

**HIT Policy Committee & National Coordinator
Information Exchange Workgroup
Provider Directory Task Force**

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September 30, 2010
9:00 a.m. to 4:00 p.m./Eastern Time
Holiday Inn Capitol Hill
Washington, D.C.

**Written testimony in red from Daniel Nigrin, MD, MS
September 24, 2010**

Business requirements: Clinicians

1. Do you currently use external provider directories for health information exchange? What are they and how do you use them?

In Massachusetts we have been using an early-phase provider directory hosted by our regional data exchange network, NEHEN (New England Healthcare Exchange Network). It has been very effective in our initial pilot efforts for clinical data exchange between providers, and is now being scaled up as NEHEN plans for broader deployment. It is used to route CCD-formatted documents to providers, and stores information about how the providers can receive the document (either electronically into their EMR, or via fax).

We also use a credentialing directory offered by CAQH; this is required by most Massachusetts health plans for health plan credentialing and enrollment.

2. What specific uses would you have for these two types of provider directory services? Would you register with such a service and use them? If not, why not?

a. Yellow pages: An authoritative resource listing clinicians and entities that is used to “look up” providers and point to routing directories

This is an important function for the provider directory service to have, and we would certainly make use of it if it were available. Although in many instances our institution knows who a referring or primary care provider is, in some instances we do not. Examples include for emergency care, out of state referrals or for new providers in the area. In these instances, it would be very helpful for us to be able to query the service to ask for specifics about a provider knowing only their name (perhaps even a partial name) and general practice location. Another possible use would be to query the service for providers of a particular subspecialty, who practice in a particular geographic area (e.g. “pediatric endocrinologists in Portsmouth, New Hampshire”). Finally, if credentialing information were available within it, it could replace the need for our current CAQH credentialing service.

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

This is an absolute necessity, and in my mind of more immediate importance than the yellow pages. As mentioned above, in the majority of cases, we (providers and their institutions or practices) already know whom to send information to; it's just that we don't know by what mechanism we should get it there. Does the provider have an EMR? If so, is it enabled to accept incoming standardized electronic payloads (e.g. a CCD)? If not, do they have a fax machine? Secure email? Only snail mail? If multiple electronic options are available, by which do they prefer receiving information?

3. What set of clinicians and entities would need to be included to make this service valuable to you?

- a. Would you only need to know how to identify and send messages to the individual clinician, or is a listing of the legal organization (practice, clinic, hospital, etc.) sufficient?

Most care is obviously local, and so regional providers are of most importance to have data for within the directory. But in the case of institutions like ours that offer care that draws patients from around the country and world, we do have a need for broader coverage of potential providers with which to communicate.

Regarding whether to have information about how to identify and send messages to the provider's organization or specifically to them – both are needed; in some instances, the workflow at a provider's organization is such that inbound data is "triaged" first, and then manually routed to individual providers by multiple potential mechanisms. In other cases, the provider is anticipating the inbound data to go directly to them, e.g. into their EMR's "inbox" or to their private office's fax machine. So for the former, the institutional routing information would suffice, but for the latter, it would not.

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

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

All of the above information would be of value. Of note however is the service location data. In an ideal case, the directory would know which service location is appropriate for a provider **based on the patient whose data is being transmitted**. In many instances where a provider practices in multiple locations, the location to which data should be sent depends on which patient is in question. Barring the ability to do this, knowing which of multiple service locations from a provider was the "primary" one, to which information should be routed, would be necessary.

In addition, the directory could serve a useful function to help us electronically **identify** and **authenticate** providers. For example, we currently have a provider portal that allows referring providers to view PHI

about their patients within our EMR. Being able to use a central provider directory to help identify and authenticate a new referring provider to our organization, especially one that is geographically distant to us, would be very helpful for us to be able to easily and securely grant portal access to that provider.

5. What data or information about your organization or your clinicians could be made available to establish directories?

a. Issues to be resolved?

We could easily share the demographics, credentials, and specialties for all of our providers, based on their NPI number. Service locations are less relevant from a routing perspective for us, as our singular EMR is available and used at all of our distinct locations. We would have a harder time populating service locations for our providers though for a “yellow pages” type function – in other words, to be able to say “Dr. Jones sees patients at locations X, Y and Z.”

6. What “trust framework” is needed for populating, maintaining and using provider directories?

a. Are there specific issues (reliability, trust, privacy, uses of data, others) you would like to make sure are addressed with respect to provider directories

The establishment of standards around minimum/required data elements, format of that data, etc... would be quite helpful. If part of the data listed in the directory is of non-public nature (e.g. DEA numbers), then by all means the security, trust, privacy and use of data issues are all of critical nature. The chain of trust needs to be maintained, just as in HIPAA. Furthermore, legal immunity needs to be established for any potential data breaches that occur while relying on the provider directory. So if information in the directory were wrong, the sending institution would not be held liable if the patient PHI was sent to the incorrect destination.

7. In what areas could this workgroup provide useful recommendations?

As above, the establishment of standards around minimum/required data elements, format of that data, format for querying, etc... would all be quite helpful at this time.

Questions primarily targeting yellow pages

8. What data and level of data accuracy is needed for your use of a yellow pages resource?

- a. Is it important that it identify all practice locations for a clinician and all organizations the clinician may be associated with and practice at?**
- b. How important is it that it be authoritative and complete, for instance containing all licensed physicians in a state?**
- c. What data elements are critical?**

Identifying all practice locations is of key importance, especially if the yellow pages are to be linked to a routing service. That said, of greater importance in my mind is that the yellow pages are complete with respect

to individuals. If organizations and providers are going to use the yellow page resource, it has to be viewed as authoritative, complete and accurate.

See question 4 above for details on which data elements are necessary.

9. How do you currently maintain the accuracy of your information in third party directories, such as those maintained by medical boards, health plans, NPPES and commercial services (lab, pharmacy, etc)?

This is done manually at the moment, with individuals at our organization who have part of their job descriptions dedicated to this. It's a highly inefficient process!

10. What's the best way to motivate providers to keep directory information up to date (e.g., link to licensing, plan participation, health information exchange activities)?

I believe that making providers aware of the effects of not keeping the information up to date (i.e. not receiving information about their patients) will be key. But if this "carrot" is not sufficient, then a "stick", linking it to licensing and making it mandatory, will at least keep the information current at the frequency required by the State's licensing board.

11. What data or information about your organization or clinicians could be made available to establish a directory?

a. Issues to be resolved?

b. If your organization maintains a provider directory, would you allow it to be accessed by outside parties in a federated structure? If so, what requirements would be necessary?

See question #5 above. Barring technical obstacles or constraints, and assuming that privacy and security chain of trust issues are dealt with, I see no issue with allowing linking of outside parties to our internal directories.

12. What do you expect from your EHR system related to provider directories? How do you expect your EHR system would interact with provider directories?

I would expect our EMR system to transparently and seamlessly interact with provider directories to route information to them, either automatically or in a provider-initiated way. So for example if my institution knows that the referring/primary care provider for a patient is Dr. X, whose NPI number is 12345 (which it would have confirmed via the yellow pages service by the way), then when I as provider for a patient sign their inpatient discharge summary or ED visit note, then the document (by institutional policy) should automatically get routed to Dr. X using routing information found in the routing directory, and delivered using our regional health exchange network.

I would also expect manual provider lookups using the yellow pages service should be available via the EMR.