PROVIDER DIRECTORY SUBJECT MATTER EXPERT WORKGROUP SUMMARY

CONTENTS

EXECUTIVE SUMMARY

For 2013-2015, the OHA is working on the development of a state-level healthcare directory or "provider directory services". Currently, the OHA and others in Oregon's healthcare landscape use a multitude of isolated provider directories, spread across state and non-state systems. Those directories are often limited in scope, data accuracy, and are costly and burdensome to maintain. In addition, there is a limited ability for health care providers to exchange health information (HIE) outside their CCO, clinic, organization, or system using Direct secure messaging because a common HIE directory containing provider messaging addresses does not exist.

A 12-member subject matter expert workgroup was convened between February and May 2014 to provide guidance to the Oregon Health Authority (OHA) on the scope, functions, and parameters for state-level provider directory services. The solution will be comprised of a set of healthcare provider directory services that connect but not replace disparate provider directories existing today. The group gave feedback on the provider directory services framework, opportunities from emerging national and state efforts and the key uses of the provider directory which are described below:

Operations: Use as a single source of truth for provider information, such as licensing, address, and affiliations data

Exchange of Health Information: Locate HIE addresses and provider information outside a system allowing clinical data to be sent to the correct recipient (e.g., referrals)

Analytics: Provide access to historical affiliations and other authoritative data for generating outcome data, metrics, and research

Specifically, the group worked on outlining the value, functions and features, users, data elements and sources, parameters and assumptions, challenges, and other considerations for each of the key uses of a state-level provider directory. Common themes from the workgroup focused on the importance of having:

- quality, authoritative data sources
- transparency and quality assessment of data sources in the directory
- common data definitions
- strong governance model that sets policies around the data and use of the directory

Conclusions:

Data sources must be trustworthy, and data policies must be in place to preserve the viability of the directory.

Data from the common credentialing solution, an authoritative data source, is a must for the provider directory

The scope of work for provider directory services needs to be scalable and expandable. Critical functions, features, and data elements identified by the workgroup will be in initial phases; later phases will incorporate other components

Governance workgroup will need to be formed and begin by late 2014/early 2015 to address provider directory policies

BACKGROUND

The Oregon Health Authority (OHA) is working toward furthering the goals of Health Information Exchange (HIE) and Health Information Technology (HIT) in Oregon which includes the development of a State-Level Provider Directory.

PROVIDER DIRECTORY PROBLEM

- There is a limited ability for health care practitioners to exchange health information outside their CCO, clinic, organization, or system. Although Direct secure messaging allows messages to only be shared between trusted, vetted parties within and

across organizational boundaries and EHR vendors, those addresses are often times unknown. This limits the ability to find providers for referrals, exchange patient information, and meet the Stage 2 transitions of care measure for meaningful use. To be effective, finding addresses and exchanging health information using direct has to be part of the provider's workflow. To be useful, the directory information must be complete and correct.

- Key information for providers, namely provider demographics and clinic to provider affiliations, needs to be known for operations and analytics. Clinic/provider affiliation is changes frequently and is difficult to keep current in any system. Other demographic elements in a provider directory may be less volatile but require using multiple sources to verify and validate. Having a primary source to validate and verify information would create efficiencies, reduce waste, and improve the ability to audit existing data sources and databases.

PROVIDER DIRECTORY CURRENT STATE

Currently, OHA and others in Oregon's healthcare landscape use a multitude of provider directories, spread across state and non-state systems. Provider directories are:

- isolated from one another
- limited in scope, data accuracy, and timely updates
- costly to maintain the same information across multiple directories

PROVIDER DIRECTORY OPPORTUNITY

- CCOs have told the Oregon Health Authority (OHA) a statewide provider directory is needed for foundational, near-term needs. They would prefer a single solution that can be leveraged by all CCOs, rather than having each CCO have to build and maintain 16 different instances of the same data element
- Common Credentialing efforts that place standards and requirements for data and maintenance of the data are underway in Oregon. This would allow use of common credentialing data and other authoritative provider data sources in the provider directory.
- Emerging national healthcare provider directory standards ("HPD") for both content and query are currently being solidified (2014). These standards allow disparate EHRs to access the provider directory for HIE without having to login to a separate system, allowing the process to fit in within the workflow.
- Data governance policies will be set and adopted. These policies set data quality standards from all data contributors (not just common credentialing) and so that confidence in the directory remains high and encourages use.

PROVIDER DIRECTORY CONCEPT

- Oregon will stand-up a set of healthcare provider directory services that will connect but not replace disparate provider directories existing today
- Access to the provider directory services will be via web portal, through an EHR/HIT, or through a flat-file exchange
- The provider directory will leverage federal and state efforts that set standards for the provider directory services and data
- The provider directory at least initially, will not be consumer-facing, but can be used by healthcare practitioners such as providers, clinics, hospitals, plans, as well as the Oregon Health Authority, and other HIEs and HISPs for operations, analytics, and the exchange of health information
- Approach to development will be iterative where each phase will build upon the last

