the ILPD would provide information about the credentials of a provider but not be used necessarily by entities to do credentialing.

**Jonah Frohlich – Manatt**

You made the distinction, Walter, thank you. I’m sorry, I have to go to another call, so you don’t wonder why I’ve disappeared. Thank you very much.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

Thank you. Thanks so much for your contribution.

**Claudia Williams – ONC – Acting Director, Office State & Community Programs**

I'm wondering, though, we already walked through the ELPD that we thought was really critical for routing and the question becomes for any state or community whether an ILPD, is the juice worth the squeeze. And I'd be curious to hear other people's views on for the ILPD, is the motivation, is it going to be worth it to build such a thing just for ... purpose? Maybe here's a way you can think about it, maybe what we're really talking about is creating a data platform for providers' information and maybe in a modular way they can choose how they want to, sort of like with a PHR they can choose to then participate in an app that does credentialing or in something that does that. I'm wondering if there's a way to think about this building out over time that allows for that information to be used in a way that matches maybe the individual's needs. I just am not sure it's going to be worth it to build this for a very narrow purpose and maybe we need to enable the use of it for other purposes without saying that that's tied up into packets what it is.

**Hunt Blair – OVHA – Deputy Director**

Not surprisingly, I agree with you. I don't disagree, Walter, with the point that you're making that in the context of this taskforce discussion and the ELPD, ILPD enterprise that we're talking about constructing, that the ILPD has a narrow use. But I do think that to the extent that ILPDs are a service in the stack that an HIE offers, and this goes also to the public health and some of the other uses for it, and actually – well, I'll leave it at that. But I think you're right, Claudia.

**Peter DeVault – Epic Systems – Project Manager**

I also really like the idea of characterizing it that way, as a data platform that different applications can be built on.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

I don't disagree with that possibility. I know when starting and building this type of data systems keeping the main purpose in mind always helps to constrain and control the effectiveness of it, I guess, and the use of it. And when appropriate, of course, using it as a platform for other uses, yes, I think it's certainly going to be an opportunity. I'm just thinking of the similar type of directories, if you will, or databases that exist on providers and how they're used and what are they limited to. I think they always have that constraint. Like the NPI, the National Provider Identifier, probably people thought that was going to be the provider directory in this country, and it serves a provider directory function in many respects, but by virtue of the content of the data that is being captured, it has a very narrow specific function and limitations, of course.

So as a data platform it can certainly be seen as a place or a system that could fulfill other functions. I think as it begins to be used, ideally the use will begin and the purpose for which it was originally built, or is being built, which is supporting these exchanges, will be fulfilled. And then as other users begin to be seen as opportunities then the directory can grow and the directory can become much more reliable as well and much more stable. So again I'm not disagreeing with the concept of the data platform, but I'm mindful of the fact that we've got to think within the context of what we're doing in this particular taskforce and avoid the scope ..., if you will.

**Claudia Williams – ONC – Acting Director, Office State & Community Programs**

I guess to the extent that what we're doing is not like with the ELPD, coming up with one set of recommendations everyone must do. I think there's an opportunity to say states need to carefully think through the purposes that this is going to be pushed to and make sure there's agreement on that and provide a flexible way, as appropriate, for folks to participate in different uses of it, but at a minimum they need to tackle data quality and business case. Without it being accurate and up to date it's not going to be useful for anyone's purposes. And maybe then the real core of what we're doing is saying from the ELPD, ILPD linking standpoint the absolute critical thing that needs to occur is the mapping between ELPD and ILPD, and if that doesn't work then it can never – so I wonder if there's a way to triage our recommendations. Some are saying here are things to keep in mind as you're doing it, some are saying

here's a way to future proof what you're doing and make it more useful, and some are saying at a minimum that we're looking at ELPD, ILPD link here's what you need to do. I'm not sure we know enough to know definitely what path things are going to take. I think we've identified risks and how folks understand them. I just think it's a different discussion here than it was for the –

