

Information Exchange Workgroup
Draft Transcript
January 28, 2011

Presentation

Operator

Ms. Sparrow, all lines are bridged.

Judy Sparrow – Office of the National Coordinator – Executive Director

Thank you, operator. Good morning, everybody, and welcome to the Policy Committee's Information Exchange Workgroup. This is a Federal Advisory Committee and there will be opportunity at the end of the call for the public to make comments. Just a reminder, Workgroup members, to please identify yourselves when speaking.

Let me do a quick roll call. Micky Tripathi?

Micky Tripathi – Massachusetts eHealth Collaborative – President & 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

Connie Delaney?

Connie Delaney – University of Minnesota School of Nursing – Dean

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Gayle Harrell? Deven McGraw? Latanya Sweeney? Charles Kennedy? Paul Eggerman? Jim Golden? Dave Goetz?

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

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Jonah Frohlich?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary

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

George Hripcsak? Seth Foldy? Jim Buehler? Walter Suarez?
Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
David Ross? Hunt Blair? George Oestreich? Tim Andrews?

Tim Andrews
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Cory Mark?

Cory Mark
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Did I leave anyone off? Okay, with that I'll turn it over to Micky.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Okay, great. Good morning, everyone. Welcome to the Information Exchange Workgroup. I want to welcome all of the Workgroup members as well as any members of the public who are listening in. Today David Lansky, our co-chair, will not be able to join us today, so I will be leading us through the call today. I believe we have two hours, that's right, Judy, is that correct?

Judy Sparrow – Office of the National Coordinator – Executive Director
Yes, that's correct.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Okay. Last time I thought we only had an hour and a half so I gave everyone back a half hour of their lives inadvertently. We would have been happy to have consumed that last half hour had I kept track of the time. But today we have two hours and we have two things that we want to cover. For roughly the first hour what we'd like to do is talk about the future agenda of the Workgroup. We have some thoughts that we want to run through, but we really want to have input from the Workgroup on the future direction, what are the things that we should be thinking about in the coming months with respect to interoperability and Health Information Exchange. And a couple of thoughts there are that we're engaged in a very detailed activity right now, which we've been engaged in really since last summer, and as we now are starting to emerge from the first phase of the entity level provider directory, and we'll talk about the individual level provider directories, I think we want to get our heads back up above the surface, to look out at what's going on in Health Information Exchange, what's going on with respect to all of the policy world that's unfolding here in front of us, and then think about how we want to be able to play in that and what are the key issues that we need to be addressing and how do we put that in the agenda for the coming months. So that's the first part.

And then for the second part of the meeting we'll turn it over to Jonah and Walter, our co-chairs of the Provider Directory Taskforce, to give us an update on the deliberations around the individual level provider directory. So unless anyone else has any other thoughts, I suggest that we plow ahead. If you could move forward to the next slide, please. Is it moving? I'm not sure I'm seeing it.

Judy Sparrow – Office of the National Coordinator – Executive Director
Yes, it's potential next steps.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
All right, hold on a minute. I have something wrong with my own.

Peter DeVault – Epic Systems – Project Manager

Hi, folks. This is Peter DeVault. I joined a couple of minutes late.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Hi. Okay, I'm going to use my local copy for now and then figure out how to get on this. With respect to the first topic of our next steps here, as I said, the provider directory recommendations are set to wrap up in March and we'll get the latest update from the Provider Directory Taskforce, and I think we want to start to think about what we as an entire Workgroup ought to be focused on next. There's certainly a large scope of exchange issues that would benefit from the Workgroup's insight, and I think as some of you are on the Policy Committee itself and a number of you are on some of the other Workgroups, we're starting to see that a lot of the other considerations in the Workgroups are starting to bump up against Information Exchange issues. And at the same time we have Meaningful Use stage two, which also has a significant component that's focused on Health Information Exchange, so I think that's sort of all of our sense and we've seen many, many statements from Dr. Blumenthal about the next phase of Meaningful Use being significantly focused on Information Exchange and interoperability.

So that's all with the things that are there in front of us. And one of the things that we may think about is two things. One is that there are many topics, there are many issues that bump up against interoperability and Health Information Exchange, and rather than doing deep dive kind of activity like we've done with the provider directory activity, which I think has been very beneficial for everyone, so it's not saying that that's not a beneficial exercise, but as we're looking out now at the agenda going forward and the Meaningful Use stage two train that has not just started to leave the station here, it may be that we want to be able to step back and say, how do we look at the universe of issues, figure out which are the ones that we want to address in some way and then take a little bit more of a lightweight approach to those issues so that we're able to see the whole picture and we're able to touch on a number of different issues and provide perspective on a larger set of issues than we've been able to by focusing on the provider directory issue, for example.

So that would be one thought about how we might want to think about it. The second thought is that Meaningful Use stage two might be the lens through which we do that. And we have here a number of succeeding set of slides, we've pulled out from the Meaningful Use stage two recommendations that the Meaningful Use Workgroup has put out for public comment, Cory has nicely pulled out the ones that explicitly relate to Health Information Exchange and interoperability, and it may be that as we go through those that that would be the appropriate lens for us to be able to capture the universe of these issues. There are other issues that some of the Workgroups are dealing with that perhaps do obviously impact and are impacted by Health Information Exchange that aren't directly Meaningful Use types of issues, and perhaps we can flag and identify those and figure out where they belong on the map. So, for example, there are things that the Governance Workgroup is addressing that aren't directly in the Meaningful Use stage two, stage three frame that we may think that we might want to have some input on. But it seems to me that for most of the things Meaningful Use stage two might be the appropriate way of thinking about that.

Turning to the next slide, and then I'll pause for comment and discussion, I just wanted to elaborate on that point a little bit just so that we're all on the same page with respect to where the process is on Meaningful Use stage two. I'm on slide four right now and it says, "MU Stage Two Process." I hope that's where the Webinar is. I can't see it right now. But just so we're all on the same page, the Meaningful Use Workgroup has developed four public comment recommendations that are now up on the ONC blog. The public comment period is through February 25th, so that's open right now and open for roughly another month. As stated right on the blog itself, the Meaningful Use Workgroup plan says the following: that they're going to receive comments through February 25th, that the Policy Committee will then revisit the recommendations and public meetings in the spring of 2011, that they will review the public comments in the context of the early feedback from providers on experience with stage one Meaningful Use, and then that the Policy Committee will consider additional input from its other Workgroups working on quality measures, information exchange, and privacy and security.

One question that I would pose to all of the members of the Workgroup here is what do we think is the best way for us to participate in and align with that process? When should we weigh in on Meaningful Use stage two related to Health Information Exchange? One approach for us to consider would be something like the following, that we start to engage on the Meaningful Use stage two recommendations that are already out there for public comment and develop a preliminary set of recommendations roughly on the timeline that the public comment period has, namely through the end of February, let's say, or even extending into March, but roughly on that timeline. Then we work with the Meaningful Use Workgroup to see if we can get to a process where we're jointly vetting the public comments along with the Information Exchange Workgroup comments, so that that's part of a process where we're working together on that from the start rather than waiting for a whole set of public comments on Information Exchange related recommendations for stage two and then getting those later in the process when we may have a very limited and short time to be able to respond to those, but also being able to work those into our own recommendations. I think we would get a lot of value out of being able to look at those recommendations as well. Then finally, developing a set of formalized recommendations for the Policy Committee really in alignment with the anticipated spring meetings as laid out there on the blog. So that would be one approach to how we might think about this.

Let me pause here now and see if others have thoughts on that, particularly if Claudia or Cory are on the phone and also any members of the Policy Committee who might have a sense of how that's going to unfold here.

Gayle Harrell – Florida – Former State Legislator

This is Gayle Harrell. May I comment? I just came on and I just heard your last few minutes of comments. I would say, as a Policy Committee member I think it's extremely important that we go the direction you've just described so that we have input into the Meaningful Use dialogue. Because such a significant part of page two has to deal with HIE. So I think that coordination and collaboration with the Workgroup listening to those comments and also participating in the comments is extremely important.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Thank you, Gayle. At the end of the day I think it's almost a question of do we start working together at the Workgroup level with the Meaningful Use Workgroup now, rather than waiting for them to develop the recommendations, deliver them to the Policy Committee and then we're commenting on those recommendations that have been fleshed out in some way. If I'm understanding you correctly, Gayle, as a Policy Committee member you'd rather see us working together before all of these are presented to the Policy Committee?

Gayle Harrell – Florida – Former State Legislator

Yes, I really do because then you're really collaborating together and I know we have some cross over numbers, but I think perhaps some of the discussion in Meaningful Use, so much of it is linked and you have to achieve information exchange to meet stage two in many, many cases, that we have some more collaboration with them. When you come before the Policy Committee, as you know, Micky, it's kind of late in the process.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Right.

