

Information Exchange Provider Directory Taskforce
Draft Transcript
February 11, 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 ... call. The public will be able to make a comment at the end of the call. Just a reminder for taskforce members to please identify yourselves when speaking.

Let me do a quick roll call. Jonah Frohlich?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary

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

I'm here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Paul Egerman? 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? Art Davidson? George Oestreich? Sorin Davis? Keith Hess?

Keith Hess – HealthRidge

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Sid Thornton?

Sidney Thornton – Intermountain – Senior Medical Informaticist

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Lisa Robbin? JP Little? Micky Tripathi?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Ted Van Globin? Kory Mertz?

Kory Mertz – NCSL – Policy Associate

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Tim Andrews?

Tim Andrews

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Did I leave anyone off? Okay, I'll turn it over to Walter and Jonah.

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

Thank you and good morning, everyone. Thanks for joining. Today we have—and Jonah, maybe I can start and I can later on turn it to you too, if that's okay.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary

Sure.

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

I wanted to mention that we have basically three major objectives today on the agenda. We want to start with a review of the Physician Compare program from CMS, which will give us some interesting insights about how individual level physician information is used. We want to also review some on the ground examples that were gathered during this week. Here, very briefly, as you might recall during our last conference call, a few days ago we came back with a consensus generally of really the level of recommendations we want to provide on an individual level provider directory are going to be, number one, a little bit different from the entity level provider directory in terms of the specificity. Number two, we thought these recommendations would not be prescriptive and very specific in nature, but rather they would be turned more into general guidelines on recommended approaches for entities that we'll be implementing and operating in individual level provider directories. So they will serve as a common framework for all the entities that we'll be, again, operating these in individual level provider directories.

So out of that we thought of providing today two important elements. One is examples of how things are being done on the ground that we can use as references for perhaps best practices and examples of approaches of how they're used as a reference for others. Then later on in the call, we will be reviewing what we consider to be the recommendations for operating requirements and business models for these individual level provider directories. We have drafted a series of recommendations that I think will be very valuable to discuss.

We do have quite a bit of ground to cover, so let's just go on and start. I just realized I'm not logged in, so what do we have on the screen right now?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary

We just went through the agenda, so can you back up one sec? Thanks. After this Physician Compare presentation, we're going to review a couple of on the ground examples that were put together by the ONC team. Then we're going to look at and review and finalize most of the recommendations, so we're really close to the end, and then I think we have a couple of points to discuss around business models, and then look at some of the policy considerations and specific recommendations from a broader policy context, and then we'll get into next steps.

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

Let's just go through the next couple of slides. This slide we continue to use as our reference. We do have all these same elements that we talk about for the entity level provider directory and we have recommendations around participants, users and uses basically. We have adjusted and updated some of those recommendations based on the comments and discussion we had at the last call, and we'll go through those updates and changes and adjustments to those recommendations later on. Also, we have functions and content recommendations we have worked through the last several calls and we have some updates too on those. Then as we mentioned, we'll focus significantly on the operating requirements as part of this in the business model, which all really are wrapped around policy level recommendations, or the recommendations around policy issues and policy actions.

Still, the concept that we, in the next slide, we will be working through those issues today and then the next call of the taskforce is February 25th, where we would be finalizing really our recommendations, reviewing any remaining additional examples, and then reaching hopefully final consensus on the recommendations that we would bring forth to the Information Exchange Workgroup. Then the Information Exchange Workgroup will meet February 28th and take action on our recommendations. Then those will be presented to the Health IT Policy Committee at their meeting on March 2nd.

That's our schedule for the coming several weeks. I think we should just go ahead and move to our next slide. I don't know, let me stop before and see if there are any general questions before we get into the presentation, any questions or comments?

All right, let's start with our presentation on Physician Compare. Let's see, do we—

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary

Kory, do we have guests from CMS from Physician Compare?

Kory Mertz – NCSL – Policy Associate

Yes, we have Regina Chell and Aaron Lartey who will be presenting for us. Regina, do you want to kick it off?

Regina Chell – CMS – Health Insurance Specialist

I sure can. Thanks, Kory. And thanks to everyone on this workgroup for inviting us today to talk about Physician Compare. I'm just going to give you a brief, high level overview of where we are, because I know from my earlier conversation with Kory I think you all will probably have a lot of questions for us and actually we have a hard stop at 10:30 on our end.

The Physician Compare Website was mandated by ACA Section 10331 and we, as with a lot of ACA, had a very tight timeline. We needed to implement the Physician Compare Website by January 1, 2011. That site did go up 12-30-2010 and what we did is used the existing healthcare provider directory and we changed the name to Physician Compare and also added the names of providers who satisfactorily reported Physician Quality Reporting System, formally known as PQRI, for the 2009 program year. Now, the legislation also does require that by January 1, 2013 we develop and implement a plan for reporting physician quality performance. We do plan to have an additional release in July of this year that will add the providers who successfully ePrescribed for the 2009 program year. Basically on that Website, it's a consumer Website that has physician practice location information, specialty information, gender, language, location of where they went to school, that type of information, and we are continuing to look at how we can enhance this Website moving forward. We're looking at such things as how to include and post physician board certification and then possibly even some linkages to external Websites, professional organizations, groups, that type of thing.

That's the high level overview of Physician Compare as it is today. It is on www.medicare.gov, is the Website to go to to link to Physician Compare. Before we open up for questions, Aaron, did you have anything you wanted to add to that?

Aaron Lartey – CMS – Health Insurance Specialist

No, Regina, I think you've pretty much covered everything. As you mentioned, we are going to display ePrescribing data this coming July and then we'll have an update to both the PQRS and ePrescribing in January of 2012. But I think you got the gist of everything else.