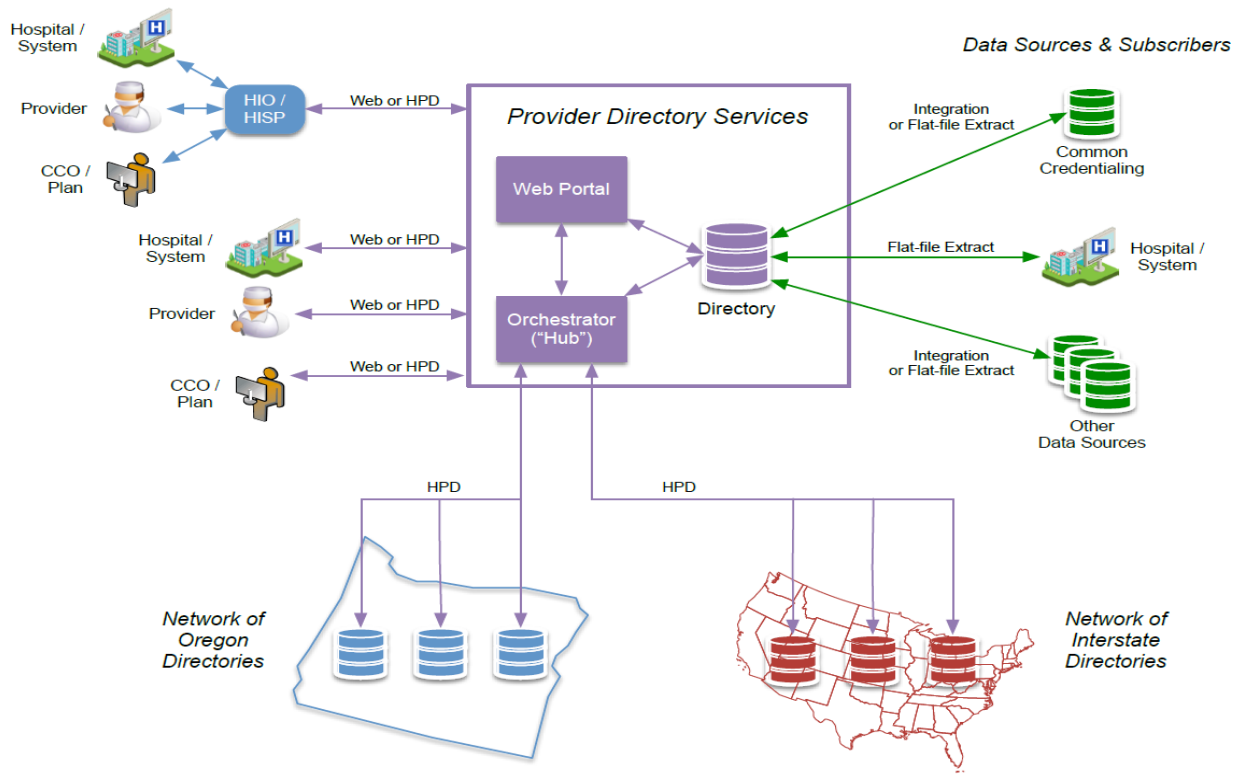


Figure 1

Figure 1 demonstrates the following:

Stand-alone healthcare directories are connected via federated provider directory services and offers a:

- ✓ Web Portal
- ✓ Orchestrator "Hub"
- ✓ Centralized database for some components

Federated Healthcare Provider directory (F-HPD) standards place criteria on how these data are stored and shared in EHRs

Common credentialing database captures credentialing data and feeds into the provider directory services

Other data sources can be integrated in if they meet directory standards and requirements

Those with HPD capabilities can connect to the network of Oregon directories and Interstate Directories

Those without HPD capabilities can interact via flat-file exchange with the centralized components of the directory

PROVIDER DIRECTORY PRINCIPLES

- Build incrementally to ensure success, but must have value right out of the gate
- Establish clear expectations regarding quality of provider information
- Centralize where needed but allow for federation of existing provider directories
- *Leverage* national and state efforts such as:
  - Emerging federal standards for healthcare directories called "Federated HPD"
    - Places criteria on what data are stored and shared
    - Adoption of those standards is expected to begin showing up in EHRs in 2015
  - Authoritative common credentialing data which is one of the main sources of data for the provider directory services

PROVIDER DIRECTORY TIMELINE

Spring 2014

- Federal funding request – Implementation - Advanced Planning Document (I-APD)
- Business Case for the Department of Administrative Services (DAS)
- Conclude Provider Directory SME Workgroup meetings

Summer 2014

- System Integrator Request for Information (RFI)/Request for Proposal (RFP)

Fall 2014

- Begin development of governance model/criteria and policies

Winter 2014-2015

- Finalize contract for system integrator
- Legislative ask authority to provide services outside of Medicaid and charge fees

January 2016

- Common credentialing database and provider directory services are operational

PROVIDER DIRECTORY WORKGROUP PURPOSE

The provider directory workgroup is tasked with providing guidance on scope, functions and parameters of a state-level provider directory, which will inform the OHA's scope of work for a Request for Proposal (RFP). The RFP is expected to be released in spring or summer 2014.

WORKGROUP MEMBERS

Workgroup members are those who represent the broad spectrum of potential users of a provider directory, as well as those with related provider directory business or technical experience or expertise. Members were solicited and selected based on their qualifications and background that would best meet the workgroup's purpose.

