



September 30, 2010

Testimony For HIT Policy Committee Information Exchange Workgroup – Provider Directory Task Force

Good Morning, my name is Dr. Steven Waldren and I am the director of the Center for Health Information Technology at the American Academy of Family Physicians, and it is a pleasure to speak to the task force on the topic of provider directories. Although not absolutely necessary, directories can play an important role in easing exchange among known parties and in enabling exchange among unknown parties. Directory technology has been around for quite a long time (e.g. LDAP, Active Directory,) and in the last decade we have seen advancement in distributed and federated directory technology (e.g. OpenID, Liberty Alliance).

Based on the conversations that I have been involved in on this subject lately, I think we must consider the risk that over-designing and too early implementation of directories might actually hinder the health care delivery reform underway, such as accountable care organizations and patient-centered medical homes, and not support other emerging trends. For example, more physicians have been going to part-time or work in multiple settings. In the “yellow pages” directory, would the physician be required to have a different directory entry for each clinic? Could the physician be forced to maintain different entries in different directories? Would the physician be required to declare a practice site? I think the “yellow pages” concept conflates two different concepts: Identity and Profile. My identity will not change, but my demographic or practice setting information will change. I may also have different profiles based on different practice settings and/or roles. I may also want to restrict access to some of my profile information based on who is requesting it.

OpenID is a standard used by many Internet firms that demonstrates the power and flexibility of separating identity from profile. Going back to accountable care organizations, perhaps the exchange I need would be based on presence. In other words, say I am seeing a patient and I want a curbside consult from an endocrinologist. With presence, I can see that she is online and available. I can quickly message her and get my question answered, no need for an appointment and I can implement the recommendation immediately. Provider directories must support the new paradigms enabled by health care reform, or the industry will find other ways to accomplish the task.

We believe that provider directories must

- be voluntary, which means they must provide value for participation;
- separate identity from profile information;
- allow the user to restrict access to information in the profile;
- federate to allow query across directories;
- be focused on what is the minimal requirements to operate as to limit unintended consequences;
- and be local in scope.

Attached is more information that answers some of your specific questions. We are excited to assist with further work to move forward the needed infrastructure to support continuity of care and care coordination. We believe the NHIN-Direct project will be a significant advancement in this regard and establishing provider directories working in concert will have a synergistic effect.

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

No, the AAFP does not currently provide health information exchange services to our members, although we are considering ways in which we may joint venture or partner with others to make such an offering, particularly with respect to the opportunities offered by NHIN Direct's protocols and standards for directed and secure health data exchange between providers and providers and patients. And in relationship with Meaningful Use criteria for such exchange. Of course, the AAFP maintains its own internal directory of member information. We believe this information could be useful to our members as they are requested to join HIEs and other organizations where population of this information could be done in an efficient and standardized manner.

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?

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

We have been actively engaged in the NHIN Direct project because of its potential value to our members in helping them to meet the health data exchange criteria of Stage 1 Meaningful Use, and to be both secure and affordable. Within this context, the Health Internet Service Provider, or HISP, will play a role in enabling physicians to use the NHIN Direct addressing and security framework, and we expect that each HISP will need to maintain both a resource and routing directory in order to allow senders and receivers to be located and authenticated so that content can be transported. From the physician's perspective, registration with at least one HISP would be required for NHIN Direct services to be available to him or her.

We have not considered an authoritative national directory service to be of significant value to our members, as so much of health care delivery is local and regional. We doubt that many of our members would register for a national service, but to be honest we have not asked this question.

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?

Again, within the context of NHIN Direct we have considered both scenarios quite carefully, and we think that both are required. Physicians need to send messages to individual physicians and to individual patients, but they will also need to be able to push messages to departments, or to practices, or to other organizations and organizational units. Again, this does not require a national provider directory to exist in order for successful operation. When we use e-mail the common practice is that all we need to know is the other person or entity's e-mail address. There is no "central e-mail address" repository or directory, and it works very, very well.

If identity, profile, and routing are separate concepts, then the same infrastructure could be used for both individuals and organizations. The identity and routing would be the same and the profiles could be different.

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.

We believe it very important to separate profile (provider type, specialties, credentials, etc.) from identity. Then allow for multiple profiles per identity to deal with multiple practice settings and relationships and to allow restricted access to certain profile information.

The most important information is the kind that would help to assure that the person to whom a message is being sent is the "right" person, e.g. Steven Waldren, MD the family physician, not Steven Waldren, MD the neurosurgeon. A minimal amount of information, such as what you have listed here would be sufficient.

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

a. Issues to be resolved?

Again, we believe that there will be many new and different types of provider directories in the coming years, as HIEs and other kinds of health data exchange organizations develop the capability to replace the fax machine and use the Internet for secure messaging across networks. In this environment, distribution of the AAFP's data and information on our members to these directories could be quite valuable in reducing unnecessary data entry and in avoiding errors. All of this is highly related to identity management, and we see our members increasingly asking the AAFP to help them with this set of issues.

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.

Without question a trust framework is required. However, there are many different ways in which one might set up and operate certificate authorities and the exchanges of certificates, and these should not be dictated too narrowly so as to avoid stifling innovation and imposing unnecessary costs. This is an area of active discussion within the AAFP leadership. Again we must not confound identity and trust with profiles.

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

We would recommend that this WG provide guidance on provider directories, but stay clear of trying to set standards or mandate conventions at this time. It is early in the development of this area of health care information management, and we would like to see the industry and the government work together to assure simple, easy to use solutions are promulgated first. It is always easy for standards to go from simple to more complex, but the reverse almost never happens. We like the approach of NHIN Direct in regard to the creation of a reference implementation of any specifications and standards, which forces a validation of assumptions and decisions based on theory.