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

This is Walter. One question I have is it seems to me that one option is to be engaged in the development of comments between now and February 25, if I'm understanding correctly, so that will be the use the public comment time period to formulate our comments and submit those to the Meaningful Use Workgroup. But my question goes into the next step, which is really, I assume that the other Workgroups in the Policy Committee would have some, and perhaps in the Standards Committee, I would think, would have some interest in jointly working with the Meaningful Use Workgroup to do this. So we might not be the only Workgroup looking for that and so it might come down to the Policy Committee itself defining, along with of course the Meaningful Use Workgroup leaders, defining how all the other Workgroups within the Policy Committee, and again perhaps within the Standards Committee as well,

work in tandem with or jointly with the Meaningful Use Workgroup. So I agree in the first step of using this time between now and February 25 to articulate our comments and send them to the Meaningful Use Workgroup. I think that the second part we might need to ask the Policy Committee how they see the Workgroups within the Policy Committee, including our own Information Exchange Workgroup, jointly working with the Meaningful Use Workgroup on this topic.

Gayle Harrell – Florida – Former State Legislator

May I comment a little bit further too, Micky. I think when you look at all the various Workgroups out there, we're so inter-related with Meaningful Use. The comment at the last committee meeting was that there needs to be maybe coordination between the chairs and chair meetings so that what happens in the Workgroups then gets disseminated to all the other chairs and there's total integration and where we're all going through the chairs.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Yes, and I don't know if Claudia has joined yet, but that has been a topic that we as Workgroup chairs, and not just me and David, but a number of the other Workgroup chairs have raised. And I know that ONC is working on a process for having those kinds of meetings. I don't know what the status of that is. Is Claudia on? I don't know if Judy, or Cory, if you have any perspective on that?

Tim Andrews

Micky, this is Tim. I think Claudia sent a note that she wasn't going to be at this meeting.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Oh, okay. Thank you.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Micky? Hi, it's George Hripcsak.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Hi, George.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

First of all, what the Meaningful Use Workgroup right now is mainly doing, because the members are spread all around, they're mainly working on the other Workgroups right now because we've put our thing out for public comments and so we don't have a lot of calls scheduled in this period while we're waiting for the public to comment, because we don't want to move forward beyond what we put out for the public and then have the public say, well, where did that come from, you put out this other thing. So I think it's very important, your first point there is to start thinking about what you think of the Meaningful Use stage two IE-related objectives right now, because as Gayle said, once you start having this meeting a day for a week and then we have the Policy Committee meeting, we're going off the cliff already doing whatever we're doing.

So I think it's very important to really think in detail and concretely what the IE Workgroup thinks of the recommendations and what direction it has to go and where we've made mistakes and where we're going to have to go faster or whatever, and then what form the working together takes. I don't want to speak for Paul Tang, we have to do something together, and I don't know what that thing is. Is it a joint call or it's some other venue, and in fact if we can do that a little bit before we get the – what will happen with the public comments, it's going to be digested by a group working on that, not by the whole Workgroup, and then the summary usually comes to the Workgroup, not every comment. So in this period we want to be prepared with being able to understand the public comments better with your expertise, in other words. But actually neither of us may be actually going through the literal comments, it may be ONC staff doing it. That's how we did it last time.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

ONC staff, right, okay.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Then they'll be giving us those summaries, us meaning you and us.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Yes.

Jonah Frohlich – Manatt

Micky, it's Jonah. I'd agree that we should definitely focus on the information exchange related Meaningful Use criteria and work with the Meaningful Use Workgroup to help refine comments and come up with really good criteria. I think right now the way it stands, I was really glad to see the Meaningful Use Workgroup actually have a very specific HIE criterion. I think we can probably work to refine it, specifically to try to encourage interoperability and to try to help support and direct the state HIE programs because I think they need to be well coordinated with the Meaningful Use criteria that's related to specific HIEs.

Seth Foldy – Wisconsin – State Health Officer

So there are a lot of public health issues that come up for two and three. Some of them are information exchange –

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

I'm sorry, who's speaking?

Seth Foldy – Wisconsin – State Health Officer

I'm sorry, Seth Foldy.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Hi, Seth.

Seth Foldy – Wisconsin – State Health Officer

Some of them are more focused on the problems of information exchange and moving information appropriately to where it needs to get. Others focused more on the issues of what might be most valuable to measure in a quality measure or to add to demographics or other considerations. I know we have a yet to be activated public health Workgroup on this taskforce, or maybe it's the other way around, taskforce on this Workgroup. An interesting question is, if we were to activate the public health taskforce, would it focus more on the information exchange elements of discussion or potentially the more holistic public health input into the stages two and three?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Yes, that's a complicated issue you just threw at us.

Seth Foldy – Wisconsin – State Health Officer

The limited set itself is pretty important and big, and of course public health agencies and public health associations are all commenting, we hope, to the other Workgroups. So perhaps we should, however, activate the public health unit to talk about specifically the issues of moving the messages around, finding the address you're trying to find, and those kinds of exchange issues.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Right.

Seth Foldy – Wisconsin – State Health Officer

And there is this big question that continues to, at least in my mind, continues to tumble along out there that we're all sort of an organized NW-HIN exchange sort of model, versus a direct sort of model and whether or not public health should be working towards implementing both one or the other or perhaps something different.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Right.

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

Micky, this is Walter. Can I suggest something? Given the fact that we have such a short time frame, I mean, February 25 is less than a month away, and considering Seth's point, it seems to me that for the purpose of gathering feedback and submitting comments on Meaningful Use stage two on behalf of the IE Workgroup we might want to consider just meeting as a full Workgroup with a very structured agenda over the next four weeks that remains between now and February 25. And in that agenda explicitly pull out the public health components of information exchange as we comment on Meaningful Use stage two and three. I fear that if we work in a Workgroup format and then bring back things in a pass for format and then bring things back to the Workgroup, we might run out of time between now and February 25. So it might be best, again, to just schedule almost weekly meetings of the IE Workgroup over the next four weeks to try to discuss and gather the feedback that we need to submit comments on Meaningful Use stage two and three.

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

Walter, this is Claudia. I like that idea and I agree with the need for some really focused time. Another thought that crossed my mind is whether we should even do an in-person meeting, maybe an all day meeting, where we really sit down and walk through everything and then maybe take away other things we need to think about or work on and bring it back to a call. Because I do worry a little bit about whether we can cover the scope we need to with, and there's a natural transition cost every time you do a call, so that was another thought I had is whether in person time would really be most productive to work through a whole set of things pretty quickly.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Right. This is Micky. I think that makes a lot of sense, Claudia. I'm glad you joined us. I guess just one very practical question. I had laid out that we might want to do this roughly in the time period of the public comment period, and I stumbled on to that I think not explicitly thinking about a very important point that George Hripcsak raised, which is that the Meaningful Use Workgroup recommendations are frozen right now while they're waiting for those public health comments, so this is a good time to be commenting on them because they are fixed at a point in time. I guess the question I have, though, is do we want to formally submit comments as a Workgroup, as a part of that public comment period as preliminary comments? Or are we really just saying well, this is a good opportunity to be weighing in but we're really working this through the Workgroup process and so we don't specifically have to adhere to February 25th, we want to formalize with Paul Tang and George how we will vet the work that we have to do that overlaps over the coming months, which I think determines a little bit how we want to set up this agenda for the Workgroup over the coming months.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Micky, this is George. I was thinking as you were talking that it's the Workgroup process that is the one that I was thinking of, but I just had the thought that if you guys come up with some new idea, it's going to be very hard to include another Workgroup's new idea if it's not part of the public comments. Formally speaking, I think we would need the public to ask for something for us to include. Now, not that we're going to increase the difficulty of Meaningful Use quickly or anything, but if there's anything that feels kind of different it would be nice if we were represented in the comment somewhere.

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

This is Claudia, and I can check back on this process. I've talked to Josh and I think that reflected conversations with Paul and others like David Lansky, but the timeline he suggested was by the end of March, but that we as a Workgroup formally forward our thinking and comments to them as a Workgroup, which is sort of one more new protocol we haven't really ever done before because it's not really, whatever. But that was the timeline he suggested, was the end of March would be a good time. And I think he was separating that out from the public comment period and creating new mechanisms. He's asked the same thing, I believe, and Paul, I don't know if you're on the line to confirm this, of the Tiger Team, the Privacy and Security Tiger Team. I think that would give us a little more time. They're looking

for our comments. They're anticipating them. And it would be at the same time that they're processing and thinking through the public comments.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

This is Micky. A couple of questions, is it possible for us to have a two staged approach, which is some preliminary recommendations that are submitted as a part of the public comment period, and then some more with the benefit of a little bit more time and perhaps the feedback from the public comments, some more finalized recommendations through the Workgroup process by the end of March?