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

But we do know, roughly I guess, what is needed in order to achieve routing, right, that is one of the purposes, if not the main. So we can prioritize and say, okay, this is being built as one of its functions to support routing. To do that you need this at a minimum and if you want to use it, there might be many other users for individual level provider directories, including things like supporting or serving as an additional source for credentialing and other things. If an entity wants to use it, and I assume, Claudia, you're talking about state HIEs looking at this, right, and saying, okay we need to build an ILPD or have some sort of an ILPD functionality to support routing, but we also think if we are going to go down that path the ILPD could be used for many other purposes, right?

**Claudia Williams – ONC – Acting Director, Office State & Community Programs**

Yes, and I guess like you said, a lot of folks are talking about building ILPDs that can be used by IDNs and maybe a local RHIO and a bunch of different users, and I think we do have to think about the value to the individual to participate. So maybe routing takes you all the way there, but I think it's quite possible, not in every state but in some states, people are going to say, like they have in Wisconsin, I don't really want to participate in some of these. I'd rather participate in one and update my information on that and then choose what services I want to use that use my information. I think we have to keep open to that and think about how that may affect our recommendations, just as you've just done, Walter.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

Yes, okay.

**Claudia Williams – ONC – Acting Director, Office State & Community Programs**

So I think the nuances, we're not necessarily saying its main function, I think we're saying the principal thing we have to tackle is the routing function and here's how we think about how that occurs, here's the mapping .... But then to make this work, its costs and ongoing operation, it may well be of interest to everybody to make up ... and here's ... think about in terms of making it more useful to others ....

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

Yes, okay. I don't know, are you still on, Jonah?

**Jonah Frohlich – Manatt**

I'm back, but I'm on a train.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

Okay. So do you want me to take over from here?

**Jonah Frohlich – Manatt**

If you wouldn't mind, please. Thank you.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

Okay. So we're finishing up the operational requirements, and I've been taking notes so we'll be updating this particular slide and adding some more definition of what we just discussed about the concept of if the principal thing we're trying to do is routing, this is the minimal thing needed. But if there are other uses that entities want to consider, then certainly this could ... as a platform for that. Any other comments on the operational requirements before we get into the discussion of the business models? Okay, let's go to the next slide.

Here's where we really want to spend the remainder of the call, is in discussing these different business models. As you recall, in the ELPD we took an approach of recommending of the concept of an Internet based, federated with some central function using registers. All these steps that we talked about in the

ELPD it seems like for ILPDs we are looking at a different sort of approach, and all the discussion that we just had points to that fact too, that this is going to be somewhat different than what we had recommended for the ELPD for the entity level. So we have some questions that we wanted to discuss and so this is where we really want to hear your perspectives to frame the recommendations about the overall business and policy approach. How do we see this really working and being operated and who operates these ILPDs, these are the kinds of questions that we are looking at and what are the approaches that we should take.

As ... pointed out, should we follow an Internet-like model with a nationally coordinated but a federated approach, which is a multiple of these ILPDs perhaps by HIE or at the state level? Since most of the states are looking at this in terms of their HIE initiatives and there's a lot of local interaction and there's this state level credentialing or state level licensing of practitioners, that kind of base, is that the approach we should be looking at? Or do we think that there should be a national provider system or national database, if you will, just to put it in those terms, that has all the providers, keeping in mind that we're talking about entity level we were talking about maybe hundreds of thousands or a few million, but here we're talking about not just a couple million but probably more than that, and it's individuals and it's all the details about him. So that's the first question. In other words, some strong opinions, as pointed out in the slide, about the fact that this can't be really done at a national level but it should be more pushed out into a federated model into some sub-national level, regional or state approaches. So let me stop there and see what are the thoughts that people have in our workgroup here.