Member	Title	Organization
Gina Bianco	Acting Director	Jefferson HIE
Christopher Boyd	Data Analyst Supervisor, MPA	Women's Healthcare Associates, LLC
Mary Kaye Brady	Consultant/Advocate	Oregon Medical Association
Erick Doolen	CIO	PacificSource
Ray Ethell	Program and Research Analyst / WVCH HIT Workgroup Member for MVBCN	Mid-Valley Behavioral Care Network / WVCH Health IT Committee
Liz Hubert	Assistant Director, Provider Systems and Strategy	Regence Blue Cross Blue Shield
Jessica Perak	Health Outcome Strategist, Underwriting & Actuarial Office	Moda Health
Robert Power	VP, CIO	Samaritan Health Services
Stephanie Renfro	Research Associate	OHSU's Center for Health Systems Effectiveness
Tina Sobey	Data Governance Consultant, RHIT	Providence Health and Services
Rebecca Stewart	Director, Provider Relations and Network Development	FamilyCare Health Plans
Hongcheng Zhao	CIO	Portland IPA

MEETING FORMAT/DURATION

Five, three hour meetings were convened between February and May 2014. The meeting content was split evenly between a provider directory orientation and education component and group discussion.

MEETING TIMES AND CONTENT

Date and Location	Topic
Wednesday, Feb 19th; 2:00-5:00 pm Portland	Provider directory and other HIT initiatives (phase 1.5) background Charter and role of workgroup Provider directory national standards Common credentialing orientation
Wednesday March 19th 1:00-4:00 pm Salem	Provider directory key uses Provider directory vision
Wednesday April 2nd 1:00-4:00 pm Portland	Direct Secure Messaging Federated HPD and Common credentialing crosswalk Workgroup breakout sessions for HIE/Operations/Analytics uses
Wednesday April 23rd; 1:00-4:00 pm Salem	Data governance Provider directory access Workgroup breakout sessions (part 2) and group discussions
Wednesday May 14th 1:00-4:00 pm Portland – State Office Building, Conference Room 1C, 800 NE Oregon Street, 1st Floor	Survey response review Vendor scan discussion System Integrator approach and next steps for the RFP Workgroup wrap-up

WORKGROUP DELIVERABLES

The workgroup was asked to attend the workgroup meetings and provide feedback and guidance to the OHA on the key uses of a provider directory including:

- ✓ Value, functions and features
  - o Users
  - o Data elements and sources
  - o Parameters and assumptions
- ✓ Challenges
- ✓ Other considerations

Common themes from the workgroup focused on:

- ✓ Data quality and accuracy
  - o Need for governance, standards, and data definitions
  - o Data must to be trustworthy and current
- ✓ Transparency of data sources
- ✓ If used for analytics, historical data are needed. If used for operations and HIE, need the most current information

GENERAL USES FEEDBACK

In the first meeting, the workgroup was asked to answer a series of general provider directory questions. This list was added to in later meetings and was used to ensure questions raised by the group were addressed:

1. How would you use a provider directory? What is the value?
    a. Validate existing data
    b. Ability to authenticate
    c. Identify providers at a Patient-Centered Primary Care Home (PCPCH) and tier status
    d. Research: Link providers with clinic sites to study utilization patterns, spillover effects, use of addiction treatment services in patient centered primary care homes, etc.
    e. Identify providers accepting new Medicaid patients (Administrative Simplification, "Admin Sim")
    f. Search parameters/capabilities
    g. Send attachments for claims currently needing to be faxed or printed via trusted secure exchange
2. What does it have to have to be useful?
    a. Common identifiers
    b. Data definitions and common standards
    c. Historical
    d. Look-up function
    e. Accurate data
    f. Current data
    g. Data is easily extracted
    h. Identification of data source for the specific data elements
    i. Ranking or assessment of the data quality (identification of what's the best data source?)
3. How does it have to work to be useful?
    a. Access controls for data entry
    b. Process for dealing with data errors
    c. Edit checks on data entry
    d. Simple user interface
    e. Ability to access bulk data in automated way
    f. Linkable to other data sets (All Payer All Claims Reporting Program (APAC), clinical data from Electronic Health Record (EHR))
    g. Simplify current process
    h. Useful to single providers as well as organizations
    i. When there are multiple sets of data returned for a provider in the directory, the view should be compressed and expanded for a single provider, rather than a long series of single records (expandable view)
4. Challenges
    a. Providers have multiple addresses
    b. Unique provider status, such as honorary, consulting, or retired providers
    c. Identify affiliations and maintenance
    d. Keeping data current
    e. Create trust in the data
    f. Transparency of data sources
    g. Funding ongoing operations
    h. Gap between Common Credentialing data and Provider Directory scope
    i. Affiliating providers to "call shares" – larger health groups with provider groups that see patients in other smaller settings
    j. Lack of unique identifiers for some healthcare entities such as facilities
5. What questions do you have?
    a. How does this relate to other states? Payments made to providers out of state
    b. What is the legal responsibility for the data accuracy and usage? State indemnity laws apply?
    c. Meaningful Use requirements?
    d. Who is allowed to access data

e. Can Provider Directory leverage Common Credentialing fees
f. Is there a certifying process for data sources? Compatibility standards?
g. Goal to be accredited by national bodies? Indicated for sources
h. Do we expect to replace local directories? Initial vs. future vision
i. Can providers opt in or out to be a part of the provider directory services?
j. What is the value of the provider directory services in 2015 without common credentialing data? What does HPD give? Is it only the secure exchange of health information use case?
k. What is the frequency of exchange between all of contributors of data in the provider directory services?
l. To what extent can technology be used to validate the data and where are there gaps?