Regina Chell – CMS – Health Insurance Specialist

Okay, thanks. I think we'd like to just give the workgroup the opportunity to fire away with your questions so we can give you whatever information you need today.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary

Can you tell us a little bit more about the source of the content of specifically where you're getting and how you're maintaining the provider listing? The point of the taskforce is for us to make recommendations to the Information Exchange Workgroup and out to the Policy Committee so that there's an opportunity to support these directories and their use for information exchange, and specifically for the Meaningful Use program for EHR incentives. We're really focused on understanding what are the requirements that are critical for standing up and supporting and maintaining these provider directories. So can you give us a little bit more background on how Medicare is supporting the directory itself, that is, the listing of the providers? You mentioned that there's a number of demographic characteristics that you collect, gender, location, names, obviously, can you give us a little bit more background? Are you using PECOS? Are you using the directory service content database for your provider listing?

Aaron Lartey – CMS – Health Insurance Specialist

Currently we're using PECOS as our primary data source. With that, we get all the Medicaid enrolled providers with that data source and we do use a third party contractor for data fields that aren't in PECOS, like hospital affiliation, residency and training data, foreign language spoken data, and we're hoping to get board certification data from the third party contractor. But the remainder, practice location, education information, and physician name, specialty, credentials, we get all the bulk of that from PECOS. The way it works is that PECOS provides us with a monthly extract, which we pull from our CMS mainframe, and we have our contractors process the information and publish it to the Website. And it's usually a two to three month cycle to do this, but we usually try to have monthly updates barring that we don't run into any issues during the processing procedure.

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

Is there any validation or verification process done on any of the information—?

Aaron Lartey – CMS – Health Insurance Specialist

Yes, there is. Usually what happens is if the provider submits, whether it's the paper 855I form or if they go into Internet-based PECOS to submit an update or change, we rely on the A/B MACs for carriers to verify that information. That process usually takes about 45-60 days for verification, and then when it's approved it's added to the following month's extract.

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

Is it part of PECOS?

Aaron Lartey – CMS – Health Insurance Specialist

Yes, it's the PECOS verification part.

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

Okay, that is part of it.

Aaron Lartey – CMS – Health Insurance Specialist

Yes.

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

How often do you, and I should probably know this, but how often do you re-verify information? Some of the information might change periodically, some might stay relatively fixed, but how often do you re-certify some of this information?

Aaron Lartey – CMS – Health Insurance Specialist

Do you mean by like performing audits within the PECOS system?

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

Or if there's a change in board certification or in the hospital affiliation or elements like that, do you do this annually?

Aaron Lartey – CMS – Health Insurance Specialist

I'm not sure if PECOS does that proactively. I can get back to you on that. But I think we honestly rely on the providers to provide those updates to the system when they occur. But like I said, I can go back and double-check on that for you and get back to you.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary

Do you have a process in place whereby providers can request updates or changes if they find errors? Is there that kind of a change control process that you have in place?

Aaron Lartey – CMS – Health Insurance Specialist

Yes, what we usually do is if they find errors on the Website we have a Note to Provider section, which is broken down by data field. We give them instructions on how to take corrective actions to get their profiles updated, whether it's submitting a paper 855I form or just going in to Internet-based PECOS and submitting the change there. We do inform them of the time period that it may take for that change to take place.

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

Any other questions?

Kory Mertz – NCSL – Policy Associate

I want to thank you both for coming. I really appreciate you making the time and describing how you support Physician Compare and the directory behind it.

Aaron Lartey – CMS – Health Insurance Specialist

Thank you.

Regina Chell – CMS – Health Insurance Specialist

Thanks, Kory, for the opportunity. We look forward actually to the outcome of your workgroup to see if there's any further collaboration later on that we can consider.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary

I think we're going to move on. We had some, and I'm not sure if we can display on the Webinar. If not, we have a document that you can see on the Webinar on the left hand pane there's a download section and you can click on it. It's a couple of provider directory examples and what we've done here is listed, based on the domain recommendations that we have been creating over the last couple of months, broken down the examples from Wisconsin and from the Indiana Health Information Exchange into its current functions and the domains that we've been discussing for the recommendations.

So if we can turn to that for a moment, for those of you who are on the taskforce document it's called "WI Wisconsin and ... Provider Directory Examples." If we walk through this, you can see a few things, first of all, the operations, who operates the directory. In Wisconsin's case we have the Wisconsin Medical Association and then IHIE, it's the HIO itself, it's IHI's that operate this and it's a results delivery service

so it's for ... IHIE ... program ... document delivery service where they're providing radiology, lab results, and other results to providers. I believe they give the providers the choice of the kind of medium by which it is received, whether it goes directly into their EHR or they have other modes for delivery.

In terms of function, the purpose for us going through this exercise is to really understand how does this directory, in these two specific cases how does it support a set of very specific functions. Because what we also need to do is we really need to try to understand and make recommendations based on well if we're making recommendations to the Policy Committee about setting up the directory we need to understand what are the business implications and the business functions that the directory can support. So if we look at the function, what use cases does the provider directory enable. If you look at on the Wisconsin side, the Medical Association, it supports some functions around information exchange, workforce planning, system and community capacity, performance measure and development, and application and research to build the evidence base and quality improvement.

On IHIE, which is specifically more around the information exchange model, again, the results are delivered through DOCS4DOCS. They maintain that directory in order to ensure that they're delivering documents to the right destinations and that then the information is cross-referenced with the information used for quality reporting in the program Quality Health First.

If you look further down at participants, what participants are included in the directory, currently only physicians are included in the Wisconsin Medical Association directory. But they are planning on expanding it to all HIPAA providers, so similar to what we are in fact considering in our recommendations. If you look at IHIE, the participants are a little bit more along the lines of what we're recommending, which is any provider who would need to get a result delivered, and that's very similar to what our participant recommendations

In terms of who registers the participants, in IHIE's case we see that before a facility goes live with DOCS4DOCS providers for registration process, and that includes adding them into the provider directory, so there's a very specific process for DOCS4DOCS. The facility is about to go live on the system and they have a registration process. Some of this has been described as well in a couple of published articles that I've read and maybe we can send those out to the taskforce for some background. In IHIE a newly registering facility sends IHIE a facility file, which includes information on the providers to add them to the provider directory, so if your hospital goes live the hospital itself has an internal directory that it would send to IHIE, for example. Then each facility would be contacted during the full enrollment process to get as much information as possible, and then each facility has a designated point of contact with IHIE. Enrollment, the point of contact is fast. The verification list is based on the information obtained from the facility file.

