# Provider Directory Advisory Group Meeting

March 16, 2016

# Welcome!

- Introductions, announcements, and agenda review
  - Welcome new members Jennifer Awa and Missy Mitchell
- HIMSS Debrief
- Scan – Provider Directory Development: Research findings
- Break
- Fees discussion
- Updates on HIT procurement and Common Credentialing
- Wrap up and next steps

# HIMSS Debrief

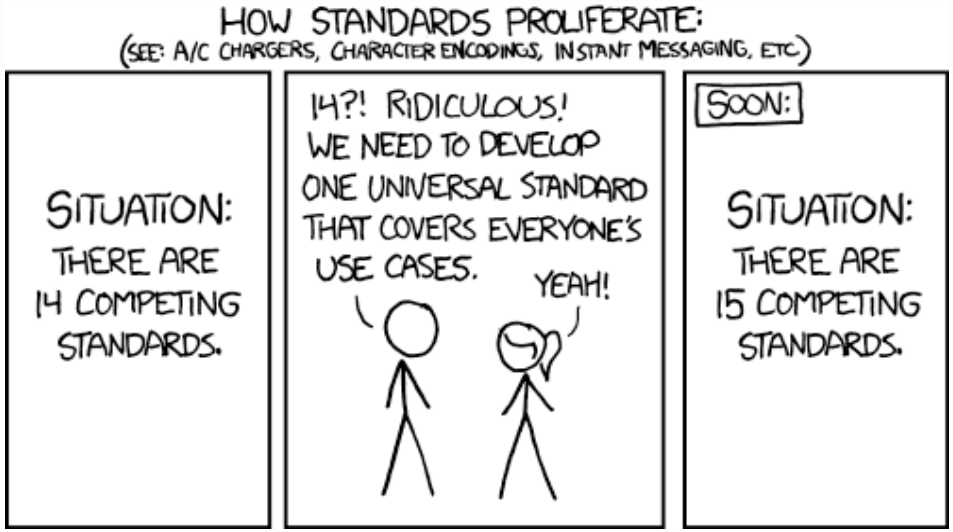
# Interoperability Pledge

90% of the companies that provide 90% of EHRs in use by hospitals nationwide, and the top 5 largest health care systems have agreed to implement 3 core commitments (https://www.healthit.gov/commitment):

- **Consumer Access**: consumer can easily and securely access their information electronically, direct it to a desired location, learn how its shared and used, and be assured that it is used safely and effectively
- **No Blocking/Transparency**: not knowingly or unreasonably interfering with information sharing
- **Standards**: implement federally recognized, national interoperability standards, policies, guidance, and practices for electronic health information, and adopt best practices including those related to privacy & security

# ONC Tech Lab Launch

- Next Chapter for Standards and Technology
- Focus Areas
  1. Standards Coordination
  2. Testing and utilities
  3. Pilots
  4. Innovation



# PROVIDER DIRECTORY DEVELOPMENT: RESEARCH FINDINGS

Gary Ozanich, PhD
March 16, 2016

HealthTech Solutions, LLC.

# Many Questions for Provider Directories

- What are their value propositions?
- Are they economically viable as a stand-alone service?
- What is the funding and fee structure?
- How are they staffed?
- What are the usage characteristics?
- What is the best technology solution?
- What are the range of data sources supported?
- How are data update & validated?
- Many other questions

# Methodology: Learn from/with Other States & Projects

- Semi-structured interview
- Ask the same questions (with open-ended probes) to SMEs/Project Managers/HIT Coordinators
- Identify similar projects (purposive sample)
- Ask subjects for additional experts/projects (snowball sample)
- Correlate answers
  - Best-practices/Lessons-learned
  - Service offerings/Pricing

# Areas of Research

- Governance/Product Mix
- Value Propositions
- Funding Models
- Experience with Current System
- Data and Data Management
- Operations

# Interviews

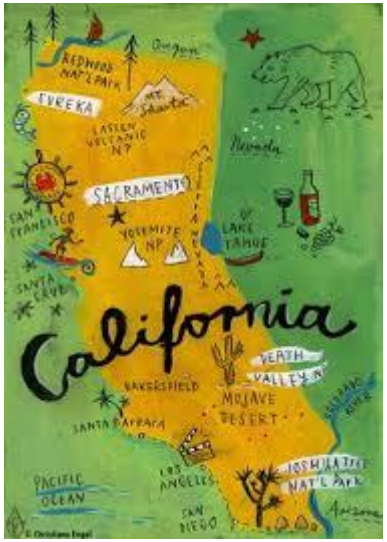
- State of Washington (Sue Merk, Executive Vice President, Washington One Health Port)
- California (Rim Cothren, Executive Director of CAHIE)
- Michigan (Tim Pletcher, Executive Director of MiHIN Shared Services)
- DirectTrust (David Kibbe, President and CEO of DirectTust)
- Colorado (Steve Holloway, Branch Chief of Public Health)
- Kansas (Tiffanie Hickman, Project Manager, KHIN)
- Rhode Island (Amy Zimmerman, State HIT Coordinator)
- Sequoia (in process)