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

As a process, I'm sure that would be possible. I'm not sure that we need in order for our comments to be considered to go through the public comment because we have our own status as a Workgroup and they've asked us in that status to make comments, and I don't think end of March, they will still be looking at those public comments. It's not like it would be the ultimate time period. My sense is we wouldn't need to do it through public comment, we could do it this other way, but certainly defer to the group if people feel strongly otherwise. I don't know, so maybe just folks can react to that.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

This is George. I defer to ONC. The thought just occurred to me was that necessary, and it sounds like you're saying it's not necessary, so that's good news.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

This is Micky. It seems to me that it would be harder to think about preliminary recommendations and then more formalized ones if we're able to just, from where we are right now, say we've got a process that gives us the benefit of having the ultimate deadline be end of March and then we're able to think about a more thoughtful work plan over that entire period.

One other question, and I don't know if anyone, Claudia or George, if you have any sense of this, any idea of how long it takes from the closing of a for comment period to being able to get some of the summarized results of the period? Obviously it depends on how many comments you got, I understand that.

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

True. I can ask Josh. Generally speaking, like for instance PCAST groups just went through the same process, but I'm sure got many, many, many, many fewer comments than is indicated from the I'm guessing it would be within a month. It might be two weeks. But I think we can expect a really high volume of comments. Let me ask Josh off line after this call. Are you wanting to have us be able to benefit from those comments before we comment?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Yes, exactly. That's what I was going to suggest is that with Josh if part of that discussion could be that instead of saying it's a hard, fixed calendar date, like end of March, that we have whatever, a few weeks after we're able to have access to the public comments in order for us to be able to take advantage of those. I think that would be great.

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

Let me ask him. I'm not sure they're going to want us, I think it's great to be informed by the HIPAA comments. Since they have a whole protocol for suggesting those and commenting on those I do think they want our comments to ... from what other people are saying. So let me just get back to Josh and talk about that a little bit and then maybe get back to you guys as chairs.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Okay.

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

Micky, this is Steve Stack. As you work through how we do this, I think even in these next two, three weeks, given the discussions that are going on with the provider directory we're still trying to create how are we going to get all these people connected, the evolution in HIEs, I think just the overall pace and rate of changes that are proposed in here. Stage two, I just think some of the evolution in here is, we're creating it at a pace without the ability to really anticipate where some of these pucks are going to stop moving, and I think that this Workgroup certainly has a lot to offer on what is technically feasible or reasonable. And not only is it feasible or reasonable, because some of it may be, but are we trying to push this faster than is reasonable or feasible. So I think we've got a lot that we can start to put our heads around for the exchange components in here, even before we have any input from other stakeholders.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Right. Yes, I'm glad you raised that, Steve, because I think that's a perfect point, because there are some macro issues I think which are quite important, which I think is what you're suggesting, as well as the micro issues of each line item on the recommendations and what do we think about those. What do we think about the jump from stage one to stage two and whether that's reasonable and whether the measure or the objective is reasonable and all of that. But there's also the larger question of in its entirety does that seem coherent as an approach to Health Information Exchange, and there are some philosophical issues as well about understandably the Meaningful Use Workgroup has wanted, as much as possible, to move from, the analogy would be moving from process measures to outcome measures and translating that into Meaningful Use objectives, moving from infrastructure specific measures to clinical process measures so to say we're not going to have an objective anymore that says you should use this technology in this way. We're going to have a clinical process measure that has some meaning clinically, with the assumption being that they would have to use the infrastructure in these two or three ways in order for them to be able to accomplish that.

But certainly one question in my mind as I go through this is, is enough of this HIE infrastructure, both in terms of hard infrastructure as well as policies, protocols, services, is enough of that out there in the field for us to be able to jump to clinical processes and the assumption that the infrastructure will come along if it's measured that way? That seemed to me to be a philosophical thing that we are probably going to be wanting to contend with as well.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Micky, this is George. I found my notes. Comment ends end of February. ONC summarizes it for us by March 24th, one month, and we meet, probably by phone first, but in person on April 5th. So that's our schedule that we have so far.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

So you expect to get the comments March 24th, is that what you said?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Yes, that's an estimate, not an exact date, but yes.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

I see. Then you need to go over the comments on March 5th?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

On April 5th.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

April 5th.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

But we may be called before that. But that's just when we're in person meeting in D.C.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Right, okay. George, we'll get some info from Claudia, but maybe it makes sense for all of us to try to huddle off line to figure out how these Workgroup processes get aligned.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Sure. Then we can get Paul in the discussion. That would be great.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Okay, great. Why don't we keep moving ahead then? On the next slide we've just thought about a high level approach, and again we'll figure out how this actually works I think once we dig down to the details and understand what we think are worth deeper dives. But as we go through I think we'll undoubtedly identify specific issues that require a more detailed assessment. One thought that we've had in some off line conversations about the way we might be able to move forward on these with that kind of lighter approach, as we were discussing, that keeps us sort of nimble but also keeps us with the ability to dig in at enough depth to be able to feel that we have some sense of the heart of the issue and be able to make some recommendations that we think will improve the process going forward and will be good substantive recommendations.

The idea was that as we start to identify a set of key topics, what we might do is then have a process where we have a volunteer lead Workgroup member, by dint of your expertise you may be volunteered, but have a process where we can identify a lead Workgroup member or two who are willing to take on a particular issue or topic. And then bring in any outside subject matter experts to supplement them and to help them with maybe a quick process where they're able to off line dig down into an issue, identify what are some of the key issues that need to be addressed by the Workgroup, and then present that back to the Workgroup so that we can have a quicker turnaround kind of process, with perhaps a few of these working in parallel rather than each one having to have its own large taskforce. And obviously it will depend a little bit on the nature of the issue and how big the issue seems to be, but it seems that a number of them may have a little bit of that flavor and may allow us to operate with more things in parallel and allow the bandwidth of the entire Workgroup to be thus expanded.

Seth Foldy – Wisconsin – State Health Officer

Now, there are four of us that do a lot of work in the public health domain, there may be more that I don't know about, and I'm wondering is it permissible for the four of us, the two chairs, I don't know if the chairs of the Public Health Workgroup are on the line, but I was wondering if the four of us could, in a sense, create a little Workgroup of –

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

Seth, I think that's a great example where there might be topics where we – I think what we were almost trying to do is partly because we are not sure we can support multiple taskforces at once from a statute standpoint, maybe not necessarily each have a taskforce for everyone, but there might be topics, like public health, where there's a quorum of folks, there's a set of somewhat complex issues to work through, and it may well make sense to have a separate group meeting a couple of times.

Seth Foldy – Wisconsin – State Health Officer

Yes, I guess I'm just trying to make sure that it's legal for four of us to put our heads together and come back as a subcommittee without a charge and a public comment period and everything else.

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

You know, that's interesting. We have five –

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Keep the door open and have us –

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

Yes. We used to have Tiger Teams that met separately, and those weren't necessarily part of the public deliberation process, and we have tried to pull those mostly into the public deliberations. So if it's a group that's going to meet more than once or twice I would encourage us to make it open and have it reported and all that, because it's part of the discipline we're trying to put on this process.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

So maybe a one meeting Tiger Team we could squeak through.

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

Yes, I think the point is just if we need to have a side conversation that is part of the process, absolutely, great. If we need a more deliberative process I think it makes sense to have it be part of it.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

I would suggest a side call, if we can organize that in the next week or two just for the people you're talking about, Seth, so that we can figure out what the scope of that is and then how to integrate that.

Seth Foldy – Wisconsin – State Health Officer

Sounds good.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Because I think you did, earlier, raise this bigger issue of what is the scope of that. Is it specifically on what we see in the stage two recommendations that are related to public health? Is it public health and HIE, or is it public health at large?

Seth Foldy – Wisconsin – State Health Officer

I guess I will suggest that we focus on the HIE related aspects.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Yes, that would be my input.

Seth Foldy – Wisconsin – State Health Officer

And feed it right back to this group and then we may go out for lunch afterwards and talk about all the other aspects.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Right.

Seth Foldy – Wisconsin – State Health Officer

And feed it to other groups.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

That makes sense. You also have a different call-in number for that one because it's a different topic.

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

Seth, this is Claudia. I can just off line just maybe help support that with our staff at ONC.

Seth Foldy – Wisconsin – State Health Officer

Sounds good.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

That would be great.

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

Okay.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

So the next set of slides, really what we've done is, and I don't know how familiar people are with the stage two recommendations that are out for public comment, but Cory was good enough to strip those out of that larger document just so we could have here at least a set that we think will lead to Health Information Exchange. Some of them are directly related, some of them more indirect, there may be some that they're even more indirect and somewhat related but they're not here. We can make sure that at least we have the ones that would be universal ones that we would want to be looking at. But just walking through these, you can see that you've got the regular ones which are ePrescribing and labs, or the ones where I've identified in page one, and then some new ones that start to address consumer engagement, for example, online secure patient messaging is in use, is that a set of things that we think are within this Workgroup's span of deliberation. I would think yes, because I think it does relate to Health Information Exchange.