#### **Claudia Williams – ONC – Acting Director, Office State & Community Programs**

I guess at this point I really would agree with the idea and I think this has been our approach from the beginning in this area, that we're talking about a heterogeneous set of activities to do this. I think folks felt it was too big a lift and too complex, at least in our initial conversations, to imagine a national approach just at this time. I would, at least for right now, tend to agree with that. I think maybe a way to twist this conversation about federated is to ask is there a light and flexible way to allow for communication across ILPDs that might have different – I don't know that we're ready to say this is the architecture, but can we use open APIs? Is there a common authentication approach we can use? Can we build it into direct – I think there are a lot of different ways to do that and that moves quickly into standards. But it feels like the goal should be a fairly nimble way to allow for, it could be saying let's go through ... process for the core set of terms, for instance, to make sure that we have the same kind of fields, at least for maybe the 20 core ones. So it feels like one very ripe area is to say we're not going to require all of these to look the same. We're not going to require them to use the same standards or architecture. But can we allow them to communicate easily across, so benefit from each other's functionality without necessarily stopping the trains and asking everyone to do things exactly the same way. That's just my two cents. I'd love to hear others.

#### **Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

But in your statement, because I think one of the big important elements is interoperability between these pushed out there, independent ILPDs. So in order to achieve that interoperability, well, yes, absolutely mandating or requiring or expecting or establishing a standard architecture and a standard operational approach might not be right. I think there needs to be some basic standard elements that are defined for organizations that are implementing or planning to implement these ILPDs so that those ILPDs can interact with the other ILPDs, and there is already work around standard messaging for provider directories and things like that. Most of the work being done by groups like IAG in their profiles for personal white pages and for provider directories, or more recently the HL7 Service Oriented Architecture Workgroup looking at provider directories of well, most of that work is about the messaging and the exchange of data between a provider directory and others outside, including other provider directories. But not necessarily the how all this gets done across the nation, for example, and not so much the architecture itself.

So there needs to be some standardization on some elements and there needs to be, in my mind, some statements of direction in terms of we expect that in order to be successfully operating an information exchange in a regional basis or a statewide basis. You're going to need to have an individual level provider directory which should have the following characteristics and just generally provide the

characteristics. And then probably the Standards Committee will work on defining the standard data elements themselves and the core data elements and all those things, and then the messaging exchange is between those. So is that in your vision too, or in the way you're thinking, Claudia, that there should be some basic standard elements so that they can become interoperable?

**Claudia Williams – ONC – Acting Director, Office State & Community Programs**

Yes, absolutely. And I'd love to hear from some of the other states that are working on it, because I think there's just going to be a huge lift at the state level to even get these things up and running. What is your data source? How do you keep it up to date? How do you get people to participate? What's the privacy? So there's a huge list going on right now and then I think there's a lot of interest ... and maybe it would be interesting to hear from some of those regional efforts to be sure that you're not building something that can't speak to the others. I guess I would just want to be judicious about what that means, about what things do we really need to standardize? Are there ways we can accommodate differences in our architecture but still share information? Do we need one way to share information or can there be more?

I think it's always tricky to try to standardize something when you don't even know what it looks like yet, and efforts that try to pre-standardize things when people are in the middle of their work can sometimes not work. I think the data element is clear. I think ways to open up your, whether it's ABI or other means, your provider directory is clear. Integrating this with your direct implementation or exchange implementation is clear. I don't know. I probably talked too much. I'd love to hear from others that are doing this on the ground about how they're thinking about what's needed to exchange with other states around this provider directory.

**Robb Chapman – CDC – Dir., Division of Informatics Solutions & Operations**

Seth Foldy had asked me to listen in, and maybe I'm jumping in where I shouldn't, but for what it's worth when we set out to do a federated directory across public health agencies in the states and at CDC where we ended up was specifying what the directory exchange protocol, what the message format and transport needed to be. And then we left it as light as possible in saying anything else about how a directory needed to be implemented at each state because we found that we really had no authority there and it wouldn't have done any good anyway. But what we found is that if everybody can agree to the directory exchange protocol, which includes the data elements and the formats for the data, and if everybody has agreed that their system needs to support that directory exchange, then that's as far as we needed to go to ensure that parallel kinds of data were being maintained everywhere. And for what it's worth, there are industry standard message formats for directory exchange out there. So that problem has been solved elsewhere.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

Thanks, Robb, for those comments. Yes, absolutely, I think that's exactly the kind of thing that we've been looking at and talking about. So this is very helpful. Other comments?

