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# Provider Directory Advisory Group (PDAG)

April 15, 2015



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# Welcome, Introductions, Agenda Review



# Agenda

- Agenda review, welcome and introductions
- Discuss charter and role of PDAG
- HIT background and legislation
- Provider Directory orientation and group discussion
- Common Credentialing
- HIT Portfolio Procurement and Project Governance
- Wrap up and next steps – conversation about the length of meeting/timing

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# PDAG Charter

Karen Hale  
Lead Policy Analyst  
OHA

The logo for the Oregon Health Authority. It features the word "Oregon" in a smaller, orange, serif font positioned above the word "Health". The word "Health" is in a large, dark blue, serif font. Below "Health", the word "Authority" is written in a smaller, orange, serif font. A thin blue horizontal line is positioned just above the "Authority" text, extending from the left side of the "H" in "Health" to the right side of the "y" in "Authority".

Oregon  
Health  
Authority

# PDAG Charter

## Objective

- Advise the OHA on a broad range of topics relating to technology, policies, and programmatic aspects of the provider directory

## Membership

- Comprised of external stakeholders representing a wide range of roles and affiliations
  - Roles – providers (including mental and dental), IT, data and analytics, billing, compliance, CIO, HIE leadership
  - Affiliations - CCOs, health plans, hospitals and health systems, HIEs, Independent Physician Association (IPA), Oregon Medical Association (OMA)

## Meetings

- Projected to meet monthly
- 2-hour public meetings
- Ad hoc meetings may also be called

# PDAG role and responsibilities

**1. Guidance:** Policy, program, and technical considerations, as Oregon moves forward to implement statewide provider directory services, which may include but is not limited to:

- Functionality, uses, and value of a provider directory service
- Data access, permitted use, data quality standards
- Security provisions and network participation
- Onboarding processes and ongoing monitoring of policies and procedures
- Fees and fee structure, if OHA is granted the authority to offer services outside the Medicaid enterprise (HB 2294)

# PDAG role and responsibilities (cont.)

## 2. Information sharing:

- Share PDAG information broadly
  - Represent/survey users in your organization
- Make connections to related health IT committees, such as Administrative Simplification Workgroup, Oregon Health Leadership Council (OHLC), Common Credentialing Advisory Group (CCAG), etc.

# Staff responsibilities

- OHA staff will
  - Prepare meeting materials, convene meetings, and take meeting notes
  - Post materials and meeting schedule to the [healthit.oregon.gov](http://healthit.oregon.gov) website
  - Report PDAG activities to the:
    - CCO HIT Advisory Group
    - Health IT Oversight Council
    - Administrative Simplification Workgroup

# Responsibilities and rules of the road

- Attend in person whenever possible
- Staff will deliver materials the week prior to each meeting
- Members will review materials prior to the meeting
- Please let staff know if you have any questions or if we can be of any service
- Preferred approach that recommendations be made by consensus

# Meeting dates, times, locations

| Date/Time                 | Location                    |
|---------------------------|-----------------------------|
| April 15, 1:00-3:00       | Portland – Lincoln Building |
| May 13, 10:00-12:00       | Salem – State Library       |
| June 17, 10:00-12:00      | Portland – Lincoln Building |
| July 15, 10:00-12:00      | Salem – State Library       |
| August 19, 10:00-12:00    | Portland – Lincoln Building |
| September 16, 10:00-12:00 | Salem – State Library       |
| October 14, 10:00-12:00   | Portland – Lincoln Building |
| November 18, 10:00-12:00  | Salem – State Library       |
| December 16, 10:00-12:00  | Portland – Lincoln Building |

# Future meeting topics

Our short list -

- Phasing considerations/Value
- Detailed use cases
- Governance – Data and Access
- Fee structures and models

What other topics should be added to our list?

What questions do you have?

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# HIT Background and HIT Legislation

Susan Otter

Director of Health Information Technology,  
OHA



# Vision of an “HIT-optimized” health care system

The vision for the State is a transformed health system where HIT/HIE efforts ensures that all Oregonians have access to “HIT-optimized” health care.

Oregon HIT Business Plan Framework (2013-2017):

[http://healthit.oregon.gov/Initiatives/Documents/HIT\\_Final\\_BusinessPlanFramework\\_2014-05-30.pdf](http://healthit.oregon.gov/Initiatives/Documents/HIT_Final_BusinessPlanFramework_2014-05-30.pdf)

# Goals for HIT-optimized health care:

- Providers have access to meaningful, timely, relevant and actionable patient information at the point of care.
  - Information is about the whole person – including physical, behavioral, social and other needs
- Systems (Health plans, CCOs, health systems and providers) have the ability to effectively and efficiently use aggregated clinical data for
  - quality improvement,
  - population management and
  - to incentivize value and outcomes.
- Individuals, and their families, have access to their clinical information and are able to use it as a tool to improve their health and engage with their providers.