I think also, which is important to know, I don't think it's noted here, it might be further down, but I understand that IHIE also goes through a reconciliation process given that some facilities would, for example, have a physician listed in multiple places if they have privileges and are in multiple hospitals. So there's a reconciliation process, I believe, within IHIE. Micky, you may know that better.

In terms of operations, what level of data accuracy is required, in Wisconsin they have a target of 95% data accuracy, where each provider is checked against 13 discrete data elements and they actually have a very specific process to ensure that they hit their target. In terms of the result from Wisconsin, their approach typically has an accuracy rate of over 98%. In IHIE's case, they have 95% data accuracy in the provider directory and incorrect data is usually due to the provider having left the facility without IHIE being updated. So much the way we are making recommendations about the need to update we've heard from Sorin and others, we do need to make recommendations about a process by which their updates are made when providers are moving in and out of facilities and institutions.

In terms of the frequency of updates, we see from IHIE that IHIE requires that their contracted facilities update their directories or their listings of providers and information on provider changes, so if someone

leaves they're supposed to contact IHIE and notify them of that change. Every facility sends IHIE updated provider files at regular intervals, they say sometimes daily, weekly, or at other intervals. What is the process for individuals, for the delegated authority to update? In Wisconsin's case, there's an opportunity to do real time updates made by an assistant administrator and providers and their authorized delegated staff, and data can be entered manually by Wisconsin administrators by a reviewed electronic feed. So it appears much like, as we've discussed, there needs to be a change control process and some pretty tight controls over how and who can make changes to the directory listing. In Indiana's case, updates are made through a facilities file and phone calls with the facility, so it's really made on a manual basis.

There are a number of additional components here. I don't think we want to walk through each specific one on the phone, but you can see that there are data source content issues, so if you look, for example, at Wisconsin, they get data from the American Medical Association and from a number of other sources, and they're combining those sources. They'll be using integrated delivery networks and data files from them. In IHIE's case they're just using the providers themselves or the facilities that contract or employ them.

I'm going to move a little further down the list. If anyone has any questions please go ahead and speak up. If we go a little further down on page four to access, what users have access to the directory, in Indiana's case we see the DOCS4DOCS program has an online registration process for users to gain access, so this is important for our operational recommendations, and it says users have to register on the IHIE portal. After an individual registers on the portal IHIE calls the facility point of contact and confirms the individual should be given access. No one gains access unless the point of contact has granted them access.

If we go down a little further to security, this is on page five, we see the DOCS4DOCS program has an online registration process for users to gain access, and that users have to register on the IHIE portal. So after an individual registers in the portal IHIE calls the facility and the point of contact confirms the individual should be given access, so no one gains access unless the point of contact has agreed to them accessing a system.

Then finally, on the audit control side, they both use time and date stamps for field changes. So there's an audit trail for changes. We're making recommendations about having audit trails for both change and use of directory service.

I believe that's it. Does anyone have any questions? This is I think helpful in us just affirming some of our recommendations and maybe finalizing some others.

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

I just thought that this is, again, to put it into context, our attempt to collect some examples to give a sense of how things are actually being done on the ground. Maybe one of the things we could do is gather a number of additional examples just to have us reference into once we complete our recommendations we can package the recommendations with providing these additional resources really as examples and other documentation. I think they really provide an excellent way of seeing how this is being done and if we can collect maybe seven or eight of these examples that provide different perspectives, I think that will be very valuable.

Dave Goetz – State of Tennessee – Commissioner, Dept. Finance & Admin.

I'm sorry. I'm in the car so I've not been able to look at that particular document. But it seems that then for the Indiana example there's a significant amount of human touch and interaction that's involved. It's not an automated system. Again, I got in a little late, but I remember hearing a little bit about what the Medicare people said, and a lot of theirs they're just relying on the automation, or whatever process PECOS has, to validate the currency of information, correct?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary

Yes, absolutely, that's right.

Dave Goetz – State of Tennessee – Commissioner, Dept. Finance & Admin.

Does Indiana have a cost allocation for what it costs them to maintain this directory?

Kory Mertz – NCSL – Policy Associate

When I was talking to them, they have about ten staff that service their help desk and they estimate that 50% of their time, of those ten staff, is just spent on maintaining the directory. So they were looking into the cost numbers and were checking to see if they can provide that.

Dave Goetz – State of Tennessee – Commissioner, Dept. Finance & Admin.

Just by a guessing rule of thumb, that's probably a ten staff, 50,000 total cost, ten per staff, \$250,000 then, right, as an annual cost for that? Plus whatever costs the facilities have in their interaction with the system, right?

Kory Mertz – NCSL – Policy Associate

Right. In Wisconsin, it's estimated that it's around \$700,000 a year for them to maintain their directory and it costs them around \$3 million to build over time.

Dave Goetz – State of Tennessee – Commissioner, Dept. Finance & Admin.

I'm intrigued by the idea of a medical society doing this. Because again in trying to find a way that somebody wants to do this whether it's for marginal cost or for other benefit, a medical society is going to want to do this, at least doctors, and they could broaden that, because of the association with membership and the value that you provide members. As an old association guy I think that way, sorry.

Kory Mertz – NCSL – Policy Associate

One interesting thing about their approach, as they've been thinking about rolling out to all HIPAA providers they want to go to some of the other associations. Like they specifically are thinking about the Dental Association, for instance, and saying we want to go to a data source that has the business needs to keep this information as accurate as we need it. That's one of their ideas for how to lower the cost of maintaining the data, by getting it from sources where the data is going to be accurate.