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

Micky, this is Dave Goetz. The only thing that seeing ePrescribing and lab work there, I don't think there's obviously any need to go diving down deep into those, but is there anything that we think needs to be red flagged in any way, because those being the critical early adopter kind of pieces that we would suggest. There may not be, but I just pose it as a question. There may not be.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

What do others think? I think as a general process, Dave, I think you raise a good general point here, which is that as a process one of the ways we might want to go through this, and I'm not suggesting we do this now, perhaps this will be the first digging in that we do at our next meeting, but that we go through these and identify for those ones that we feel like we've already covered and have been substantially a part of stage one in some way, shape or form, that we have some way of getting some sense of how is that working, if I'm understanding you correctly.

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

That's correct. And not spending a lot of time with that, but just kind of a quick check in to make sure we're not missing something in those.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Right. And then that would I think help frame our understanding of whether we think the proposed stage two makes sense, for example. So the lab results one is a great example, all it says is it doesn't raise the objective in any way, shape or form or say anything else, all it says is take it off the menu set and make it core.

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

Right. So if we do that to people what does that mean?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Right. And it may be that there are some things that are not here that we think ought to be considered. So I'm going to go all the way back to last summer when as a working group we did recommend that a part of the hospital Meaningful Use measures be that they deliver labs according to the certification standards that was not finally accepted, but that might be just an example of some of the things that aren't here that we may want to say, based on what we know of what's going on in the markets that might be a good one to raise again as a recommendation.

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

True.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

The other one; I'm sorry, did someone

M

Sorry, Micky. I would certainly be in support of that. I don't think we've completely figured out what we're doing with labs, for example. And given that there's increased priority on space under the HIE cooperative agreement program to figure out lab interoperability as part of their program information notice, I still think it's not an issue we should ignore and we can support somehow.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Right. By "we" I assume you mean we as a country have not figured it out.

M

This Workgroup certainly hasn't, and I don't think the country has either.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

That's a great point. Another one here, apart from the consumer engagement one, which I think is a whole new area for us and would love to get Workgroup perspective on that, is the quality measures. I know David Lansky is not on the call, but he is the co-chair of the Quality Measures Workgroup and I think David would very much like us to weigh in on the Quality Measures topic from the Health Information Exchange perspective. So as he had discussed, they seem to be making a lot of assumptions in that Workgroup about what an HIE infrastructure, however you want to define that, would be able to support, but that's all a set of assumptions that they're making without having the input of our Workgroup in terms of what we think would be supported and what's reasonable to expect.

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

Micky, what you're saying is making me realize there might be a really interesting link between these two kinds of phases of our work, the first focus on Meaningful Use issue and then the next sort of a topical modestly deep dive, and that is that I always think of at least the agreement program as trying to feed ahead of the puck of where providers are, like giving them the capabilities they need to do what they need to do, working with pharmacies and working with labs and making sure that that stakeholder end is also held up.

So let's say in stage two we make a recommendation that we think something should go forward and we understand there are some risks about our current momentum or our current status that might actually speak to the scope we need to look at also as we look at labs. So for instance if we say we think the nation should move toward electronic ordering of labs, that's just an example, then we can start to talk about what we need to do in the next year to enable that to happen. Then when we move over to that other discussion that's a deep dive or a modestly deep dive, we can use that initial framing to say here is some low-hanging fruit and next steps that we really need to tackle here, so the policy leaders, here's the regulatory stuff we need to do, here's the stuff we should be doing in the grant programs, here's what we need from a standards perspective, and kind of link between these two conversations and not lose track of the insights we get in Meaningful Use as we move over to that next set of discussions. And it also, like Jonah spoke up on labs, I always think of Jonah as the one that might carry forward that discussion, so even identifying some of our leads on those topics as we go through the stage two stuff so they can be helping to capture the conversation moving into the next phase.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Right, that makes a lot of sense. It also is very helpful in identifying Jonah as our lead on the lab taskforce.

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

Yes. Sorry, Jonah.

Jonah Frohlich – Manatt

This is Jonah. I withdraw my previous comment.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

We've already figured it out. No more deliberations needed.

Jonah Frohlich – Manatt

Yes, the last ten minutes have been very productive.

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

Micky, this is Steve again. I'm looking at a larger grid here that's not on your slides yet there for the proposed stage two, stage three measures. There are those things this group probably will have concrete and put into, so we were just having a discussion about if the nation moves towards ordering lab tests electronically, but there's an ironic disconnect between the Meaningful Use and the HITECH funds incentivizing clinicians and providers to use these things. But for incorporating clinical lab test results into EHR structured data, for that requirement, as you look out to stage three having 90% of lab results electronically ordered and stored as structured data, the bulk of that thing is not just the clinician ordering them, that's what they can control, it's the system being able to produce it. So there are things in here that right now that is not possible for most people to do, so it's not that they may not choose to do it, it's just not possible, it's not reality at the moment. So I think we need to tease out those things where we can specifically say that we're not there yet, so it may not be reasonable to put that at stage two at this point in time.

But there are other things that this group may or may not take on or discuss about making available to patients their clinical data. So what if the patient has a breast biopsy and there's a requirement that they have to be able to see their test results within 24 hours of being available and they go on line and find out they have an invasive carcinoma of the breast and now all of a sudden they're at home looking on their computer finding that stuff and they're terrified and then start clamoring to call to get information, as opposed to having waited that one next day to go see the physician in the office as was planned to actually discuss all the information. So there are layers to this onion, I guess, and probably one of the most important part will just be what is technically feasible or likely for the group. Then there's another layer that I'd still like us to get to and try to comment to, but it will probably have to be a second tier priority for us, which is just are there unintended consequences for some of these things that are outlined?

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

Steve, this is Dave Goetz again. That's what I was trying to say I think in a sense, is where do we have a red flag that we've just got to say hey, wait a minute, you need to understand and we need to maybe be helpful in defining what crosses those barriers, but where the barriers really are.

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

Right.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Other thoughts? Just being cognizant of the time here, I guess based on all of this, which has been a great discussion and feedback, it seems to me that perhaps for the next call where we start to dig down into this, that we start to think about just really drilling down into this grid. And there are various ways that we can do that, either just do it in the order that it's presented and start walking through, or group it into categories and think about them in categories. If people have thoughts on that right now, or afterward if you want to do it via e-mail, that's fine, or we can come up with an approach and just start from there. But I think, thinking about Dave's comments and Steve's and others, that it seems like there are a few key questions for each thing that we probably just want to be able to lay out, which is what is the current status of that particular activity, whether it's ePrescribing or labs, whatever, what do we know about that? Does the staging seem reasonable in certain ways in terms of the ability to accomplish it, or if not, what are the key things that would need to happen in order for that to be something that could be an appropriate challenge and a threat, but something that is accomplishable by most people, for example. And I'm just thinking out loud here, but we can start to lay those out. If I'm understanding correctly, that might be the way for us to begin to attack that. Does that make sense?

M

Yes.

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

Micky, I like the approach, it's Claudia. I'm wondering, do you folks want to try to do an in-person meeting, let's say mid to later February? Either way it's fine, but if we do want to do that we can start planning it.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

I agree with you, Claudia. I think an in-person meeting would be great. I'm a little bit worried about HIMSS happening right in the middle of that time period.

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

Right.

M

Who isn't going to HIMSS?

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

We can do it at HIMSS, do it a day early.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

We could do that.

M

That would actually be great, if we could do that.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Right.

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

Okay.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Maybe we can poll to see who won't be there.

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

Yes, we'll round-robin everybody on who's going to HIMSS and who isn't. The other thing is, even if people aren't planning to go they can figure out a way to call in. We don't want to make people travelers one more time if it's not needed. Okay, so we'll try to figure that out over the next few days.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Okay. Then just moving ahead here, because I want to make sure that we give Jonah and Walter the full hour on the ILPD conversation, jumping ahead to slide ten, the other thing that's here in parallel that I think we just want to remain cognizant of and at least my sense of it is that our consideration of these things that we're just going to talk about in a second, can still be within the frame of the Meaningful Use lens. I know I'm mixing metaphors there, sorry. But I'm speaking particularly about the S&I framework, and for those of you who are not familiar with it, that was out for public comment as well. We've got a couple of slides here describing in general what the S&I framework is supposed to accomplish. There are two focus areas for them. One is the Transition of Care initiative, which is essentially tightening up the CCD C32 specifications. Then the second is a lab interface initiative. Those are the two, I think, coming out of the public comment that they decided that they're going to focus on.