SPECIFIC USES

In subsequent meeting, three key uses, Operations, Exchange of Health Information, and Analytics, were identified and used as a basis for the workgroup discussions:

OPERATIONS

Description	Use as a single source to verify provider information, such as licensing, address, and affiliations data based on an authoritative data source
Uses	✓ Validate and scrub own data (ability to compare information to the definitive source) ✓ Referring provider uses provider directory to find other provider ✓ Associating providers to organizations (something that changes all the time) ✓ Eligibility or audit information (going to one source for attestations or referrals)
Value	✓ Single authoritative source - it's expensive for all users to do it independently and a burden to providers (sending the same information over and over) ✓ Accurate data (credible data), more accurate it is the more valuable it is ✓ Low/No Cost (if it is valuable data then users will pay for it) ✓ Improve ability to pass audit/compliance (regular validation of the data) ✓ Improve data quality and gain confidence in "own" data source ✓ Community contribution
Parameters	✓ Identification of where is the data coming from (data source) ✓ Credibility of data element (include age of data) o Association of provider and organization must be correct o Transparency of data sources; validating rules and 'weight' or credibility factor….so consumers of data can determine its value, as a user it would be good to know when and how the data have been validated/audited ✓ Use common identifiers (specialty codes, LUHN NPI, including tax ID o Standardizing data types
Assumptions	✓ Frequency of updates to the data are required by common credentialing or other governance requirements ✓ Commonality of how data are entered into the system ✓ Vetting the credibility of data initially and ongoing ✓ Data quality tiers that are assessed and displayed to users ✓ Body to govern the data, policy, data management (standards) o Participants must meet certain standards
Users	✓ Program/clinic staff ✓ Patient-Centered Primary Care Homes (PCPCHs) ✓ Referring Providers ✓ Cost Containment/Medical Management Third-Party Administrators ✓ Insurance Plans (analytics, prior authorizations, quality reporting) ✓ State programs and public health
Data	✓ Associations with the user's role to organizations and anything necessary for URAC,

elements	CMS, NCQA etc. PCP designation ✓ Open/closed practice (accepting new patients) ✓ Clinician and administrative staff fax/phone/email/Direct contact ✓ Specialty, degrees, plus areas of interest (esp. for Mental Health) ✓ Office hours, DOB et al ✓ Philosophy of care

EXCHANGE OF HEALTH INFORMATION

Description	Locate HIE addresses outside a system allowing clinical data to be sent to the correct recipient (e.g., referrals)
Uses	✓ Facilitate transitions of care o Referrals ▪ Query on all data/demographics to meet needs of patient; use larger pool of data to search on additional variables to select provider (i.e. Spanish speaking) o Patient is out of town and seeks medical attention- attending practitioner needs to exchange info w/patient's PCP o Find Direct addresses ▪ View affiliations and insurance, ▪ Identify who is in the Trust Community o Identify if referring doctor is "in network" or part of a CCO
Value	✓ Streamlined, secure method of sending specific clinical data to the correct person (minimize risk of sending a referral to the wrong healthcare professional) ✓ Find specialists ✓ Workflow efficiencies
Parameters	✓ Ability to query insurance network information ✓ Contain direct addresses and other contact information including physical location ✓ Ability to query on multiple data points w/ multiple parameters - Multi query/return in multi match ✓ Ability to use information within EHR - API to EHR ✓ Keep user in their workflow
Assumptions	✓ Discreet data to go paperless ✓ F-HPD standards are adopted ✓ Credentialing information available and meets standards for security and quality
Users	✓ Referring doctor's referral staff (providers not likely) ✓ Plan's care manager ✓ Receiving doctor ✓ Hospital discharge clinician
Data elements	✓ Health plan network ✓ General demographics ✓ Hours of operation ✓ Language ✓ Direct address ✓ Accepting new patients

ANALYTICS

Description	Access to historical affiliations and other authoritative data for generating outcome data, metrics, and research
Uses	Generally – ✓ Analytics and research ✓ Produce quality metrics: o Claims by group o Adolescent well-care o EHR – hypertension o PCPCH designation and tier o Good to know which EMR is being used Specifically – To identify ✓ how care varies across practice sites, within/outside of PCPCH's, CCOs, etc. ✓ targets/deficiencies based on availability of EHRs
Value	Understand implications of higher PCPCH tier levels Higher level = higher reimbursement Identify best practices, feedback to tier standards Public dataset – replicate for research value which translates into payer decisions
Parameters	✓ Accurate (ish) – Identifiers need to be correct, ex. NPI and address ✓ Needs to be linkable with other data sources (e.g. claims) ✓ Tie provider NPI and address in provider directory to the claim ✓ Reconciliations of addresses, names, etc. ✓ Addresses have to match USPS standard: either filter on front end or work/aggregation on backend
Assumptions	✓ Identifying information ✓ Historical information to account for changing provider/clinic affiliations over time
Users	✓ Health plans ✓ Providers ✓ OHA/PCPCH program ✓ CCOs ✓ Patients (possibly in the future) ✓ Federal agencies (see the organizations that are existing in the state)
Data elements	✓ Need provider/clinic affiliations (includes name and address o Clinic NPI and provider NPI ✓ Provider specialty, provider type level degree ✓ PCPCH tier with timestamp for PCPCH tier certification ✓ Provider/clinic NPIs – TIN ✓ Identify EHR system, version o To fuel EHR upgrades ✓ Direct address, link back to provider ✓ Facility level authority ✓ DME, lab, radiological – one place to update info