Dave Goetz – State of Tennessee – Commissioner, Dept. Finance & Admin.

Well, as someone ... a membership role, I'm not certain. But the model in making the cost embedded in a benefit of membership because you then get a benefit from it by having the registry—I don't know. It's just something that I Did I shut everybody up?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary

No. Dave, the interesting thing about PECOS for me, and you basically alluded to it, is that we heard from the Physician Compare folks that PECOS is the actual service that's being provided on one hand, but it's the Compare Website and function that's really the value driver. It's fulfilling the business needs. I think given some of the cost estimates we just received I'm kind of curious as to whether or not there's a real scalability question here and whether there are too marginal costs here, or if this is something that's just linear. Is it just something that needs brute force to get through and to maintain? Or, are there any economies of scale, if we're talking about larger environments, and I'm just thinking about the state of California, we have 120,000 providers, so I'm wondering whether or not some of our recommendations really need to consider the scale factor and whether or not ... for any economies to be found.

Dave Goetz – State of Tennessee – Commissioner, Dept. Finance & Admin.

Well, I'm getting to learn my new company's associations and if my inbox gets too full I can't send e-mail, so therefore I then curse and go clean out my inbox. So the problem here is what is the value to the individual provider, what would they lose that they value if they don't go in and maintain current information and how would you know that, to kind of drive it down to the lowest level.

Keith Hess – HealthRidge

We send results to 5,500 physicians and we've got about 3 million results per month that we send, and we've pushed down that responsibility in electronic form back to the practices. Specific to that point is if the information isn't updated, it's separate from our messaging application, it's more of a user setup. So we have about two people who do it compared to Indiana, mainly because we've identified to that point that the individual at the site is part of our HIE management software, where all that information is maintained at the physician office. The ... is that because all of their results come through us, if they don't update it and there's not good information then they're not going to get their clinical results, so they'll quickly contact us so that they're getting it. So it's a 2 versus a 10 or 20 kind of a thing for, in our case, 5,500 physicians.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary

So that would seem to indicate that part of our recommendation needs to be that there be some sort of shared responsibility.

Keith Hess – HealthRidge

We would highly recommend that.

Tim Andrews

I think, certainly based on my experience in general and certainly, Jonah, in your case with 120,000 providers, that's the only option that is rational. I think there are many people, to Dave's point, that have incentives here. So providers have incentives for membership, perhaps. PECOS works because you don't get paid if you don't have the proper information in the payments directory. As HealthRidge points out, another benefit is if you're getting information results delivery, you will get the results. So there are several incentives, but I think fundamentally you have to find some—CAQH tried to do it by providing one point where everybody can dump their information so the provider gets the benefit of presumably multiple institutions being able to access the data at one point. The ultimate abstraction is that one, if you can find a few places where various entities like a HealthRidge and Medical Society could get their information and you increase the incentives for the providers, because you get multiple incentives across different institutions but you add complexity in terms of coordination. I think fundamentally you've got to find a way to distribute it, or certainly at the several ... across the country you're going to have real scalability issues.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary

Yes, I totally agree with that. Keith, one thing that in my past experience has been an issue, especially with respect to something like lab results where it's regulated by CLIA, some of the pushback we get is that the labs with ... we need to guarantee that the result gets there. So if there's a problem with a provider directory, i.e. the provider or somebody doesn't update their information and the lab result doesn't get to them because the provider listing is incorrect, are liable, do you deal with that? How are you able to work with the CLIA regs in that respect?

Keith Hess – HealthRidge

We certainly have, whether it's a CLIA or whether it's a contractual responsibility that we have that responsibility to getting it to that physician. What we have found, since we have 5 HIEs and about 40 hospitals, national labs, local labs, it ends up being about 97% of the content providers that if you're an active physician it's almost a fallout. Where if you're active at all and you getting a result then if there's an error in our physician address book then it does not get to the physicians, the physicians are no longer practicing. So it's a couple of things. First is a very painful one-time setup to make sure that that initial address book comparison is correct. After that, it tends to, that if a physician moves or if a physician change that impacts their electronic ability to receive information, they move from group to group, they move from IDN to IDN, and then they're not just practicing medicine anymore. We certainly have that responsibility, but in practice that once there's a preponderance of data going through the exchange that it works very well. We do have both national labs participating and we have, I believe, seven local labs

participating. If there's great concern just in function and certainly in the contracts require us to do that, but in function it's working rather well.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary

Do those national labs, for example, rely on the internal directory structure that you have, or do they use their own proprietary directories?

Keith Hess – HealthRidge

They rely on ours to deliver to the folks we send the results to.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary

Is there some sort of a waiver or a responsibility that you take over that you will be liable for things like ensuring that regs like CLIA are followed?

Keith Hess – HealthRidge

Yes. Some of the relaxation in CLIA has made it a lot more palatable as far as the report of record that happened last year.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary

Right, thanks to the IE Workgroup in part.

Keith Hess – HealthRidge

Correct. It was a good thing.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary

Absolutely. Okay, any other thoughts regarding best practices? I think I heard Walter mention maybe having a couple of other examples that can be listed here as background material. I don't know how we might go about doing that. I think I'd turn to my ONC colleagues and others to see whether or not that's within the scope or is that feasible and how we might do that. We can take it off line.

M

Yes, Jonah, we can about that off line and maybe brainstorm some other examples.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary

Okay. All right, then let's move on.

Dave Goetz – State of Tennessee – Commissioner, Dept. Finance & Admin.

Kory, contact me. I found one inside my new quarter, so I need to understand exactly what it does but it is another example ... doing something. So I'll try and get the write up on it.