**Kevin Hutchinson – Prematics, Inc. – CEO**

If you want, again, practical stuff, the New England Health Exchange has been implementing provider directories in Massachusetts and is talking to the other states now, and I'd say two things. One is, I would second what was just said. Protocols are a lot easier to standardize, and that's ultimately what really counts anyway, particularly given the earlier conversation that mostly these things will be embedded as infrastructure and other uses, other applications. So really what you need is, how do you call an open API or the CDC calls it in their ... efforts they call it protocols. I agree that's the right approach. NHIN, by the way, has published both their data and their API, so they've made their API open and I think they're more than willing to work.

The other thing I would say is use cases are really helpful, actual work. I think the CDC effort was driven because they needed things to happen and NHIN was driven because they needed things to happen. So it's a whole lot easier when you have a set of transactions or use cases that you have to fulfill and then it becomes a matter of okay, I need to get this information so what can I do to make it as easy as possible, as generic as possible, as interoperable as possible. But I would agree, I think there are sources, places we can look for standard transports and standard protocols, and that would be a logical spot, and places

where people are doing actual work because then you can see in practice what's really needed in terms of the functions in the data.

**Hunt Blair – OVHA – Deputy Director**

I think that the most crucial thing is that the addressing convention or standard or whatever of the individual and the entity in both the ELPD and ILPD, that's got to be rock solid. And from there presumably most of the rest of it will follow and it will allow for variation in the development of ILPDs in different states and different entities because of different, more locally focused needs. I think what this whole morning's discussion, and maybe I'm focused on this because of the PCAST Report Workgroup and a blog post that Wes Rishel put up this morning, what we're talking about is the directory structure for an ultra large scale system that we're designing. And we're designing it and building it, and we don't know what it's going to look like. So we have to build in the flexibility for it to go in directions that we don't anticipate now while hopefully making it possible to carry forward whatever we build as a legacy into the new system that we don't know what it is yet.

**Claudia Williams – ONC – Acting Director, Office State & Community Programs**

Yes, good point.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

Excellent point, absolutely. One thing I was thinking—and this is very helpful because again, Wednesday we're going to have a meeting with the Standards Committee leadership and John Halamka. Someone mentioned a couple of comments ago the New England Exchange, and John, who's the vice chair of the Standards Committee has shared with this group of the Standards Committee leadership the example of how NHIN does provider directories. So I was just thinking that it would be helpful for our group here, as we're now defining the scope of our recommendations in terms of the overall approach. One of the things that we could possibly do, because in reality HIEs are going to be looking for this kind of information, is to identify some examples of how this is being done today and provided as examples of how this could work at a regional and an HIE level. I know basically those examples exist, but it's sort of a way of saying there are some basic principles we're establishing.

One is we understand, and this is the reason we're working here, we understand that HIEs and the whole HIE, Health Information Exchange, needs ILPDs to be able to route information and there could be other uses of it. We understand that HIEs need some guidance on recommendations about how to implement them. We also understand that in order to create an interoperable system across HIEs there has to be some standardization of some elements, and Robb provided some of the examples and others have talked about here the kinds of things that we might want to concentrate on in terms of recommendations of where the Standards Committee should define standards. Then in order to support some of this need for guidance on recommendations, we can identify and document a few examples of how this has been done. NHIN would be one, certainly, I think the Indiana Health Information Exchange would be probably another one, and there could be a few other examples of how provider directories at the individual level have been done.