CHALLENGES AND MITIGATIONS (IF NOTED) COMPILED FROM ALL THREE USES

- Maintaining a repository of quality data
- Location identifiers
    - Different clinics operating in same location (e.g. suites)
    - Can have the same address for two clinics
    - Providers working at multiple sites
    - High frequency of changes to provider affiliations
- Need for historical data for analytics
    - Mitigation: solution has ability to store or otherwise manage historic data
- Buy-in for the credibility of the service
    - Mitigation: Connection w/EHR – able to access directory information from EHR
- Some attributes not in HPD or CC
    - Mitigation: Identify updated and non-credentialing updated data
- High dependency on the credentialing database (without OCCS not sure if the PD would be able to stand on its own)
    - CC is one of the most important features and process to update and maintain record should be easy
    - Providers that are NOT credentialed would need additional governance and policy
- Governance of the program - protect privacy and regulate data access, permitted uses, participation, data quality requirements, and security
    - Need to be able to adjust directory policies over time as needed
    - Managing improper use
    - Agreement on codes and standards (creating reference list and definitions)
- Multiple EHRs with varying degrees of adopted standards

WORKGROUP SURVEY

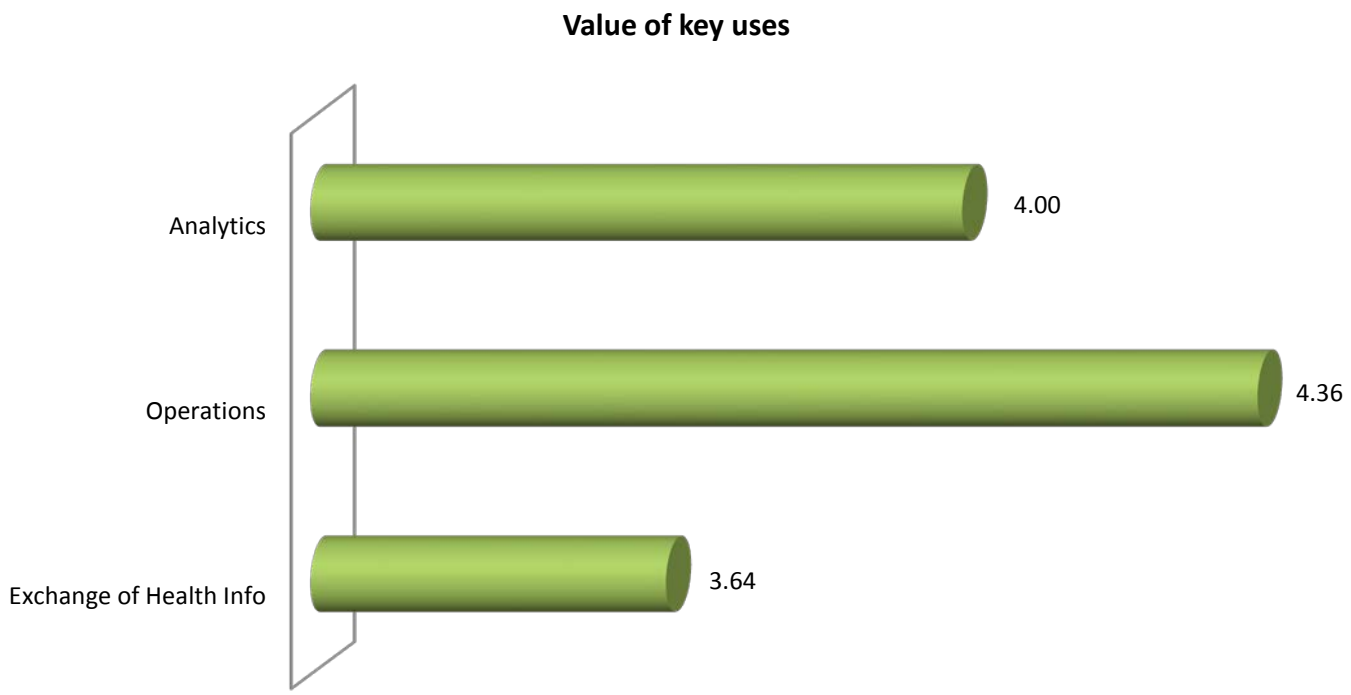
- Purpose:
  - collect workgroup member feedback on the value of the uses for the provider directory
  - assess a handful of high level data governance questions
  - log the importance of certain individual data elements it may contain.
- 11 out of 12 total responses

GENERAL QUESTIONS REGARDING VALUE AND USES OF THE DIRECTORY

Value assessment of key uses

1. Of the three key uses for the provider directory, rank the value to your organization for each use.
11 total responses:

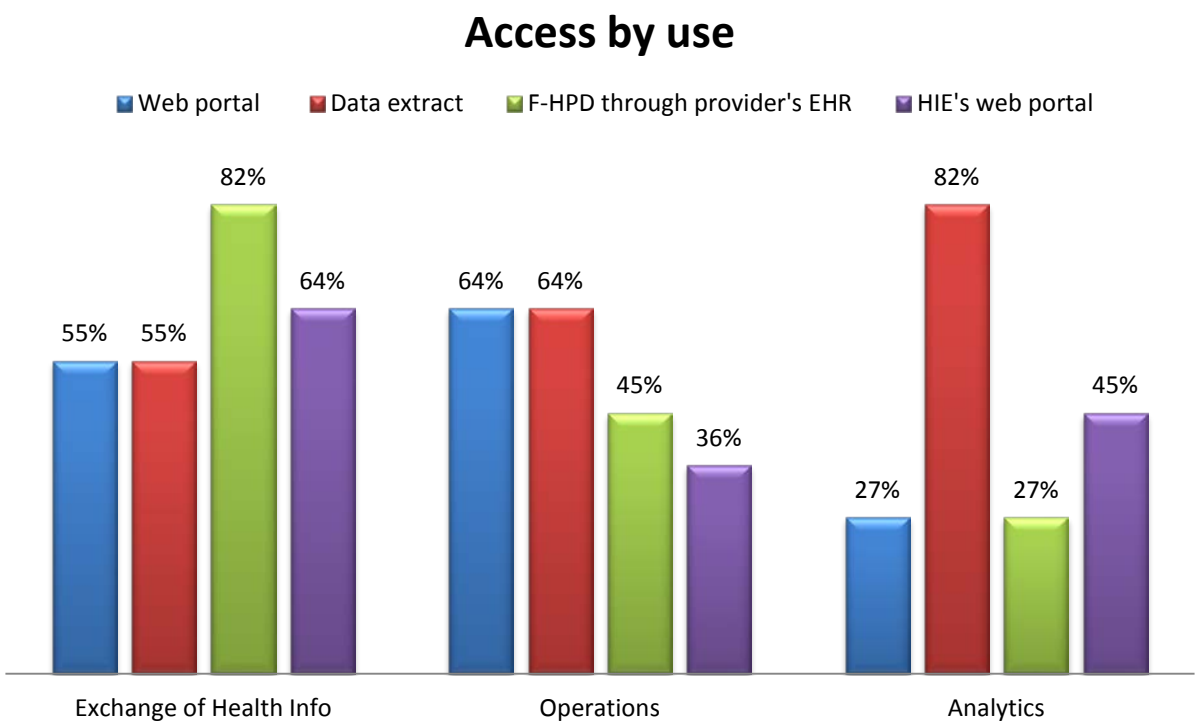
	Very valuable	Valuable	Moderately valuable	Less valuable	Not valuable	Average
Exchange of Health Info	2	5	3	0	1	3.64
Operations	8	1	1	0	1	4.36
Analytics	4	5	0	2	0	4.00



Access

2. Of the three key uses for the provider directory, how do you expect you or your organization to access the data? 11 total responses:

	Web portal	Data extract	Federated HPD through provider's EHR	HIE's web portal
Exchange of Health Info	6	6	9	7
Operations	7	7	5	4
Analytics	3	9	3	5

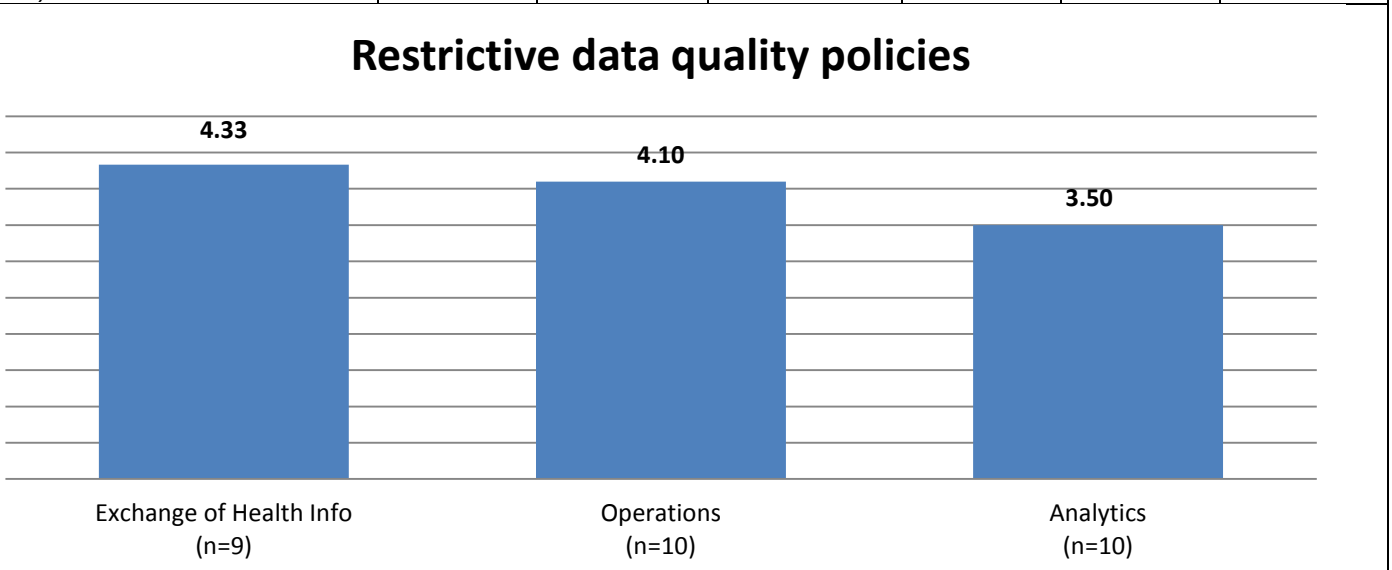


Data contributions

Data "in" the provider directory services can come from multiple sources. We expect authoritative data to come from the common credentialing solution but *other sources* are possible including provider directories from Health Information Exchanges, EHRs in a practitioner's office, other state directories (licensing, EHR Incentive program, etc.), plans, and more. Data and data source quality assessment can reveal whether data and its source are reliable and trustworthy. The following questions apply when data are used from *other sources.* Please indicate your preferences based on the following:

3. What would be a general level of tolerance for the quality of the data and data source?

	Very restrictive	Restrictive	Moderately restrictive	Less restrictive	Not restrictive	Average
Exchange of Health Info (n=9)	5	2	2	0	0	4.33
Operations (n=10)	5	3	1	0	1	4.10
Analytics (n=10)	2	2	5	1	0	3.50



4. Would you find it helpful if the quality of the data and data source were rated and those ratings were presented to the user to discern?