Kory Mertz – NCSL – Policy Associate

Okay, thanks, Dave.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary

Okay, we're going to move on to the revised recommendations. I think this is based on, and if we go to slide eight we can start recommendations we've made over the course of the last few weeks, and these are more or less done and the purpose of this isn't really to review them. We've made a few changes to some of them based on input and we want to make sure we get them all and get your approval, because essentially this likely will be the last half of ... before we send the recommendations up to the IE Workgroup.

First of note on slide eight is that the recommendations that we've been making fall under one or two categories really. One is around recommended practices, and those are items that should be considered in establishing an ILPD, so these are recommendations about how we would suggest that ILPDs be

established in the field. The second is that areas required to enable basic interoperability, and that specifically states will have different use cases for ILPDs that ... content and functionality. What that really means is that not all states are going to be building on ILPDs necessarily for the same purposes. Some might be doing it for delivering CCDs, some might be for supporting lab transactions, possibly both, or other use cases. What we don't want to do is we don't want to necessarily make an ILPD recommendation that is supposed to conform to just one use or business case, that they need to be flexible enough to meet the needs of states which vary. So that's the two categories that we've been bucketing our recommendations ..., or just two ways of thinking about how we're making our recommendations.

On the next slide, we're discussing the participants and we added a little bit more clarity and focus to this recommendation, and this is how it's worded. I'm going to basically read these and then pause for any comments or thoughts about it because after this if you don't get any I'm going to basically walk them up and say we're done.

The first around participants, our recommendation here is that participants are individuals who can be listed in an ILPD and should include all individual healthcare providers who are licensed or otherwise authorized by states to provide healthcare services. These are individuals involved in health information exchange transactions, whether they're receivers or seekers of information, and those that need to be identified at the individual level for purposes of receiving or requesting or otherwise carrying out health information exchange, or requesting other information, excuse me. That's the recommendation around participants. Any thoughts or comments?

Great. Let's move on to the next one, please. Users, our recommendation stands, we have three of them really, that users with access to ILPD content should include clinicians and support and administrative staff. Second, is that well-defined roles and rules-based access policies for users and operators of ILPD services should be put into play. These policies should be set at a local level and considered federal and state law regulation and accepted practices. Third, some sensitive content, state license, DEA numbers, etc., need to be restricted and user access to this information limited. Any thoughts on users?

Carl Dvorak – Epic Systems – EVP

A quick question for you, is there a section that would deal with individuals inside a public health agency or inside a laboratory that we might want to have back and forths with or further detailed lookups and such? The notion that you're licensed to practice by a state, I'm not sure how that transcends the public health world. If we'd need to be able to find individuals from the public health sector in the individual provider directory, if that's a two-way thing. I know they're going to be in the entity level, so I was curious if we envision having an opening for that here.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary

That's a very good question. I don't think Art is on the phone and I don't know that Seth is on the phone either. They're the ones who I think would have more expertise to answer that particular question. Kory, can you please make a note that we need to send a question out to Art and Seth, because I think that's an important question and I recall that it's been raised in the past and I don't think that we've appropriately addressed that in these slides. So I want to make sure we don't lose it.

Kory Mertz – NCSL – Policy Associate

Okay, thanks.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary

Yes, good suggestion, thank you. Let's move on. I don't think we really need to go through these ... the scenario listing. We did get another slide from Art, because there are six scenarios, and the last scenario, the public health alert, is a push scenario. There's also a request to add and make that more robust and have a pull scenario for public health, specifically when their particular outbreak investigation

and other types of public health investigations where information might need to be pulled by a public health agency. I don't know that we have that slide. I only saw it this morning.

M

Jonah, it's not included in this batch, but we sent it out individually to everybody.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary

Okay.

M

You can download it on the slide too, if people didn't get it through the e-mail. But they should have gotten it. We're pulling it up here.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary

Great. Let's just walk through this quickly. It's unfortunate that we don't have Seth or Art here because they can help walk us through this. You know what I'm going to recommend, since they are not here I'd feel a lot more comfortable if they were here presenting this, if one of them were here presenting this, because I don't have the background expertise to be able to make their points.

Tim Andrews

I certainly have, at least not that I can play one on TV, but a number of states have asked for very similar kinds of things. They call it "public health investigation." And right now most public health systems code most of their information through paper, so local departments are pulling up and ... to the state and actually a lot of it ... its way into the CDC. But what they would like and what they have difficulty doing is noticing an aggregated trend, obvious things like the chief complaint of lots of throwing up and diarrhea in a cluster of hospitals and clinics which might indicate, for instance, a salmonella outbreak. So they want to be able to say notice any large ... within a geographic cluster and then let me drill down. Now that I've found that, gee, it looks like there's too much to be explained by normal activity of these kinds of complaints that suggest perhaps an outbreak of this kind of public health communicable disease or condition like salmonella. I'd like to now go down and look further into these records to understand a little bit more than just the two complaints, can it be explained by something else or should I really go the red alert here and so we'd better investigate this quickly because we could have something serious in the nature of public health. That's the poster child of ... that I'm aware of.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary

Okay. Well, it certainly makes sense to include that. We've heard on multiple occasions that the direction should support that kind of an investigation. I don't know, Walter, if you're on the line as well, given your own background, but I don't see why we wouldn't want to include this and add this particular pull scenario, public health investigation scenario to our use cases.

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

Absolutely, there clearly are three or four possible scenarios around public health, and probably even more; some are more push, some are more pull. I think this one certainly is something we should include. There's a need to communicate directly with an individual provider on a follow up for a particular public health case, there is a need to communicate an alert to a defined group of providers with more of a mass mailing but directed to specific individuals, if you will. There is certainly a need to request information about a patient or follow up information or contact information for follow up on a particular public health report, so there are different push and pull type of applicabilities related to public health and so I think they should be listed and this one should be included, yes.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary

Okay, let's do that and we can update that last slide. If we can just go back to the main deck we're going to go through our next recommendation, which I think is around functions. We have four current recommendations around content. The first is that individual providers and not entities or organizations

should be listed in the ILPD. The individual provider types listed in the ILPD should conform to federal and state rules on who's licensed or otherwise authorized to provide healthcare services. So this is just a specification of the participant recommendations that we've made on content.