There are a couple of different angles that we can take on how we want to weigh in on those. One would be to just look at them and provide some recommendations. But the other might be really for us in the context of our looking at the Meaningful Use requirements and recommendations, that labs, for example, as we look at labs and as a part of that conversation take the S&I framework into account, to say that from what we're seeing and what we think might be appropriate and necessary with respect to labs, does

the S&I framework, as we understand it, accomplish that? Or are there some recommendations we might have for those who are driving the S&I framework to make it aligned with what we think would be best as it relates to Meaningful Use stage two.

I don't know if anyone's familiar with the S&I framework or has any thoughts about that. If not, we can just keep moving and we'll just sort of take it as a Workgroup chair responsibility to make sure that we've still got that on our radar and that we're not letting that go on without our being able to comment on it.

Jonah Frohlich – Manatt

Micky, this is Jonah. My take is that our role in specifically the lab S&I framework pieces, they're really looking for technical and operational solutions for simple lab interoperability. I would suggest that we track what they do and consider what are the policy implications are of those technical and operational solutions. Because one of the things I think we saw during the NHIN direct initiation is that they started to explore their charter and were getting into areas of governance and privacy and security and authentication without the immediate connection with the Workgroups and the committees. I think they ended up resolving that, but we certainly don't want that to happen in this next iteration since there's going to be three S&I initiatives launching in the next week. We can probably just fairly simply to make sure that we're tracking it and that there's some relationship we're working considering a policy and making policy recommendations about what they're doing.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Right, I think it makes sense. What's the third one, Jonah, do you know?

Jonah Frohlich – Manatt

I do, but I don't really know what it is. I'm not really sure. It's something like comprehensive care. I'm not quite sure what it is, but Claudia might know.

M

The third area is the CDA consolidation project, so it's also working on simplifying the CCD.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Oh, okay. That's different than Transition of Care?

M

Yes, it is. It's a separate area.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Okay. Yes, I think that's a great point, Jonah. It may be that one of the things we weigh in on is just the timing of it. We don't really know that, but as we start to think about the timing, and to Steve's point, what is reasonable at certain periods of time with respect to the infrastructure that's in place, maybe we would come down and say that something seems unreasonable, for example, unless the S&I framework in that area is able to accomplish what it says it's going to accomplish in time for that to be well penetrated in the market, for example.

M

Right.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Okay, and maybe one of the things we can try to do for the next meeting is perhaps have Doug or someone involved in the S&I framework just give us some background presentation on what that process is going to look like so that we can plug into it appropriately.

M

Yes.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Okay, so on the last slide here before I turn it over to Jonah and Walter, the potential areas for us to focus on, and Cory did a great job, I think, in pulling together these slides for this meeting and put down some sort of preliminary thoughts on what the timing might look like for this. I think that the idea here, and Cory, correct me if I'm wrong, is that for February and March, I think I tweaked this a little bit, but February and March would be that we're looking at the stage two Meaningful Use recommendations in the S&I framework in their entirety and then probably identifying some drill down areas, some of which we can do in parallel, some of which may take deeper deliberation and some thought and then try to put those into a timeline that extends out beyond that. But I'm not sure exactly what drove the order in which these are laid out here, but my own perspective would be that things like Transitions in Care and Quality Reporting ought to move up, but again, Cory, I don't know if you're on the phone if you had a driving perspective on this.

Cory Mark

Yes, Micky, I'm on. I don't think so. I think it was just kind of putting down a straw man to throw out. I think if we have other orders we should definitely change it up.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Okay. I don't think this is something we need to decide here, because I think it will be part of what comes out of the next two months as we think about the Meaningful Use recommendations and what we think is important. But if people have thoughts right now, that's great. Otherwise, I think we can close up this part of the conversation with the takeaways being that we do want to engage as a Workgroup on the Meaningful Use stage two recommendations that are out there right now. But this seems like an appropriate time to do that, because they're frozen right now by the Workgroup while they're waiting for public comment and that we will, offline, work with ONC and the Meaningful Use Workgroup to really set up a process for us to be able to develop a set of recommendations that will be incorporated in the deliberations that the Meaningful Use Workgroup has. So the next call we'll dive into the actual stage two recommendations that are out there.

Unless anyone has any other takeaways, I am going to now turn it over to Walter and Jonah to talk about the status update on the individual level provider directories. Okay, hearing none, Walter and Jonah?

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

Let me maybe start and pass things along to Jonah. Actually right now I'm on another call as well. So the report, if you go to the next slide, these are the elements of our report, basically what is the status of the ELPD recommendations, a very brief update; our revised floor plan in terms of timeline of when we would be delivering the ILPD recommendations; review and confirm the first round of recommendations focusing on users and uses, basically use case scenarios; the functions and functionality of the ILPD and the content elements; and then have the chance to review and discuss the operating requirements and business models and then the policy issues basically and finish up with some next steps. That's our goal for the call today. Next slide.

Very briefly, the ELPD recommendations were delivered to the Standards Committee January 12th. The Standards Committee is deciding who to assign the responsibility of developing those standard recommendations, but it is looking like it will be the responsibility of the Security and Privacy Workgroup, working along with the S&I framework team, and certainly working along with other Workgroups within the Standards Committee.

The S&P Workgroup currently is focusing on digital certificates, so that has a lot of related topics to the provider directory. The time frame for developing recommendations will be defined in the next few days actually and we expect ongoing exchange between HITSE Security and Privacy Workgroup and the Provider Directory Workgroup to help clarify the policy recommendations. We're moving along in the Standards Committee to try to take the next steps in the standards development part. That's basically where we are with ELPD at this point on the Standards Committee side. Next slide.

This is the ILPD framework. This is the same frame where we decided to use, as we did with the ELPD framework, so developed the same kind of recommendations along the lines of the users and users' functions content, operating requirements business model and then the policy recommendations. So we're following the same framework. Next slide.

This is our revised work plan. Before we were going to try to finalize the recommendations by February, but suddenly with the holidays and all of the other work that had been done, particularly some of the standard work that we did on the ELPD, we had to push this out to the March meeting. So this is what it looks like now. We expect that today we will be able to finalize some of the confirmed recommendations on several of the components and finalize some of the discussions of the business requirements and policy issues, and then over the month of February basically finalize the policy issues and get approval of the recommendations by the Information Exchange Workgroup by February 28th and then present those to the full Policy Committee by March 2nd, so the timeline now.

Let me stop there and see if there are any questions at this point. Jonah, is it okay if I transfer this to you? I need to make a few remarks on another call that I'm on. Is it okay if you take it on from here?

Jonah Frohlich – Manatt

Sure.

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

We're on the recommendations slide, so if you can move to the next slide and I'll turn it back to you, Jonah.

Jonah Frohlich – Manatt

Okay. Since we've reviewed these a number of times I'm going to really go over them very quickly so that we can get to the substantive issues of recommendations. On users, we described a host of potential users that we need to consider having access to the ILPD. We consider all healthcare providers, whether physicians or clinicians or dentists, those that are involved in Health Information Exchanges, and those that need to be identified at the individual level for the purposes of receiving or requesting health information. For our recommendation around users I think we might want to have a little bit more detail and context for this. If we consider our use cases, and there are about a half dozen of them, the use cases include both provider and hospital entities that would be looking up clinicians, providers in the directory, they're public health entities, they're potentially labs, potentially even health plans, so I'm wondering if we want to craft specifically a little bit more detail on who would have access.

So for example, we don't necessarily expect that it's going to be a nurse in a hospital that's looking up an individual physician. It may be an administrator that is looking up a specific provider in a directory. For those on the phone, do you think that that is a reasonable class of users that we want to include, and if that is the case what are the other considerations, i.e. do we need to make a recommendation around access limitations or uses for accessing it for different classes of users.

Peter DeVault – Epic Systems – Project Manager

This is Peter DeVault. I'll comment a little bit on that. I think it's kind of confusing the way this slide is laid out. The list of users obviously isn't necessarily the same thing as the list of people who should be in the ILPD. And the question of access rights is really a very different question than who should be in it.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary

Agreed.

Peter DeVault – Epic Systems – Project Manager

But yes, I think it's reasonable that administrative users would need to access it, absolutely.

Jonah Frohlich – Manatt

Right. So I think that we had a slide on content, I'm going to check and see if it's in here and make sure we describe that. I would suggest that for this discussion we're talking about users, we're talking about who is actually going to be accessing an ILPD. Unless other people feel that we need subsequent discussion, I think it's pretty important that we be fairly specific on who's going to be actually using the services and potentially what are the policy recommendations around the access and limitations of that use per category of users. So let's start with that. Let's limit this to the actual users, not the content, not who's listed in the directory.

Seth Foldy – Wisconsin – State Health Officer

This is Seth Foldy. It's a little hard to divorce the two. Let me just ask, are we pretty sure then that the individual level directory will not be a place used to discover where to port information to for automated exchange of health information? In other words, it's only going to be a person and it's never a port for connecting for sending information. Because the two are very different obviously, but they could potentially be both in the directory that people are looking for.