**Tim Andrews**

I would definitely keep the CDC work on the docket as well.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

Absolutely.

**Tim Andrews**

Their model is a federated model of working with the state, so there's probably some things to be learned there.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

Thank you, yes, absolutely, that would be another example. How does that sound to people, if we begin to gather and document these examples and provide them as part of our recommendations, not that this

is the recommended way, but this is a few examples to provide guidance to HIEs? Does that sound valuable to people that we do that?

**Jonah Frohlich – Manatt**

Walter, I think that makes a lot of sense and it seems to align more with where we're trying to grow in the ILPD business discussion. I don't think we can be really concrete about what they should be doing. We can just find examples of what you could do in terms of a business model and revenue stream.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

Right. Claudia, from your experience or perspective, and your role in the HIE environment, would that be helpful to have as well?

**Claudia Williams – ONC – Acting Director, Office State & Community Programs**

I think it would be really helpful, because I think it will hinge our recommendations or best practices ... to things that are going on, on the ground. I think that would be great.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

Wonderful. So we're now really in this slide, the third sub-bullet under the first bullet which says "Who operates ILPDs?" and then the whole registration process, who registers individuals. To some extent we're saying we're not going to really provide policy recommendations about who should be doing this and that.

**Claudia Williams – ONC – Acting Director, Office State & Community Programs**

I think it would be really helpful, based on the case studies we hear from now, to get the best practice. I think so many folks are tackling this, so I totally agree that we're not driving towards a uniform way. But I think to the extent we're unearthing what's worked and what hasn't and what the data quality is, that's as useful to share as anything else. So I wouldn't shy away from this area, but I agree that we're not trying to come up with one way of doing it.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

Exactly. That's the concept is really we're not pushing for a particular way of approaching this, but more best practices and very critically certain standards for certain aspects for this to be interoperable, really. Well, that probably simplifies quite a bit the set of recommendations that we would be doing. I think this is the right level, the right way to approach it really. I think it's very consistent with what everybody has said here. So we're going to provide more, what you see in this slide about the registration process and maintenance and access and use, we're really going to provide examples and best practices of how some of these elements are done, including who operates the ILPDs, and not really drive a specific recommendation towards that. Does anybody disagree with that approach? Okay, I will take silence as consensus, so we'll move forward with that idea. We'll, again, begin to document that and glad we have already started documenting some of those examples with the examples by NHIN, and Robb, I think we'll communicate with you to get a more detailed description of the CDC approach.

If we go to the next slide, the next slide actually talks about a couple of other elements of this ILPD, the data content, which is one of the things that I think we mentioned would be helpful to look at recommending some minimum set of standards if ILPDs are to support a Health Information Exchange and be interoperable. Now we listed here a few items, and a number of these items can be drawn from the best practices and examples that we will be documenting. But certainly one of the ideas, and coming back from the original concept of ILPDs being put together and organized in a common way across the nation, some of the original ideas we had were that the sources that could be used would be NPPES, the National Payer and Provider Enumeration System, the one that supports the NPI today, state licensure board, and CAQH. So this would be probable recommended sources for ILPDs that entities are creating. And again we're looking to how current examples have used or connected to these types of sources, or they might be other sources that they recommend to use to begin the population of these ILPDs. The question about validity, so what's a minimum level of accuracy needed for data assurance, this is probably another area where we would want to look at some of the examples and see what level of

validity and accuracy they are using. And again, sort of creating a concept of some recommended ways but not forcing the specific levels of requiring those kinds of specific levels.

The standards we talked about, as Robb mentioned and I mentioned earlier, there are standards in the industry already about messaging, about content, about exchange between provider directories and between entities using provider directories and the provider directories themselves. So I think this standards area will be the one that the Standards Committee would be really, in my mind, expected to contribute and to look at identifying those industry standards that exist and where there might be gaps.