# Initial Observations

- Variety of operating entities
- Affiliation with HIEs
- Provider Directory may be “bundled” as part of a service or positioned as more than a directory
- Approaches to sustainability are evolving
- Technical solutions are “one-off,” immature, or in one case a repurposed customer relationship management (CRM) solution

# California

- CAHIE is an association of 15 California HIEs
- PD is aggregated from members
- PD is bundled as part of membership fee
- User Target: Providers
  - Low adoption (in the 000's)
  - Used for referrals
  - Initial enthusiasm with some drop-off
- Identified issues with HPD Standards
  - Adoption
  - Implementation



# Michigan

- MiHIN—Network of 13 public and private HIEs
- Built on Salesforce.com (CRM)
- In practice not used as traditional directory service
  - Structured as use-case driven within a master data environment (e.g., case management/coordination)
  - Not a "look-up" tool but "an active care delivery service" with patient/provider attribution. "Not a white pages service for physician listings"
  - Integrated with CQMR
- Surcharge to CRM license, Payer subscription fee
- Demo is set for March 30th

# Washington

- OneHealthPort provides single sign-on, HIE, and Provider Data Service (PDS)
- PDS is used for aggregating data but not licensing
- Demand has been slow but picking-up based on Direct Secure Messaging (DSM)
- Use Cases: DSM, referrals, patient attribution
- Bundled as part of the HIE Subscription
- Free look-up

# Colorado

- Dept. of Public Health, Health Equity & Access
- Been live 30+ days
- Relationships with the two large state HIEs
- Funded through state general funds & HITECH
- Future plan is to be subscription-driven by payers and providers
- Research Focus: Clean Data & Data Resource
- Directory services
- Home-grown solution

# Kansas

- KHIN-based directory primarily for members
- Built from ICA-HISP solution enhanced by Blue Print
- Bundled with HIE subscription
- Usage and take-rate has been slow
- State credentialing is a data source, but at a standstill due to budget issues
- Does not support HPD
- DSM addresses a driver

# DirectTrust

- DirectTrust is a HISP (not a directory) but provides directory services
- Operates Direct Trusted Agent Accreditation Program
- 13/40 members contribute to the directory
- Hesitation to share data with a third-party
- 14 data elements captured, members responsible for curation
- Annual membership fee
- Home-grown system
- DSM addresses a driver: Federated 1-Time Look-up

DirectTrust The most trusted names in healthcare exchange.

# Rhode Island

- The PD is operated by the Rhode Island Quality Institute in partnership with the state HIE
- Funding by SIM & the RIQI per member per month (PMPM), plan for subscription model
- In the testing phase, anticipate external go live in June 2016
- Initially focused on state users, identified strong provider demand
- Developing a record of best source using an established data source priority logic for each identified data element
- Technical assistance provided by state staff—developing provider directory 'masters'

# Vendor Information

Current Solution Information

# California

- External Vendor: Home Grown

- Implemented the solution with a ‘big bang’ approach including all use cases (no phasing)
- Operating Costs have been within the forecast
- Support HPD (Version IHE HPD 1.1 CA)
- No bulk uploading allowed
- Utilize DSM, no data extracts are produced

# MiHIN

- External Vendor: Salesforce

- Implementation phased by use case
- Operating costs have been within forecast
- Supports HPD (at this point)
- Allow bulk uploading
- Historical data is maintained
- Solution is an active care directory (provider relationship tool)

# Washington

- External Vendor: HCRAD, local firm

- Implemented in a phased approach
  - Meaningful Use Support
  - DSM addresses
- Operating costs were within forecast and were significant low
- Does not support HPD
- Allows for bulk uploading and data extracts are available
- Historical data is maintained for 12 months

# Colorado

- External Vendor: Internal SQL database, utilizes Rhapsody licensing tool from CDC
- Currently still in development
- Operating costs have not been within forecast—need for purchase of additional programming time
- Does not support HPD

# DirectTrust

- Solution has been internally developed

- Did not take a phased approach to implementation
- Supports HPD and is LDAP compatible
- Solution is not a public directory, end users are HISPs
- Bulk uploading is available