Jonah Frohlich – Manatt

I would suggest that, and we're now into content, so we're just starting ... and I apologize, it's just that obviously if the answer to my question were oh, yes, include that too, then the universe of users changes radically.

Seth Foldy – Wisconsin – State Health Officer

Let's go back to the content. On the content side I think we have agreement that this is really about the individual providers, the physicians or the nurse practitioners, or whomever is actually listed at the individual clinician level.

Jonah Frohlich – Manatt

That might happen at the enterprise level, but we won't worry about it here.

Seth Foldy – Wisconsin – State Health Officer

Right, exactly. So we would not be listing, for example, a hospital clinic. We would not be listing an immunization registry for a region or a state.

Jonah Frohlich – Manatt

Very good.

Seth Foldy – Wisconsin – State Health Officer

Those would be listed potentially in the ELPD.

Jonah Frohlich – Manatt

Got it.

Seth Foldy – Wisconsin – State Health Officer

So given that, given that we are talking about potentially like a white page listed thing of providers, do we want to specifically make a recommendation here about the categories of users who would access this service and how specific do we want to get? Do we want, for example, to say that we're talking about a clinician category that would have access to this directory service and that there's a second category of users who have access which are administrators and potentially a third category, and I'm not exactly sure what that would be, but do we envision having multiple categories of users, and if that is the case do we want to make very specific recommendations about how those people can access the service?

Jonah Frohlich – Manatt

This is Jonah again. If we imagine a patient looking to hook up their PHR with their provider, would they use this directory?

Seth Foldy – Wisconsin – State Health Officer

We have not envisioned that use case at this point.

M

But I think the question is the important one, which is as it points out that use cases really need to drive who should have access to it. So one of our use cases is, I've forgotten actually the specific content of the use case, but whoever in a hospital or wherever else would be performing those functions, are the kinds of people that would need to access it. That's probably the best way to go about trying to answer the question of who should have access to this by looking at the use cases.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary

Right. So if we go to the next slide, just to help advance the specific policy recommendations we have six scenarios. It's the clinic to clinic exchange, push and pull, hospital to clinic exchange, push and pull, last clinic, and then public health. Those are the six that we've described. So if we want to look, for example, at the clinic to clinic exchange we're talking about an organization, an ambulatory clinic of some kind that is looking up an individual provider, associating that provider, once found in the ILPD, to an entity, and then initiating a transaction once that entity's certificate is validated by the receiving entity's certificate. So we can imagine in that scenario that we have front office and back office staff and we would have clinicians of various types. We can envision a medical system, a PA, a physician, nurse practitioner, a range of clinicians, and then we can envision front office staff who are doing admission intakes and then follow up. I would imagine that in this recommendation we would want to specify that both the administrators of the clinic and the clinicians would have got this to this ILPD. We would not want to necessarily say that only physicians can look up, or only nurse practitioners can look up providers in the directory. So I would suggest the recommendation, and I'm just putting this out there, would include administrators and clinicians. Does anyone have any thoughts on making that specific recommendation?

Carl Dvorak – Epic Systems – EVP

This is Carl. I agree with it.

Peter DeVault – Epic Systems – Project Manager

This is Peter. I think maybe rather than "administrators" we should be clearer. I like the words "back office" and "front office" staff. I don't want it to appear that we're talking about managers only either.

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

Jonah, this is Steve Stack. Blair had created a diagram and there's a little chain that a few of us had a few days ago. Do you remember that e-mail exchange?

Jonah Frohlich – Manatt

I do.

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

Okay, and then I sent a longer reply that seemed to end the discussion, so either it was so off base that it wasn't helpful, or it just got lost. But I'm wondering if the way we define this is the most pragmatic way, in that I was envisioning the ILPD as the white pages by means of which you found people or entities, and the ELPD was the one that actually had the routing information or the credentials necessary to actually exchange information. So the ILPD points to an ELPD, and so the first thing is, the point you just discussed a few minutes ago, is it too narrow to define it just as a human being, as opposed to I'm a doctor, I want to send a care summary to hospital A because my patient is on their way there for surgery, and so I want to push information to them. But I don't know how to run information so I need to look up hospital A and find it and then that would then be the tool that would link to the ELPD and put my EMR in touch with their EMR and effect the transmission of information.

So one, I question if it is too narrowly defined to say it's just an individual as opposed to also entities, because I think it minimizes the white page value of it. Then second of all, as far as the ELPDs, I would think that, oh, I'm sorry. Who can use it or look at it? I would say that the information presented to people looking at it as a white pages should be basic fundamental and what's necessary, so name, specialty, address, phone number, NPI number for like a doctor, but it shouldn't show other things like DEA, date of birth, stuff like that that could make it easy to take someone's identity. If you do it that way then anybody can look at it. You don't have to restrict access to it. You just have to restrict who is actually allowed to gain entry as being listed in that directory. But that sounds very different than I think what we're describing right now.

Jonah Frohlich – Manatt

I'm not too sure, Steve, the significant differences in what you just described, which I think I agree with and what we're describing here. So when we had the content discussion and we described some of the important attributes and data elements last week with CAQH, when Sorin presented, it was clear that we needed all of those demographic components for the ILPD, plus we needed some additional data elements to help with a provider's identity, because there are multiple Mark Smiths who practice in large metropolitan areas and we need to make sure we distinguish who's who. What you're talking about in terms of exposing certain content and not others I think is really critical and needs to be part of one of our recommendations. So I envision, again, that we have a recommendation that says front and back office staff, along with clinicians, have access to the provider directory but they only are able to view demographic information about a provider, and no information that might compromise the identity and the privacy of a clinician and compromise that. So that could be one of our recommendations. I'm not sure that we necessarily want to say the universe can view the directory. I don't know how or why necessarily we would want that in the use cases that we're describing unless at some point in the future we expect that the directories would be used in some much more comprehensive way, which they might be.

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

Jonah, I'm not thinking of the ELPDs as something that the end user queries or searches. I was thinking of that as a behind the scenes kind of a network communication between the ILPD and the ELPD. So the first issue is just if you wanted to send information in a push manner or a pull to request it between a hospital, an ambulatory surgery center, a laboratory, those wouldn't be listed in the ILPD. So now both the ELPD and ILPDs would have to have query functions, which seems to blur the possibility of segregating those. And the other thing is I think it's very difficult to anticipate when you say who would have access to, the individual clinician, or the office manager, but then what about all their nurses and then what about their med techs. So each setting probably defines the roles and the responsibilities somewhat uniquely. So I think if you make it very restrictive, you design a system that makes it hard to realize the value of all of these different scenarios. Now, you can create workarounds, I guess, you can have the agent of the office manager, which may be a med tech, but again I think that if the information presented in ILPD is not compromising to the clinician there would be no reason why you'd have to worry about restricting it, because the safeguard on the appropriate exchange of information will be did an appropriately authorized entity try to send information to an entity appropriately authorized to receive it. I kind of saw that at the ELPD layer of this.

Jonah Frohlich – Manatt

So the first issue, I think we recommended that there was some discoverability capability in the ELPD, so that there was the ability to actually, if there was not complete understanding of where the ELPD was, that the system would allow for that discoverability. So I think that does take care of that. I think in the ILPD as well there needs to be searchability and discoverability because that's really just the main function.

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

Jonah, this is Dave. Are we not really talking about role-based security that is specific to each individual entity?

Jonah Frohlich – Manatt

Right.

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

So I guess you'd have to understand how that was set up, but it should be up to an individual practice to decide in some ways. Somebody who's got the front office person who does absolutely everything is going to want to put a different set of role-based securities and be accountable for that on someone who's then a multi-specialty practice.

Jonah Frohlich – Manatt

Right. Okay, so just to finish the last thought, there should be discoverability, as we mentioned, in the ELPD and the ILPD. That's one of its core functions. And what you just brought up, Dave, which was also a point of Steve's and also Carl's, I think, Carl, it was you who said this, that we want to be more inclusive in, say, front and back office staff and not just say managers can use the ILPD and all clinicians. What people are saying is there needs to be fairly universal access to the ILPD, at least to the demographic information contained within the ILPD, but that the other information, the personal identifiers like the DEA number, the state license number, those need to be specifically hidden from all users and that that's more of a function of the host of the ILPD, whoever is supporting it, whether it's an HIE or a HITSP or someone else.

Peter DeVault – Epic Systems – Project Manager

This is Peter, by the way. But yes, I do also advocate for broader access to it.

Jonah Frohlich – Manatt

Okay. Excuse me, sorry.

Peter DeVault – Epic Systems – Project Manager

That's all right.