Then the last point there, kind of linkages between ELPD and ILPD, this is established when collecting the ILPD content. This is, again, another important point we highlighted earlier about the connection between the ILPDs and the ELPDs. So this could be another functional element that links to this data content that we would need to be looking at.

Let me stop there and see if there are any comments about the data content aspect of this. And again, in light of the discussion we just had and concepts about what areas we should focus on in terms of recommending the ... standards this will be probably one of them. Any comments, reactions?

#### **Robb Chapman – CDC – Dir., Division of Informatics Solutions & Operations**

One item that I know we touched on earlier, I don't remember exactly how we were phrasing it, but I think it had to do with the motivations that could be put in place to help ensure that information is kept up to date. There was a time in the past when CDC was considering trying to get into the business of establishing a federated directory of providers for entirely another purpose. This is many years ago, and it's an effort that fell somewhat by the wayside, but where we ended up was that working with the licensure boards was our best bet in terms of having a data source that would be most likely kept up to date. We certainly thought it was well beyond our capability to provide any better motivation than that and so our effort focused on collaborating with the federation of state medical boards, for example, to see about access to information that was already being collected.

#### **Hunt Blair – OVHA – Deputy Director**

I appreciate that point, but I think that one of the things that we've discovered in Vermont and in conversations with other states, is that unfortunately the licensing boards aren't necessarily the most up to date sources. Hence, going back to the discussion earlier about ILPDs serving a number of different functions, that one of the functions we're looking at in Vermont is to utilize it as the authoritative repository of the data for various purposes for public health and licensure, as well as for exchange. But I think that the point that you raise is right. That going back to the slide, Walter, I think we want to say that there needs to be some recommendations about reconciliation and verification at the maintainer of the ILPD level. That part of what lets you into the game of being an ILPD is that you assure that you have the governance that ensures and enables the integrity of the data basically. So we should be explicit in our recommendation that one of the things that we want to make sure that ILPDs do is that, that they have to provide data integrity or they're not players in this.

#### **Sorin Davis – CAQH – Managing Director, Universal Provider Datasource (UPD)**

I have a question on that, because it is an important point and I agree with you. We've talked to lots of licensing boards also and they have problems with maintaining their data current. But, for instance, licensing boards that were also deemed a primary source for the license itself. So it sounds like we're going down a path that speaks to how will we verify some of this data. I'm trying to avoid the use of the term "credentialing" here, because we have a problem with that. But it comes down to how do we know that data is current and accurate. Different sources may be valid sources for specific data elements, licensing board for the license, no question about it, if we needed specialties ABMS would be such a source. But when you get into what we're really trying to get at, which are practice locations, contact information, there really is no current and up to date independent source short of the provider themselves.

#### **Hunt Blair – OVHA – Deputy Director**

Right, so I think that the verification is exactly the right word. And a component of validating, verifying the data integrity is that the ILPD, the entities that run those, state HIEs or whatever, that governance

agreement will need to enable the different sources of data, just as you're saying, Sorin, that clearly nobody's more authoritative about the license than the board of practice. They might have a physician's home address not where they practice, let alone the couple of different places where they practice. So they'll have to be, even for the ILPD data integrity, that kind of federated governance structure, which again goes to the point of why I think it's got to be at the state or sub-state and bigger areas, sub-state level, to deal with that granular level of detail that's going to be lost as you go up.

**Sorin Davis – CAQH – Managing Director, Universal Provider Datasource (UPD)**

Yes.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

Yes, great point. I've been taking notes. These are the kinds of policy recommendations that will be important to spell out to establish for entities that will be getting into the development of ILPDs, without prescribing specifically how they do it necessarily, and then provide them, again, with examples of how some entities are doing it today. Then we talk about governance in here, we talk about the accuracy and the validity, the verification of the data, those kinds of things, so great points. Any other comments on this one?