# Kansas

- External Vendor: Informatics Corporation of America
  - Software: CareAlign
  - DSM is housed directly through HIE

- Phased approach, bundled through the HIE and initial implementation did not include all use cases
- Operating costs have been within forecast and minimal due to the Provider Directory being a bundled service of the HIE
- Does not support HPD
- Does maintain historical data
- Allows for bulk uploading, DSM and data extracts are available

# Rhode Island

- External Vendor: InterSystems

- Phased approach, based upon data sources, users will be phased beginning with state users and followed with hospital systems
- Operating costs have not been within forecast due to the expanded cost following the initiation of system design and development
- Does not support HPD
- Allows for bulk uploading, file layouts are provided for imports and extracts

# Conclusions

(In Process)

# Value Propositions (many)

- Accurate and up-to-date information
- DSM address—referrals and transitions
- FTE in maintaining proprietary directory
- MU support
- Control flow of information
- Patient/provider affiliation
- Active care relationships
- Efficiency of resources

# Summary

- Provider Directory solutions appear most effective when bundled with additional services including health information exchange or active directory (care coordination) solutions.
- Provider Directory solutions are resource scalable
- FTE requirements vary based upon the range of services and role of vendor

# Summary

- Operating costs appear to be effectively forecasted and maintained during operations.
- There was unanimous agreement that a subscription model is preferable to a usage-based model.

# Discussion

Questions??

# Provider Directory Fees Discussion

# Fee structure development activities

Understand the current state for provider directory fees and costs

Develop draft fee structure principles

Continue fee structure development

| Discuss, refine, and add fee definitions | Fee categories/bundles |
| --- | --- |

Develop fee structure options and considerations

| Benefits | Challenges | Considerations |
| --- | --- | --- |

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# Provider Directory Services

**Data services** – data scrubbing, quality scoring, matching, and maintaining

**Web portal** - Query the web portal and export results;

**Data extracts** – Predefined, static extracts of data from the provider directory

**Data mart**- Customizable, “real-time” extracts of data from the provider directory

**Integrated provider directory** - Integrated access to and from the provider directory via an Application Program Interface (API) or web services

# Three sample Provider Directory structures to discuss

1) Fees based on # users and services

2) Fees based on types and size of organization and services

3) Fees based on annual revenue and services

**Note: these are only for discussion purposes only and are intended to be used as a starting point for further refinement, disagreement, and/or validation**

# 1. Fee structure based on # users and services (Sample)

| Services | Basic | Plus | Premium | Enterprise |
|---|---|---|---|---|
| Web-Based Query Access | <10 | <20 | <30 | 30-50* |
| Extract(s) Per Month** | 1 | 2 | 5 | Unlimited |
| Data Mart *** | -- | -- | -- | Unlimited |

| | |
|---|---|
| **Different fees may apply for initial (onboarding) vs. ongoing participation** | **Special fees and discounts:**<br>* $X.XX for each additional license<br>** Additional extracts can be purchased for $X.XX per extract<br>*** Data Mart can be added to any subscription for $X.XX annually<br><br>10% annual data contribution discount/early adopter?<br>HIT Integration (may have no charge, additional charge, or a discount) |

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# 2. Fee structure based on organization type/size (Sample)

| Each subscription level includes web portal access | Basic | Plus | Premium | Enterprise |
|---|---|---|---|---|
| Provider Practice and facilities | | | | |
| Tiered based on # providers | <10 | <20 | <30 | 30-50 |
| Hospitals | | | | |
| Tiered based on annual revenue | $0-50 MM | $50-200MM | $200-1 BB | >$1 BB |
| Provider organizations (Long term care, nursing facilities) | | | | |
| Tiered based on # beds | <50 | <100 | <200 | >400 |
| Payers | | | | |
| Tiered based on # of covered lives | <30K | <100K | <250K | >250K |
| State Agencies | | | | |
| Medicaid share | $ x | $ x | $ x | $ x |
| Other state agencies | $ x | $ x | $ x | $ x |
| HIEs, EHR vendors/hosted solutions, IPAs | | | | |
| Active users? | <10 | <20 | <30 | 30-50 |
| Gross sales? | $0-10 M | $10-100M | $100-500M | $501 M + |
| Other? | $ x | $ x | $ x | $ x |