Information needed for an individual provider listed in the ILPD should include demographics and these include the name, provider type, specialty, name and address, practice telephone, e-mail address and hospital affiliation, and then we split it into two categories. The second is potentially sensitive identifiers, NPI, DEA, state license number. Third is there should be limited access to and tight policy regarding access to potentially sensitive identifiers to minimize the risk of fraud and identity theft. The fourth is that existing sources of content, state licensing boards, health plan vendors probably add federal government PECOS, etc., should be considered as content providers to ILPD operators. ... data integrity will be the key to success and it may be necessary to use multiple data sources to populate the content in the ILPD. For instance, licensure boards may be authoritative on licensure information but may not be similarly authoritative on practice locations. Those are the four explanations we have on content. Any thoughts or suggested changes? Okay, let's move on to slide 13.

Functional capabilities, so we have four recommendations here currently. ILPD services should, first of all, support directed exchange functions, send and receive as well as query and retrieve. That doesn't mean it can't support a third party exchange model, but that's not what the basis of our recommendations is on right now. The second is that it should provide basic discoverability of an individual provider and their practice locations and that the service should support querying capability at multiple levels, we heard that Monday, practice name, provider name, specialty, etc., so ... this discoverability and this querying capability at multiple levels. The third is that it provides both basic discoverability and tight linkage to an individual provider's ELPD listing.

The fourth is that it supports audit trail capabilities we talked about in number three as well and wanted to make sure that it was understood that when you're looking up an ILPD, in the tight linkage with the ELPD you'd be able to pull up information that the ELPD service would offer. Meaning you could understand that the ELPD listing for the provider you're going to send information to, that their service supports a C32 or other specific message types. So that what the tight linkage to an individual listing means. Any thoughts on functional capabilities?

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

Jonah, just one thought. As we get into the operational requirements, I think we're going to see that number four on the functional capabilities is more an operational requirement. So I think that might be one that we might want to consider dropping from this particular area of functional capabilities and keeping it under operational requirements. The other three I think are perfect for functional capability descriptions, but the fourth one I thought it probably fit more under operational requirements. I was looking at which number, we do have one, I think, someplace in the operational requirements that talks about audit and other trailing.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary

Right. I'd like to hear from others, but the one issue which to just reconsider is that if we're thinking about what the service actually needs to do, there needs to be the ability in the service itself to track who accesses it and then operationally there needs to be a process by which the service tracks users. So there needs to be a set of policies and procedures for regularly reviewing audit trails or signaling some sort of a breach or change that might not be authorized. I think we might need to have it in both places, but I'd like to just hear from other people on this particular point. Again, this is about functional capabilities. This set of recommendations about what the service actually needs to do and the operational requirements which we'll see next is really making recommendations on how the service needs to operate. So how an operator, whether it's a HIS or an HIO or some other entity actually manages the service and ensures that there's some service level requirements and agreements in place.

Hunt Blair – OVHA – Deputy Director

I agree with the point that you're making about how it should appear in both places.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary

Okay, well why don't we move on and we can discuss further. Slide 14, so we have a number of operational requirements and I'm wondering, Walter, do you want to walk through these? I know you made a couple of changes and added some which I think are really important here. I'm happy to do it, if you prefer. Why don't I go ahead then? In slide 14 on the operational requirements, again, these are recommendations that we are proposing to make for what we're calling operators of an ILPD. These are institutions, they might be state grantees for the HIE cooperative agreement program, for example, but these are recommendations that we're considering making for those operators and how they should build and maintain these directory services. There are a couple of pages of these, so I want to make sure we have a chance to go through this.

One is that we recommend establishing defined policies and procedures and provide a structured and secure mechanism for individual providers to enroll and verify information used to populate the ILPD. So again we've seen that in the IHIE examples, that those sets of policies exist or they have a process for that. The second is that we recommend establishing policies and procedures to verify ... information provided by individuals enrolling in the ILPD, so there needs to be a verification process. The third is that data elements included should at least meet the minimum data set recommended by ONC for recommendations for the ... Policy and Standards Committee and that data elements should follow national standards definitions for content. The fourth is that we recommend establishing policies and procedures that define who can access and use the ILPD. The fifth, we recommend that we ensure that the ILPD is able to interoperate with other ILPDs developed and operated in a manner that follows these recommended standards.

Any thoughts on these five recommendations? There are more on operational requirements for the next page, but I'll stop here for a moment. So there's no disagreement about these recommendations?

Hunt Blair – OVHA – Deputy Director

I've got to get off the call for another call, but I just wanted to say that I think that this and what's on page 15 represent a good outcome of our discussion from the other morning.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary

Good. Thanks, Hunt.

Hunt Blair – OVHA – Deputy Director

See you guys.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary

Let's go to slide 15. Further, recommendation six is that ILPD operators should provide a mechanism for individuals listed in the ILPD, or delegated authority, for instance, staff or entity administrators, supporting providers who practice in their institutions. Again, much like IHIE they refer to a point of contact in those institutions, to correct and update listed information and update and resolution process and change to ... policy should be put into place by ILPD operators to manage the change request process. Number seven, recommend establishing policies that require individuals listed in the ILPD to update periodically their information and from what we heard from CAQH it should probably be at least three times per year, or as individual providers change practice location and affiliation. Eight is that we develop and put into place audit trail policies and procedures to track use and investigate inappropriate use and breaches. Nine is that we develop procedures and a set of policies to link and update a provider's ILPD listing and their affiliated ELPD listing. Thoughts from over here, to make sure we've got it right, any suggested changes?

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

Sorry. Number eight was the one that I was referring to that links back to number four of the functional requirements.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary

Right.