Tim Andrews

This is Tim. I would agree. I think Dave made the right point, which is ultimately there should be role-based access control that's just a matter of defining roles and who's in charge of assigning them, and then you can match your access patterns up to the roles. I think the larger discussion about ILPD, ELPD, I don't think Paul Egerman's on the call, right, I'll do my best Paul Egerman interpretation of a gravelly voice, but I think he really wanted the ILPD and the ELPD to be separated. And it's hard to do this and there was a comment before about probing through the use cases, and we may need to work through the use cases a little more carefully and in more detail the stuff that's out. But the use case here isn't necessarily the use case that the end user completely sees, and I think that's why Jonah was sort of saying that there isn't really disagreement here because even if the ILPDs and the ELPDs are separate, it's straightforward to think of building an interface such that the end user doesn't necessarily see them as

separate. So if you look up a hospital it's just smart enough, for instance, to know that I look up in the ELPD, not in the ILPD.

I think the reason that Paul especially, and maybe Carl, were very insistent on separating them, is the ILPD was not supposed to contain electronic coordinates and was really supposed to be limited to demographic information and other things, and at least, as I understood it, the use case there was, as Jonah pointed out, you're really trying to differentiate when you have confusion because of name ambiguity or partial understanding of the provider that you're trying to get something to. There's no particular electronic routing information there, it's got to be embedded in the message in some form because ultimately you have to know when you send it to a hospital that it's going to Doctor X at that hospital. But that's not an electronic routing piece of information as techies would normally think of it, it's an embedded piece of the message that gets routed to the hospital and then the hospital unpacks it and figures out how to get it from there.

So there was a natural separation to say, okay, ELPD is where we put things that actually have routing information and then we can send messages, really send electronic messages, too, and their endpoint from that perspective at the network architecture level, but we need more information, both to get it beyond that endpoint, ultimately the hospital wants to get it somewhere more specific, and to resolve this ambiguity problem that we might know it's Dr. Smith, but there might be several of them, or even Dr. Smith might practice in two different locations and we might be able, by using that information, to disambiguate. But you can layer interfaces on top of that that would combine this functionality so that it would look like a complete white page. I think that may not be clear if you're not thinking about it and embed it in the process pretty deeply, but I think that was the idea.

I do think there was one more element, and that was we could foresee an enterprise level directory that could be nationwide to facilitate exchange among EHRs, and I think people realize that the individual level provider directory might actually need to be a state by state or even regional initiative and matching up with other activity in the region in order for it to sustain. One other comment I'll make is as we say the words "role-based security" I think it probably conjures up something slightly different for all of us. My experience, though, is as we look out at the hundreds and hundreds of thousands of users that might touch this thing I think we're going to want to recognize that the essential simplicity will be needed here. I think if you're an employee of an entity that has an entry in an enterprise level director or your physicians' in an individual level provider directory we might just want to have a one-size-fits-all simplified mechanism here, because I just don't know that in real life implementing some notion of role-based security will yield the sort of results that we imagine it might. We might want to think about simplification there.

Jonah Frohlich – Manatt

So let me say this, and thank you for channeling Paul very effectively there, Tim, that it sounds like there are three recommendations about users and use. The one is that front and back office staff and clinicians should have access to the basic demographics of an ILPD. The second is that we recommend that other identifiable information that can compromise a provider's identity not be exposed to any of the end users. The third is that role and rules-based access should be considered but probably implemented locally, but that we're not making a recommendation for how it's going to be done at the local level, but that it needs to be considered. So I think that's a really good point. I think we could make a whole host of recommendations and for a host of reasons it may not fit all sizes. First of all, I think I've captured the discussion and those three recommendations and perhaps not missed anything; if I have, please speak up now and then we can move on I think to the next area. I'm taking the silence as saying that I got it and I'm going to move us forward.

Okay, good. What we have here, let me see what I've got here, we've got our scenarios. We did talk a little bit off line about public health and I'm wondering if we want to dive into that, but we have the six scenarios that are listed here. And I think there are common threads in each one of the use cases and then the privacy and security considerations, so I'm on slide 20. I think this is fairly straightforward. The scenarios are not all that different from each other when you look at the ... there in the appendix. But

slide 20 represents the six scenarios that we propose to recommend for the first set. The common thread is really about the linkage between the ILPD and the ELPD, which we discussed at length, and then the privacy and security considerations, all use cases are contingent upon following federal and local law and that full use cases add a layer of complexity that requires a stronger focus on ... and privacy and security rules, and things like patient preference is on those.

Before we move on, this is I think more or less complete. Any comment on the public health side from anyone if you want to elaborate this?

M

It sounds like from what was said earlier the concept of a use case where a provider is seeking to find out how to communicate with a public health entity, whether it be a department or a reporting system, would do so through the enterprise level and therefore we might need to consider adding a use case to the enterprise level but not to the individual level, so that finishes one item that I had raised.

Jonah Frohlich – Manatt

So to reiterate for the Workgroup, because I think that was an offline conversation, and for the public's benefit, what we didn't articulate in the ELPD use case, which is something we had actually discussed at multiple times during the previous ELPD Workgroup calls, is that we should consider a use case whereby clinicians are submitting immunization records to a region or state immunization registry, for example. And there are other registries that you can envision, public health registries, cancer registries, lead screening, others, that we could envision would take advantage of the ELPD infrastructure to perform in that function. So unless anybody disagrees, I think we want to try to make sure that we do not lose sight of that because I think it's a very valuable function and probably pretty important for the states that are implementing HIE under the ... program and the public health departments that operate in those states.

M

Basically the situation is that the clinician does not know where to send and uses the directory to figure out how to send. After a while hopefully this will quiet down when all the relationships are created, but there's always new physicians and always changes.

M

Right.

Jonah Frohlich – Manatt

Unless there are any objections, I think we want to make sure that that is considered an ELPD, even though it's a little bit late, but I do want to make sure that we don't lose it. Let's move on to the next slide, please. We're getting now again into the content and I think we need to make a distinction here. So again, this is the content. I think the first thing we need to do is to make sure we articulate who we're recommending is actually going to be listed in the ILPD, which we had some of that in the previous slide on use and users, which was confusing, I agree. Let's talk about, first, who would be listed in the ILPD. We've heard from public comment and others that physicians and physician equivalents, nurse practitioners, perhaps nurses and DOs should be listed in the directory. Not being a clinician I don't know if we have clinicians in our taskforce or those listening, I'm both challenged here to try to make a recommendation about being very specific on who we think should be listed here, so do we have others who have a feeling about specifically saying it's physicians, it's DOs, it's nurse practitioners, it's physician assistants, medical assistants, etc.

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

This is Steve Stack. First of all, there should be no distinction made between a DO and an MD. The DOs and MDs are the traditional definition of physicians. As far as the other, I guess you can say allied healthcare practitioners or limited scope practitioners, I don't know what the appropriate term is that's not offensive in any way, but you have optometrists and psychologists and podiatrists, so I think it gets very difficult if you're going to go down a degree path. Medicare has guidelines for who is defined as a

broader definition of physician as used by Medicare for people who are able to bill Medicare, and finding that definition and seeing how that describes it might be a more appropriate thing because chiropractors and those other kinds of examples of clinicians, advanced nurse practitioners, and physician assistants, they can all bill Medicare. They may not all want to be listed in the directories, some of them who are actually running independent medical practices would definitely want to be in the directories, but some of those other ones who may not themselves run a practice should certainly have a role defined for access to using the directories.

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

Jonah, this is Walter. Sorry, I had to step back. I wanted to comment on this point. When we describe the users, which I agree also, there was confusion about the term, but we talked about the definition of who would be listed really is individual healthcare providers, and that's actually a very specific defined term in many different ways, but one of the ways of course is regulatory ways that define who healthcare providers are. HIPAA defines them, and certainly there are a number of other regulations that define them, but what we also describe in the recommendation was that it would be all individual healthcare providers that are involved in Health Information Exchanges. So I don't know that we need to create a very comprehensive list. We can give examples, but we don't need to create a comprehensive list of every type of individual healthcare provider that would be eligible to be listed in the ILPD by virtue of defining it using a regulatory reference, I think we would be okay, again, giving a number of examples to help understand who we are referring to. But the critical part is that they will be expected to be involving some Health Information Exchange and that they need to be identified as individuals receiving or seeking that information for which the ILPD will support. So I think with those two clarifications we would be probably okay in terms of defining who would be expected to be listed in these ILPDs.

Jonah Frohlich – Manatt

Okay, and I agree. I think we need to come up with a laundry list of who's in and who's out. I like the idea of using either a HIPAA definition, if that's specific enough, or if the HIPAA definition starts to get into actual entities it might start confusing the issue. Steve mentioned who's eligible to bill for Medicare, and I just want to put some parameters around this to give enough guidance so that people are not confused about it, because it's very easy for us to even slip in the confusion on ILPD and ELPD. I don't know if Cory or Judy or Claudia, you're on the line, if we can look up, for example, get a source for who's included and who can bill for Medicare and then look at what is included in the definition of a HIPAA provider, HIPAA covered provider. I'm not sure what the right term is. But at least give us an opportunity to just look at those definitions and if those are appropriate I'd much rather use those than us try to define it because I don't think we'll be effective if we do that.