**Extracts included:**
Basic – 1
Plus – 2
Premium – 5
Enterprise – unlimited plus data mart

**Different fees may apply for initial (onboarding) vs. ongoing participation**

**Special fees and discounts:**
10% annual data contribution discount
Additional extracts
Data mart
HIT Integration

# 3. Fee structure based on annual revenue (Sample)

| Annual revenue | Standard | Data mart |
|---|---|---|
| $0-10 M | $ | $ |
| $10-100M | $$ | $$ |
| $100-500M | $$$ | $$$ |
| $501 M + | $$$$ | $$$$ |

| Standard includes: | Different fees may apply for initial (onboarding) vs. ongoing participation | Special fees and discounts: |
|---|---|---|
| Web based query access<br>5 data extracts | | 10% annual data contribution discount<br>Additional extracts<br>Data mart<br>HIT Integration |

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# Questions to answer with fee structures

**Per fee structure:**

1. What are the benefits to this particular fee structure? Does it benefit one type of organization over another?
2. What are the challenges to the fee structure?
3. What are other considerations for this fee structure
   a) How well does the fee structure support the fee principles?
   b) What would make the fee structure better?
   c) What changes would you make to this fee structure?
   d) If you had to pick a fee structure, which one is your favorite? Least favorite?

# Questions to consider with fee structures

**Applies to all fee structures:**

1. What are your thoughts around fee discounts?
   a) Early adopter – What would constitute an early adopter? What are the parameters? Would early adopters receive a discount every year?
   b) Data contributor – what is a good discount rate? Renewed annually if they are still contributing?
2. Thoughts around whether fees for initial participation which will include onboarding should be higher or lower compared to ongoing fees.

# Options and Considerations for fee structure #1

| Benefits | Challenges | Considerations |
| --- | --- | --- |
| • Same concept for all orgs – how you use the provider directory determines which tier you fall into<br>• Keeps separation of users for portal and for DataMart<br>• Cost of managing the fee structure is the simplest | • Need to get a better understanding of how many users would actually use the system<br>• Is it the most appropriate way to gauge access? | • Increase the number of users in each tier or define more buckets |

# Group exercises

- Split up into 4 groups
- Discuss fee structure questions with your group's facilitator
- Staff will compile responses and report back to the PDAG
- Groups will need to wrap up conversations by 12:40

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# HIT Procurement Updates

Rachel Ostroy

Implementation Director

# CMS Approval!!!

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# ….and now the fun begins!

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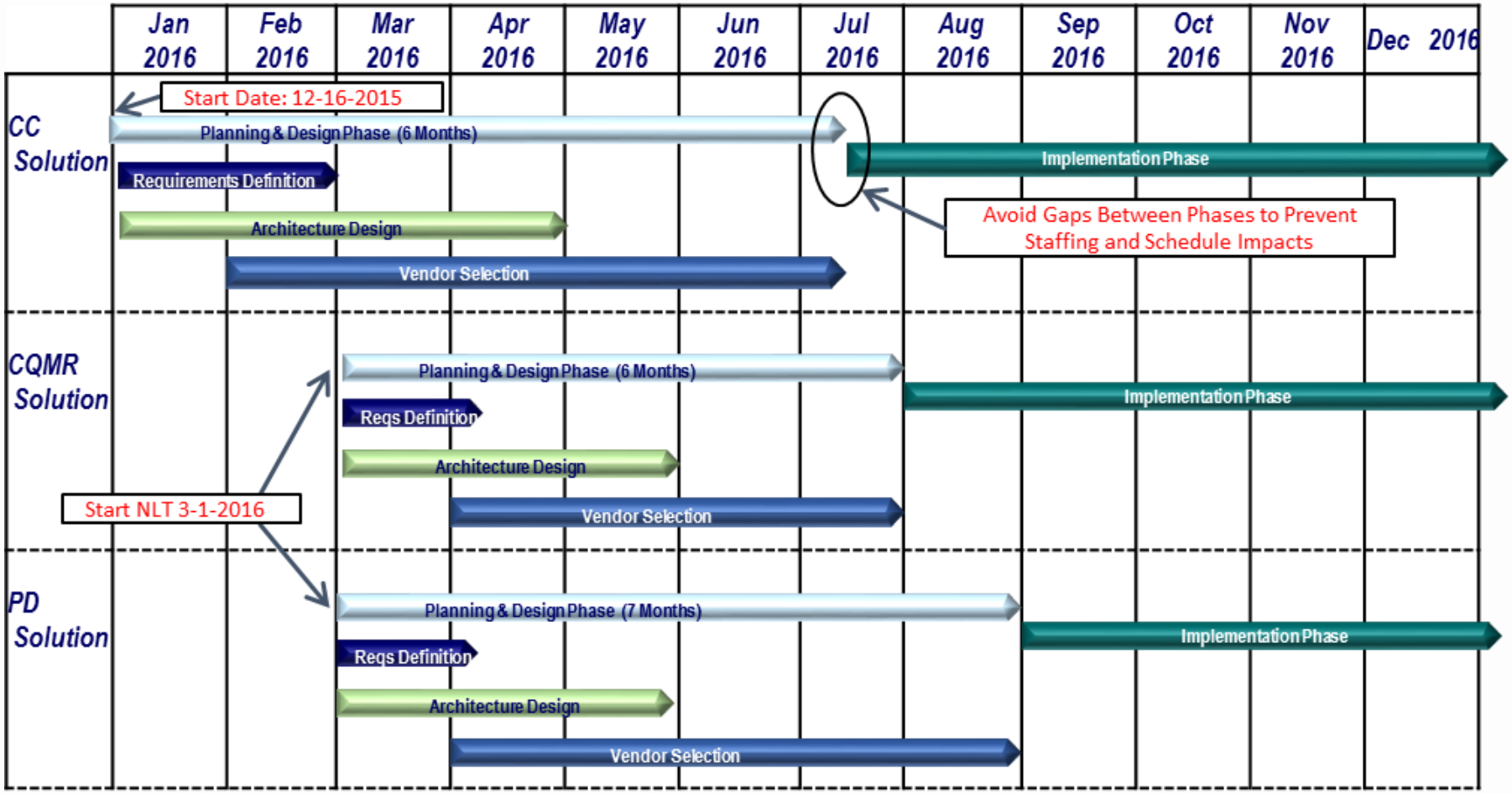
# New Scope (Amendment 10)