Okay, the next one is security. Actually, the previous slide, we have two more, so security, we noted here a couple of points, how with security and data use rights and that could be managed, should there be a consistent set of national policies, even if implemented by a federated set of registrars. Here again we're not really talking anymore in this kind of approach about registrars per se, and the security side, again, would be more recommendations about the expectation will be that there will be appropriate governance and data use access controls and rights will be managed and appropriate security will be implemented in the system itself to do things like avoid inappropriate access and inappropriate updating and those kinds of issues. Then auditing, of course, maintaining some audit trails, and certainly we talked about the expectation that some of the information would need to be maintained historically. So all those things would be the things that we would be spelling out in our set of recommendations, but again as high level recommendations, not so much as prescriptive ways of how security would be done and those kinds of things. Again, is this consistent with what we've been talking about now with this approach on our recommendation for ILPDs?

**Claudia Williams – ONC – Acting Director, Office State & Community Programs**

One thing that's interesting is I think we have, as you've mentioned, revealed or exposed some potential recommendations and best practices just even in this conversation. So one thing maybe we can do, maybe Kory, you can help us take a lead on, is just even maybe doing a one pager or a two pager on some of the domains that we've laid out and maybe some of the initial starter recommendations. Then if we go to talk to some folks in the field or have some case studies, we can be testing those against those conversations and sort of have an iterative way to get to what we might want to present back.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

Great, that would be very helpful, absolutely.

**Claudia Williams – ONC – Acting Director, Office State & Community Programs**

Whatever we do next we don't have to treat it as needing to line edit yet, but just does it feel like it represents a conversation and let's test it against real life.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

Yes, great. That would be very helpful, Kory, if you could take the lead on that.

**Claudia Williams – ONC – Acting Director, Office State & Community Programs**

... Kory.

**Kory Mertz – NCSL – Policy Associate**

We'll see what we can do. The next call is on Friday and then our last one is on the 28<sup>th</sup>, so we have a limited time.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

Yes. Again, we wouldn't be really providing detail recommendations on things like security or all the other elements, but more high level recommendations about the need to include these kinds of elements.

**Claudia Williams – ONC – Acting Director, Office State & Community Programs**

So I'm wondering if there's a way to buy ourselves a little more, like I think two more meetings might be enough if one of them is a call with some of these case studies, but I'm thinking Friday will be tough to do that. Is there a way that we can borrow – I'm just trying to think through how to –

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

Yes, how to process this. So if you recall at the beginning of the call we had the schedule, so February 11<sup>th</sup> is our next call and between February 11<sup>th</sup> and February 20<sup>th</sup> we don't have anything scheduled. February 28<sup>th</sup> is the IE Workgroup meeting, so we could potentially add another call between February 11<sup>th</sup> and February 28<sup>th</sup> that would allow us to, I mean maybe even close to February 28<sup>th</sup>. So the week of the 21<sup>st</sup> of February, so we could actually bring back the revised set of – so this Friday the 11<sup>th</sup> we would bring in some of these new perspectives in as much a complete approach as possible, just laying out the new frame for the recommendations and provide a couple of these examples, perhaps. I know in NHIN already John has shared those examples of how they handle provider directories with his okay and we can distribute those to the workgroup before Friday and maybe a couple of examples of perhaps CDC we could document that example as well. So by this Friday we could do some of that, not the whole layout of the recommendations, but the framework. And then maybe the week of the 21<sup>st</sup> we can schedule a call, and I know that's the week of HIMSS, the annual conference, but perhaps we can schedule a call there and finish up before the call on the 28<sup>th</sup> of the full IE Workgroup. Would that be doable, do you think, Kory and Claudia and others?

**Claudia Williams – ONC – Acting Director, Office State & Community Programs**

I think what you said was to maybe try to pull into the case studies, at least informally this Friday, and then see whether we needed another call in between. We can certainly go back to the testimony from NHIN and synthesize it. I think, from the CDC example, ... maybe it's possible for you to map that out a little bit for us, maybe with some standard domains we're looking at, data quality, ... patient, and then I think the Wisconsin example might also be an interesting one to pull in.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

Which one?