	Very helpful	Helpful	Moderately helpful	Less helpful	Not helpful	Average
Exchange of Health Info (n=9)	4	3	1	0	1	3.33
Operations (n=9)	4	2	1	0	2	3.00
Analytics (n=10)	4	3	2	0	1	3.50

DATA ELEMENTS

Based on the data element and use, rate the value or importance of each element:
1 - must have
2 - nice to have
3 - not needed
Average responses are shown along with the count of responses to each element

Data Elements			Availability			Value assessment per data element					
			HPD	OPCA	Not Available	HIE avg.	HIE count	Operations avg.	Operations count	Analytics avg.	Analytics count
Provider	Identifying Information	DOB, SSN, Immigrant Visa Number		X		2.3	7	1.6	9	2.0	9.0
		Educational Commission for Foreign Medical Graduates (ECFMG) Number	X	X		2.9	7	2.4	9	2.9	8.0
		State/Federal ID (Oregon License or Registration Number, Drug Enforcement Administration Number, Controlled Substance Registration Number, Individual NPI Number, Medicare Number, DMAP Number, etc.)	X	X		1.6	7	1.3	9	1.4	8.0
		Provider Name*	X	X		1.0	7	1.0	9	1.1	8.0
		Other Names	X	X		1.9	7	1.4	9	2.0	8.0
		Phone/Fax/Email	X	X		1.4	7	1.1	9	2.0	8.0
		Gender	X	X		1.9	7	1.4	9	1.8	8.0
	Address	Practice Address*	X	X		1.3	7	1.0	9	1.1	8.0
		Alternative/Billing Address	X	X		2.1	7	1.4	9	2.1	8.0
		Legal Address	X			2.3	7	1.6	9	2.5	8.0
		Home Street Address	X	X		2.9	7	2.6	9	2.8	8.0
	Professio	Specializations*	X	X		1.0	7	1.0	9	1.0	8.0

		Principle Clinical Specialty, Additional Clinical Practice Specialties	X	X		1.1	7	1.1	9	1.1	8.0
		PCP designation	X	X		1.5	6	1.4	9	1.5	8.0
		Board Certification/Recertification Specialty Type	X	X		1.5	6	1.1	8	1.6	7.0
	Status	Active, Inactive, Retired, Deceased	X	X		1.4	7	1.1	9	1.2	8.0
	Languages Supported*		X			1.9	7	1.3	9	1.8	8.0
	Other Professional Actives (Telemedicine)			X		2.0	7	1.9	9	2.0	8.0
	Direct Address		X			1.2	6	1.5	8	2.6	7.0
Organization	Identifying Information	Federal Tax ID, SSN	X	X		1.3	6	1.1	8	1.1	7.0
		Organizational Name	X	X		1.0	7	1.0	9	1.0	8.0
		Department	X	X		1.8	6	1.5	8	1.9	7.0
		Clinical Information Contact	X	X		1.8	5	1.5	8	2.0	7.0
		Billing Information Contact		X		2.0	5	1.4	8	2.0	7.0
		Phone/Fax	X	X		1.5	6	1.1	8	1.9	7.0
		Email	X	X		1.9	7	1.4	9	2.3	8.0
	Address	Practice Address*	X	X		1.1	7	1.0	9	1.0	8.0
		Alternative/Billing Address	X	X		2.1	7	1.3	9	2.1	8.0
		Legal Address	X	X		2.4	7	1.7	9	2.4	8.0
	Business Category		X			1.8	6	1.6	7	1.6	5.0
	Specializations		X			1.4	7	1.2	9	1.4	8.0
	PCPCH designation and tier				X	1.7	7	1.7	9	1.4	8.0
	Office Hours				X	2.0	7	1.7	9	2.0	8.0
	Languages Supported*		X			1.7	7	1.4	9	1.9	8.0
	Direct Address		X			1.3	6	1.8	8	2.6	7.0
Credentials	Credentials/ Certifications	Name*	X	X		1.3	6	1.0	9	1.3	8.0