**Executing Amendment 10 on the existing Oregon HIE Solution Contract:**

- Scope includes conducting the planning and design phase for Provider Directory, CQMR and SI requirements stated in the HIT portfolio SOW
- Tasks include product evaluations, securing a product subcontractor for the PD and CQMR solutions, procurement, contracting, interface and integration solutions, common access solutions, data management, and project management service
- Contract type is Firm Fixed Price (FFP), completion-based; completion milestones are the deliverables in SOW

# Overall HIT Project Summary



# Vendor Product Selection Process

| Del-10 (Interface Req Spec) | Del-6 (CC Market Analysis) | Del-7 (RFP) | Del-8 (Final Recommendations) | | |
|---|---|---|---|---|---|
| **Refine the Need** | **Conduct Market Analysis** | **Release RFP (Full & Open)** | **Evaluate Proposal Responses** | **Hold Demonstrations** | **Deliver Final Assessment & Recommendation** |
| 1. Finalize product requirements<br>2. Define Integration and Interface requirements<br>3. Create minimum qualification list for viable vendors<br>4. Prepare announcement for upcoming RFP posting | 1. Research based on OHA RFI responses, PDAG and other sources<br>2. Allow interested vendors to create accounts in Harris acquisition website<br>3. Issue NDAs to viable vendors<br>4. Develop Evaluation Matrix | 1. Develop, Review, and Post RFP<br>2. Manage Q&A period<br>3. Receive responses from vendors | 1. Evaluate products against detailed requirements & evaluation criteria<br>2. Engage vendors with necessary questions/ clarifications<br>3. Recommend top 3-5 products | 1. Demonstration sessions for top 3-5 products.<br>2. Request best and final offer | 1. Present Recommendation:<br>a) Summarize responses<br>b) Analysis<br>a) Evaluation criteria<br>b) Demonstration<br>c) Benefits/risks<br>d) Cost<br>e) Implementation Timelines<br>2. Finalize selection<br>a) Recommendation<br>b) Identified Risks |

*OHA Review and Acceptance*

Proposal Evaluation includes:
a) Analysis against Evaluation criteria
b) Benefits/risks
c) Cost
d) Implementation Timelines

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# Common Credentialing Updates

Melissa Isavoran

Credentialing Project Director

# Current Progress

- Procurement Update:
  - Harris to release RFP March 31, 2016!!!
  - Vendors to request an account by sending contact information to Harris at OregonCCprocurement@harris.com
  - Vendor selection to be in July 2016
- Fee structure development work continues:
  - Ambulatory surgical centers surveyed
  - Independent physicians associations being contacted
  - Health Plans, Coordinated care Organizations, and Dental Care Organizations being researched
  - Hospital revenue identified
- Other upcoming work:
  - Outreach and marketing planning
  - Rule revisions via a rulemaking advisory committee (SMEs)

# Updates and next meeting

Karen Hale