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

So we decided to keep that under functional requirements, is that right?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary

We did, but again if others feel differently, let's hear from them.

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

I think I'm fine.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary

Okay. Let's move on to slide 16, please. All right, I think this is the end of them. Recommendation ten is that ILPD operators should ensure that each entry has at least one ... ELPD entry associated with it. I think this is one we should probably make sure people feel comfortable with, and I'll come back to it in a second. Eleven is to establish appropriate linkages between ILPD and ELPD to allow interactive access to information about the entities associated with individual providers listed in the ILPD. Twelve is that we recommend implementing security policies and procedures that ensure that A) data contained in the ILPD is appropriately protected from unauthorized changes; B) authorized individuals have access to the data for purposes of updates and changes; and C) access to information contained in the ILPD by external users is appropriately managed.

Just let me point out number ten and ask the group the following. One can envision a scenario whereby a directory is managed and maintained by a HIS or a state or a state designated entity, for example, and it is comprehensive, or at least it is authoritative and it lists providers who might not have an EHR or they may not have registered their ELPD but they are in the directory. So in this scenario what we're saying with number ten is that only individual level providers who have a system at the end and are listed in the ELPD would have a listing here. So I want to see whether or not people agree with this.

Kory Mertz – NCSL – Policy Associate

One thought I have here is that this could potentially limit some of the other use cases that states would consider, for instance, if they're trying to go down the quality improvement route or quality tracking. If all the providers aren't in it, that could pose a problem for a use case like that.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary

Agreed. What if in another specific use case you may have providers who are interested in receiving, let's say a ... has the capabilities to deliver lab results but the endpoint is another EHR and they like to have those results resolved at the end of a ... or a portal.

Keith Hess – HealthRidge

We include all of them. Even though we're 97% electronic there's still 3% which are manual, and they have a need to receive it. Whether it needs to be discoverable outside of the HIE can be debated, but we certainly have 100%, especially as the NHIN gets developed there's still those manual processes, so short term we would argue that there's a need for all of them. Long term it might be debatable, but our business is we have all of them in.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary

Okay. So would anyone object if we removed number ten or modified it in a different way? If I don't hear any objections I'm going to recommend that we strike it. Okay, let's move on.

This is a little tricky, we're on slide 17.

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

Jonah, maybe let me suggest that we go to slide 18 first and then we can come back to this one, because I think that slide 18 is probably linked to the previous set of recommendations.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary

Yes, let's do that. We put together four high level policy considerations for ILPDs and I'd like your feedback on these. These are new and these are specific policy actions and recommendations that were suggested that they be considered. Number one is that CMS should make NOR and PECOS content available to ILPD services funded through state HIE cooperative agreement programs. Number two is that state HIE cooperative agreement grantees supporting the development of ILPD should be required to follow these recommendations that are ultimately approved and adopted by ONC and CMS. The third is that the federal EHR certification process should incorporate the Standards Committee and ultimately ONC and CMS adopted recommendations related to this EHR certification criteria. The fourth is that CMS should consider how they could require state Medicaid agencies to incorporate ILPD use as they approve Medicaid HIT plans and fund state EHR set of programs. These are the bigger policy levers and finance levers that CMS and ONC could consider using to try to encourage the use of standardization of ILPD services, so these are pretty important, obviously and I would like any feedback that you have on these.

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

Jonah, this is one addition, I guess. Certainly I totally agree with this one, but one addition is the concept of asking or requiring that ILPD operators. This is a policy related one so it's not so much an operational one, but that ILPD operators register their ILPD someplace, I don't know if that will be beneficial, so that there is a known set of ILPDs and known ILPD operators in some registry. That would be the only element so that there could be a way of knowing is there an ILPD in Michigan, in Massachusetts, in Minnesota. Is that something that might be valuable to include and to consider as a recommendation?

Dave Goetz – State of Tennessee – Commissioner, Dept. Finance & Admin.

How far down into category granularity do you want to take that?

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

My thought was just merely a Web-based listing of ILPDs and ILPD operators and a link. It was only that, so that then people can go to those places whenever they need to.

Dave Goetz – State of Tennessee – Commissioner, Dept. Finance & Admin.

Just as an argument, I'm not arguing against that, but I'm just trying to think through.

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

Exactly, no I understand. I was just trying to clarify that it would be just very high level, simple listing –

Dave Goetz – State of Tennessee – Commissioner, Dept. Finance & Admin.

Since we continue to have people aggregate and consolidate practice areas, certainly we're seeing a lot of that. Would you consider a large practice group an ILPD operator? Maybe I'm just way off base here, but they're a feed source to an ILPD. The reason I'm thinking about this through the state HIE lens, the state HIEs need to know that someone out there has data. Now, how these guys would operate their own ILPDs and would interact with a state HIE I think is another question. That's what I'm trying to get to, and I'm not being very articulate here and I apologize, but just trying to think that through a little. And also examples around four, but we'll get back to that.

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

You have a very good point. ILPD at the end of the day, like you point out, is a clinic with a director or providers, an ILPD is the clinic that maintains that an ILPD operator or is this more directed to –

Dave Goetz – State of Tennessee – Commissioner, Dept. Finance & Admin.

There's an

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

These are organizational ILPDs.

Dave Goetz – State of Tennessee – Commissioner, Dept. Finance & Admin.

Right. Does an IPA run a directory? I don't know. They could. They could be a good source for information.

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

That's what I wanted to pose, whether that was a benefit of including a recommendation, it would probably be a two-part recommendation. One is that ONC or CMS or someone establish a site for ILPD listings and that ILPD operators be expected to be listed in this listing of ILPDs. So I'm just posing that question as whether we want to consider that a policy recommendation or not.

Dave Goetz – State of Tennessee – Commissioner, Dept. Finance & Admin.