		Status (Active, Inactive, Revoked, Suspended)*	X			1.4	7	1.0	9	1.4	8.0
		ID	X	X		1.7	7	1.2	9	2.0	8.0
		Issued Date	X	X		2.0	7	1.3	9	2.0	8.0
		Expiration Date	X	X		2.0	7	1.2	9	2.0	8.0
	Education/ Residencies/ Fellowships	Course of study, Degree, or Program Name	X	X		1.9	7	1.6	9	1.8	8.0
		Status (Active, Inactive, Revoked, Suspended)	X			1.9	7	1.4	9	1.8	8.0
		ID	X	X		2.3	7	1.9	9	2.4	8.0
		Issued Date	X	X		2.4	7	2.0	9	2.3	8.0
		Institution Name/Address	X	X		2.3	7	2.0	9	2.3	8.0
	Provider Peer References			X		2.4	7	2.4	9	2.8	8.0
	Continuing Medical Education (CME)			X		2.6	7	2.1	9	2.4	8.0
Affiliations	Provider/Organizational Affiliation*		X	X		1.3	7	1.1	9	1.0	8.0
	Affiliation Status		X	X		1.3	7	1.0	9	1.0	8.0
	Affiliation Purpose (admitting/attending privileges)*				X	1.7	6	1.5	8	1.7	7.0
	Affiliation Dates	Effective Date of Affiliation Start		X		1.9	7	1.7	9	1.4	8.0
		Date of Affiliation Application		X		2.4	7	2.1	9	2.4	8.0
		Date of Affiliation End		X		2.0	7	1.7	9	1.4	8.0
	Historic Affiliations			X		2.4	7	2.1	9	1.4	8.0
Other	Professional Liability	Professional Liability Insurance and Carrier		X		2.6	7	2.1	9	2.5	8.0
		Attestation Questions/Professional Liability Actions		X		2.6	7	1.6	9	2.3	8.0
	Historic Practice or Work History Data			X		2.3	7	1.8	9	2.0	8.0
	Practice Call Coverage			X		2.1	7	1.7	9	2.5	8.0
	EHR Incentive Program data				X	2.3	6	2.4	8	2.3	7.0
	Urban vs. Rural designation				X	2.3	6	2.3	9	2.1	7.0
	All payer all claims data				X	2.4	5	2.0	8	1.7	6.0

	Accepting New Patients*		X		1.3	7	1.4	9	1.9	8.0

HIGH VALUE ELEMENTS: These elements represent those in the survey that had an average value score <1.5.

	HIE	Operations	Analytics
Accepting New Patients*	1.3	1.4	1.9
Affiliation Status	1.3	1.0	1.0
Affiliations - End date	2.0	1.7	1.4
Affiliations - Start date	1.9	1.7	1.4
Affiliations - Historic	2.4	2.1	1.4
Credentials - Education/ Residencies/ Fellowships Status (Active, Inactive, Revoked, Suspended)	1.9	1.4	1.8
Credentials Issued Date	2.0	1.3	2.0
Credentials Name*	1.3	1.0	1.3
Credentials Status (Active, Inactive, Revoked, Suspended)*	1.4	1.0	1.4
Credentials/ Certifications Expiration Date	2.0	1.2	2.0
Credentials/ Certifications ID	1.7	1.2	2.0
Organization Alternative/Billing Address	2.1	1.3	2.1
Organization Billing Information Contact	2.0	1.4	2.0
Organization Direct Address	1.3	1.8	2.6
Organization Email	1.9	1.4	2.3
Organization Federal Tax ID, SSN	1.3	1.1	1.1
Organization Languages Supported*	1.7	1.4	1.9
Organization PCPCH designation and tier	1.7	1.7	1.4
Organization Phone/Fax	1.5	1.1	1.9
Organization Practice Address*	1.1	1.0	1.0
Organization Specializations	1.4	1.2	1.4
Organizational Name	1.0	1.0	1.0
Provider Alternative/Billing Address	2.1	1.4	2.1
Provider Board Certification/Recertification Specialty Type	1.5	1.1	1.6
Provider Direct Address	1.2	1.5	2.6
Provider Gender	1.9	1.4	1.8
Provider Languages Supported*	1.9	1.3	1.8
Provider Name*	1.0	1.0	1.1
Provider Other Names	1.9	1.4	2.0
Provider PCP designation	1.5	1.4	1.5
Provider Phone/Fax/Email	1.4	1.1	2.0
Provider Practice Address*	1.3	1.0	1.1
Provider Principle Clinical Specialty, Additional Clinical Practice Specialties	1.1	1.1	1.1
Provider Specializations*	1.0	1.0	1.0
Provider State/Federal ID (including NPI)	1.6	1.3	1.4
Provider Status	1.4	1.1	1.2
Provider/Organizational Affiliation*	1.3	1.1	1.0

Key:
Included only in Federated HPD data model (F-HPD)
Included only in the Oregon Practitioner Credentialing Application (OPCA)
Included in both OPCA and F-HPD
Not included in OPCA or F-HPD
* NCQA X12 standard element
Average value is 1.5 or greater but was noted as high value (<1.5) for another use category

PROVIDER DIRECTORY SME WORKGROUP PHASES AND PRIORITIES AND SURVEY FEEDBACK

The group was asked to provide feedback on the survey results as well as prioritize next steps for the future phases of development.

OHA Priority areas for 1st phase

- HIE
- Analytics
- Operations

Refer to survey elements summary document and/or high value elements by use. Are the elements described as high-value in the survey the right elements? Are there any additions or deletions?

Use	Additions	Deletions
HIE	gender languages PCP designation	
Analytics	languages	
Operations	DOB EHR version PCPCH	

What are your wish list items for the next phases of the provider directory?

1) hours of operations (facility hours, provider hours at that facility)
2) nights and weekends flag (nights and weekends)
3) other services offered (not specialization) that are alternative or additional to an existing specialization such as weight management
4) County designation (geographic data)
5) memo/notes/blank fields for contact information that may not fit a designated field
6) FQHC flag/Community health center
7) CCO affiliation