Greg

Jonah, this is Greg. I can get that together.

Jonah Frohlich – Manatt

Excellent. Okay, so for our next group we'll finalize the content recommendations based on some of those categories that we get. In terms of the content itself, once we have that list I think we're pretty clear on what's needed based on the previous conversations and CAQH discussions. The basic demographics, the one thing I want to distinguish here, because I think the recommendation is pretty important, as we just mentioned in the last group, is there are basic demographics that are related to a patient's name, their address of the location that they practice at, and other general demographic information, and then there's the identifiers that are much more sensitive, NPI, DEA, and state license, for example. I would posit here that we want to specifically make a recommendation that says we have a listing of identifiers, our basic demographic identifiers that are required, and that they're listed as follows: name, location of practice, and a couple of other basic characteristics. Then the others around the NPI and DEA, they're also required but not exposed and that the split, we say this is the content but some of the content is more or less public and other content is specifically not and restricted. Any reason why we wouldn't want to do that with the recommendation or if anyone has any comments? Okay, so I think the recommendation's going to be pretty straightforward then.

Can we go to the next slide, please? Next slide again. I think this basically gets to the point that we just mentioned about identity theft and that we want to make sure our recommendation covers that. Okay, next slide, please. So slide 24, recommendations on functional capability of ILPD. We'd say that you need to support direct exchange, that's send and receive as well as query and retrieve, so it's push and pull. Our recommendation would include that there would be some basic discoverability of the individual provider location and about that now, I guess I'm not sure where this fits in, to provide the basic discoverability of individual provider's security credential. I'm probably going to ask Tim to help me explain this, and I'm sorry for being so dense, but when we say the individual provider's security credential, we're not talking about their ELPD certificate?

Tim Andrews

Yes, we are. I put that note in the comments. Walter worked on these slides and that probably wouldn't be clear. You've made exactly the point. To someone just looking at that, at least as I understood it and Walter agreed, the intent was not to include security credentials in this directory, the ILPD, that you wanted to be able to get to relevant security credentials presumably through the links to the ELPD.

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

Yes, I'm sorry. I forgot. The third bullet should have been deleted on this slide. I know Cory sent me an e-mail last night and I didn't realize he was referring to this third bullet. But yes, clearly the intent, as Tim just pointed out, is not to provide in this provider directory any security credentials for individuals, but this will be linked to the ELPD.

Jonah Frohlich – Manatt

Fair enough. So I think, just deleting it, we might say, like the fourth bullet, this provides the mechanism by which the individual provider's listing is linked to the ELPD's security credential. I like that, because that's an important function, as opposed to saying that discoverability is out there at the individual security credential, which actually doesn't exist. Okay. So if we can make that change I think this is an important recommendation and one that should minimize confusion. The fourth is the links to interactive ELPD for basic information regarding Information Exchange capabilities. So again this is much like what we just said that the ILPD connects to an ELPD so that the provider that's looking up, or the practice, or the clinic, or the hospital that's looking up the individual provider can then see the associated ELPD's exchange capabilities. They'll be able to see well, I have a CCD. I want to send it to Dr. Jones. Dr. Jones practices here. Their EHR supports the C32. I can send this. That's my understanding of this recommendation. Do others agree that that's a good recommendation in terms of the functional capability of an ILPD? I'm going to take silence at any point is a case that there's no disagreement.

Peter DeVault – Epic Systems – Project Manager

This is Peter. I'm a little bit concerned about including functional capabilities in the ILPD. It seems like that information should really be in the ELPD, or maybe I misunderstood what you're suggesting.

Jonah Frohlich – Manatt

That's an important point. So are we saying, for example, that that function rests in the ILPD or that the actual function is that, and this is important, that the function is that the ILPD points to the associated ELPD and it's the ELPD's function that lists the security, the capabilities of receiving certain kinds of content.

Peter DeVault – Epic Systems – Project Manager

That's how I've had it working in my head.

Jonah Frohlich – Manatt

Yes. I think that's right. So I think we need to change this to reflect that much like we just ... the third bullet, that the ILPD allows a provider to link to discover a provider's location and their ELPD's capabilities, which included the ability to exchange the

Peter DeVault – Epic Systems – Project Manager

Okay.

Jonah Frohlich – Manatt

And the fifth is that the mechanism for individuals listed in the ILPD should have delegated staff to correct update listed information. So what we're recommending here, and I think this is also important, is that there needs to be a corrective mechanism, there needs to be change control issues, change control, but there needs to be a corrective mechanism to identify, for example, errors or omissions in an ILPD so that you can have a way to continually improve data quality in the ILPD. I don't think we want to get any more specific than that, other than to say that given that we can envision an ILPD might be in use and used many, many thousands of times in one community, those who are using it and identifying errors need to be able to somehow have a process for correcting, maybe not themselves but at least submitting a request to correct an entry if they find an error.

First of all, does anybody disagree with that? And second, if they do how we may want to modify that specific recommendation or provide additional context or detail. Okay, if I don't hear anything I'm assuming that we're okay. Okay? Let's go to business models. I think we're actually coming pretty close to the end of our discussion on recommendations here, which is great.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Jonah, this Micky. I think between five to eight minutes or something, because we have the public comment period at the end as well.

Jonah Frohlich – Manatt

Correct, absolutely.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Thanks.

Jonah Frohlich – Manatt

Sure. Business models and operating requirements, first of all, the overall approach, are we following an Internet-like model, nationally coordinated federated approach? I think it's an important question in terms of an operating requirement or even it goes to the business model, are we talking about the same – I'm under the impression that we're not talking about the same kind of national registry like the ELPD is, where we actually have something like a national registrar that is coordinating and providing updates, where regional registrars are continuing adding ELPD entries. But do we want to make a recommendation that does have more of a natural federated approach so that we can have either regional, statewide, multi-state ILPDs either feeding content to a national directory or pulling content from some sort of a national directory if one is ever established or an authoritative source ever identifies. I think the question is here, do we want to try to make a recommendation around source of content for these ILPDs.

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

Yes, and this is Walter again. Part of the question relates to how the model for ILPD would parallel with the model for ELPD, since we're creating those links for discovering the entity level security credentials and things like that, and identifying the entity level information about the location of the individual providers. So this overall approach certainly has to take into account how we are looking at the ELPD approach, and that's why the question was do we use it similarly, after all it's from the one that we use for ELPDs to do the individual level provider directory.

Jonah Frohlich – Manatt

Okay, well, you know what, one of the issues that we really need to consider here is as we've heard many times from those who provided comment is just how challenging it is to actually maintain, to build and maintain a source of content for directories, from health plans, from CAQH, from Surescripts, etc., and from our medical board. So we can envision a recommendation that says we want to try to coordinate and facilitate a better process for updating regional or national directories, leverage what exists today, but I think this ultimately goes to the notion that it's incredibly challenging to try to maintain a directory like this and that we can envision doing this in 56 states and territories independently or we can envision doing this potentially one or multiple times, but having a much more coordinated effort and having self-corrective mechanisms for correcting content. I'm guessing from the silence that people are either very tired after a two hour call and are ready for public comment, or we don't really have a recommendation on this.

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

Let me suggest that we create a couple of potential approaches to bring to our next call for discussion, because I think that this is a very difficult question. Going from the ELPD federated approach to thinking of a federated approach for ILPDs with millions of entries potentially, I mean, literally there's 1.3 million physicians in this country, just physicians, MDs, and so I think we need to probably think through off line, if you'd do a couple of possible models to bring forth and have an additional discussion about this. So I was suggesting maybe we can do that off line.

Jonah Frohlich – Manatt

Yes.

M

I agree, for whatever that's worth. Because I think this is one of those things where we just don't know what's going to work.

Jonah Frohlich – Manatt

Yes. Okay, well I'm going to, Walter, unless you want to proceed a little bit further, I think we're close to coming to the end of our time and we have public comment.

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

No, I think we should just take it off line.

Jonah Frohlich – Manatt

Judy, if we can please open up for public comment.

Judy Sparrow – Office of the National Coordinator – Executive Director

Sure. Operator, can you please invite anybody from the public who wishes to make a comment to identify themselves?

Operator

(Instructions given.) We do not have any comments at this time.

Judy Sparrow – Office of the National Coordinator – Executive Director

Great, thank you. Thank you, everybody.

M

Thank you.

Jonah Frohlich – Manatt

Thanks, everyone. I really appreciate it.

Judy Sparrow – Office of the National Coordinator – Executive Director
Bye-bye.

M
Bye.