If we think about that we want them to meet the operational criteria, there should be some way for them to certify that in fact they meet the operational criteria, and again depending on how fractioned these things get out there. I'm sorry. So they could register and say hey, I've got one. I'm compliant. I'm not compliant. Here's how I know I'm compliant. I'm just doing this for my own internal purposes but it's a potential data source if you can figure out how to take it, reconcile it, and incorporate it in a larger compliant ILPD. I don't know. I'm just trying to think of all the different ways people are going to be dealing with this out there, where they have aggregated information for their own purposes.

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

Any other perspectives on this?

Dave Goetz – State of Tennessee – Commissioner, Dept. Finance & Admin.

On number four, one of the things that it seems to me that it also is going to be driven down through is Medicaid has provider level contracts, right, so should it be a condition of a provider level contract with a state Medicaid agency that they are a member of a compliant ILPD? I'm just trying to think how you go from a health IT plan and an incentive program that is going to reach some via the Medicaid providers, but it's not going to reach all of them.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary

Right. That's a good question, and I was, when making this, trying to consider how we can align the various funding sources for the incentive program to support the ILPD concepts that are potentially going to be developed in the various states. Part of what I think might be important is that if, for example, interoperability requirements in the Meaningful Use program are such, these criteria, these EHR Meaningful Use criteria are such that a provider directory can support a handful of the Meaningful Use criteria, whether it be sharing lab results or sharing CCDs or other kinds of information exchange transactions, and ILPDs are considered to be critical to support those transactions, that there be some mechanism and alignment whereby the Medicaid agencies in the various states who are supporting the EHR programs and they're submitting these IAPDs and the state Medicaid HIT plans, that they consider how they're contributing to the development and the ongoing support of those ILPDs. Because if they're needed in order to carry out these transactions, that at least for the Medicaid providers there should be a way for the Medicaid programs in various states to support their exchange needs that would potentially mean supporting an ILPD, some sort of a shared cost issue. I'm not exactly sure how to frame that. This was an attempt to try to frame that specific consideration in this recommendation, because I think it's important to make sure that that funding and operational stream is aligned with these recommendations. It may not have been adequately addressed in this particular bullet.

Okay. Any other thoughts on these? I think we're done. All right, do we have anything else?

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

Jonah, just for planning purposes for our next meeting, do we have the schedule? Can we put it back on the screen just to figure out what next steps will be. Were you going to go there, Jonah?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary

That was it.

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

Okay, go ahead. Sorry.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary

I'm wondering, I don't know how much more we really need to work on to finalize the recommendations and needing another call on the 25th. So I think we're pretty much there. I'm going to make a recommendation that we make a couple of changes that were suggested today. I have four of them here, we send them out to the workgroup, we ask for final comments, and we make the revisions, any that we get through the distribution, and then on the 28th, we just present our recommendations to the Interoperability Information Exchange Workgroup. I want to make sure that if we do that, that people are okay with that process. I'm doing this on the fly, so, Walter, I don't know how you feel about that.

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

I think that's great. I think we can do it that way. One question that I know will come up, if not at the IE Workgroup, at least at the Standards Committee as it happens with the ELPD is the cost. I know we skipped that slide that talked about cost and revenue ..., but we can probably—I don't know how you feel about that, Jonah. If we're not going to have a conference call on the 25th and we bring these recommendations to the IE Workgroup based on just our editing of today's slides at the IE Workgroup we can have the conversation about these cost and revenue questions. I mean if there are any issues around that.

This one is a little bit different. We had this slide in this particular point when we were thinking that there was going to be some more formal structures, sort of a centralized ..., federated approach to the way we recommended the ... ELPD, but we're moving away from that and focusing much more on a fully federated approach here. But still there's the question about cost, of course, and the revenue model is more probably how are the examples that we provide in these various examples we'll be gathering, how are they approaching the revenue if there's any element around the revenue related to the provider directory itself? All this of course is probably embedded in the functions of the Information Exchange itself. We can just bring that up at the IE Workgroup and discuss it there rather than having a separate discussion here, don't you think?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary

Yes, I think so. I think any recommendation we make has to be quite general and really have to consider just raised considerations. We've heard from and we've seen IHIE, we've heard from HealthRidge, and we've seen Wisconsin. I don't think anybody has solved it, but there can be some recommendations about, and I like what Keith mentioned about HealthRidge and specifically the shared responsibility to minimize costs for ongoing maintenance. I think we can make that kind of a consideration then, and that the directory has to support a very specific business case that you're trying to solve. Because the directory itself has no intrinsic value, it's only intrinsic value is the functions that it supports that really drive the value of it. I think we can make those general kinds of comments or recommendations but I don't think we can be probably very specific.

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

Yes. Okay.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary

Great. Well then why don't we scratch the 25th and we're going to make some revisions based on today's comments, we'll send them out for you all to look at, make any comments, and we can make some of those higher level recommendations around business model. Then we'll discuss on the 28th that we'll make these recommendations that we're going to make to the Policy Committee on March 6th. Then, Judy, I think we're ready to open up for public comment.

Judy Sparrow – Office of the National Coordinator – Executive Director

Operator, can you open the line to see if any of the public have comments on this?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

While we're waiting, Jonah and Walter, I just wanted to thank you again for your continued leadership on this. I think it's been great.

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Absolutely, great work.

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

In turn, on behalf of Jonah and myself I want to thank the ONC staff because they've been just incredible to work with, to pull all this information together, organize all these materials, so thank you to Claudia, to Kory, to Tim and anybody else involved.

Operator

We have no public comments.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary

All right, thanks for bearing with us, everybody. It feels like we're coming to the end of an ... marathon, and I appreciate your patience on this. We'll send out some revisions and then we'll look forward to talking with you and other members of the HIE Workgroup later this month. Thanks, everybody. Bye-bye.

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

Thanks, bye-bye.

Public Comment Received During the Meeting

1. For each of these directories, what are the "data"? Is it text, image, video, etc?