**Claudia Williams – ONC – Acting Director, Office State & Community Programs**

Wisconsin.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

Oh, Wisconsin, okay, yes.

**Claudia Williams – ONC – Acting Director, Office State & Community Programs**

..., Linda. I'm just trying to think through our conversation today, were there other cases people really wanted to bring to light besides NHIN, CDC and I'm suggesting adding Wisconsin?

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

Indiana was the only other one that I thought might have something, the Indiana Health Information Exchange.

**Claudia Williams – ONC – Acting Director, Office State & Community Programs**

Yes.

**Hunt Blair – OVHA – Deputy Director**

I would second including Indiana. They have talked about the challenges that they faced with their provider directory.

**Claudia Williams – ONC – Acting Director, Office State & Community Programs**

Here's another suggestion, and, Kory, please stop me in my tracks if this isn't feasible, but maybe what we need to do is we need at a staff level to have conversations with these folks and document it in slides, rather than having them— If we want them to testify or be available for our call I don't think Friday's realistic, if it would feel sufficient for us to synthesize either from testimony or from conversations with them, I think Friday might be realistic. Could you folks need and want a chance to actually interact with those guys, or would it be enough for us to do the work?

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

I was thinking more of doing the work. I wasn't thinking of having –

**Claudia Williams – ONC – Acting Director, Office State & Community Programs**

... them on the call, okay.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

... having them on the call. I can forward you the materials that I got from John, which are pretty much public documentation of NHIN's work on provider directories, so I can certainly forward you that, and then with John and others or some of the people that are on this call even, we can complete the information about NHIN. But yes, I was thinking more of doing that than having people come to the call.

**Claudia Williams – ONC – Acting Director, Office State & Community Programs**

Okay. Before Kory shoots me, let me talk to him a little bit off line and think through how we get from here to there by Friday. If it feels like even to do that we just need a little more time, then maybe we'll look for another date that's a few days later. But otherwise we'll try to do that and we'll try to target the set of questions that we talked about today, but bringing out the experience of these entities in dealing with that.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

The other thing was we were thinking, or I was suggesting, I was suggesting having another call of this taskforce the week of the 21<sup>st</sup>, perhaps even Friday the 25<sup>th</sup>, which is the Friday before the 28<sup>th</sup> and Monday the 28<sup>th</sup> when the Information Exchange Workgroup meets. So if we have a call that week we will be able to finalize and get the appropriate approvals from every one of the recommendation we would present to the Information Exchange Workgroup. And that will give us another opportunity to bring back all the remaining points. Would that be feasible? Is that something we can do?

**Claudia Williams – ONC – Acting Director, Office State & Community Programs**

I think from the ONC end we can. I think it's always tricky to schedule, but we could give that a shot. It does feel like we'll need one more call.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

Yes, absolutely. It gives me the impression that clearly we need one more call after Friday's call to finish up all our recommendations in this new framework of how we're going to approach the recommendation for ILPD. So let's try to do that and we'll meet again on Friday. I know it's five minutes before the call so we need to open it up for public comments, but we will meet next Friday, this coming Friday, at 10:00 and then we will be scheduling another call the week of the 21<sup>st</sup> to finish up our recommendations. In the meantime we'll be sending e-mails to the workgroup for additional feedback.

**Claudia Williams – ONC – Acting Director, Office State & Community Programs**

The only other thing is we may need to delay the Friday if we just need a little more time to do that staff work.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

Okay, so we'll just keep Friday as a reserve date, and if we need to push it to the next week, the week of the 14<sup>th</sup>, we can do that.

All right, well I'm going to turn things to Judy for the public comments.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Operator, can you inquire and see if anybody from the public wishes to make a comment?

**Operator**

Yes. We do not have any comments at this time.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Thank you. Thank you, everybody. Thank you, Walter.

**Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO**

Take care, everyone.

**M**

Thank you.