# EHR Adoption and Meaningful Use in Oregon

- Oregon providers have been early adopters of EHR technology
- Currently, Oregon is in the top tier of states for providers receiving EHR incentive payments, with
  - more than \$290 million in federal funds coming to:
  - nearly all Oregon hospitals and
  - nearly 6,000 Oregon providers
- However, more than 100 different EHRs are in use in Oregon

# Health Information Exchange in Oregon

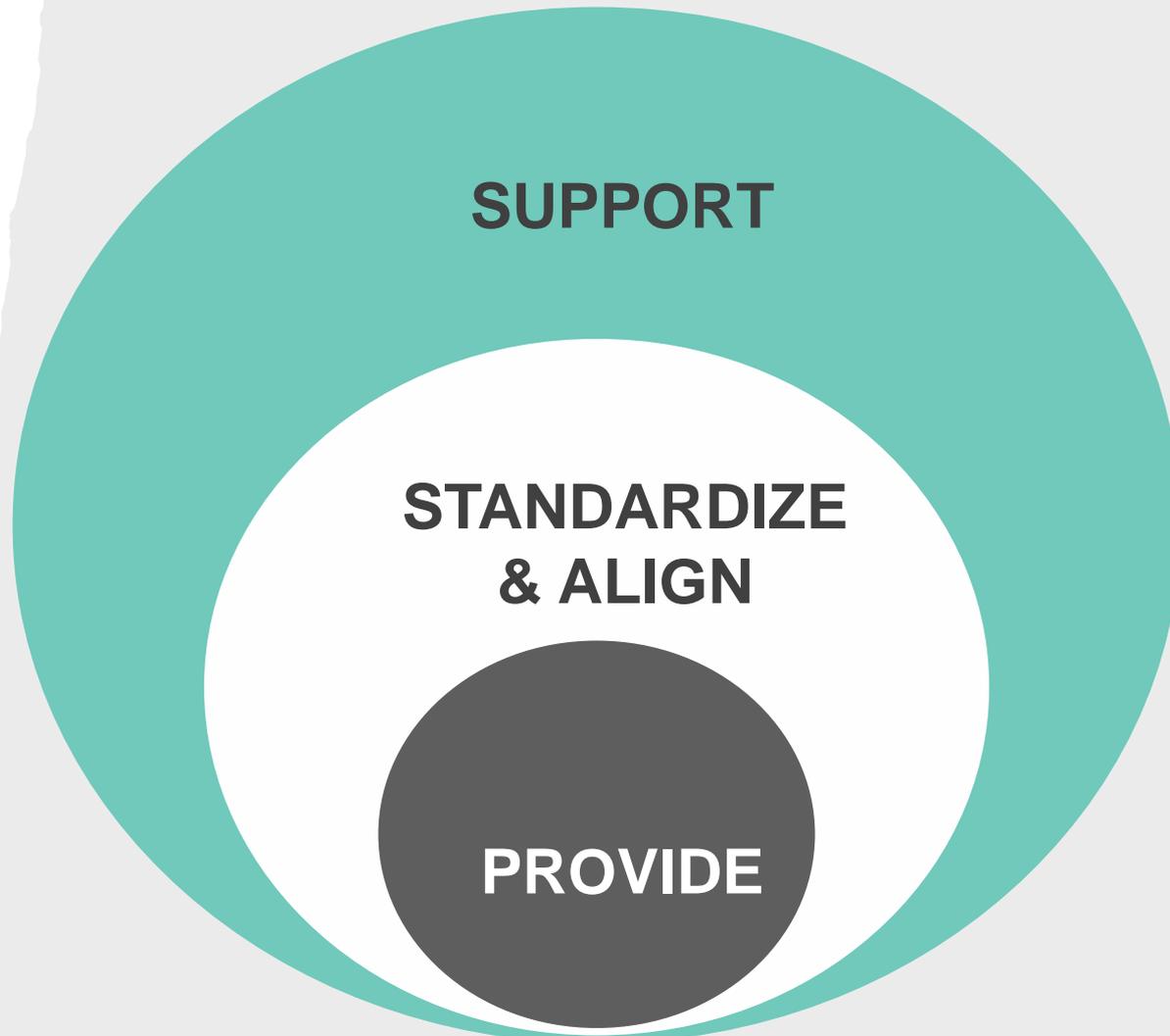
- Several community HIEs:
  - Jefferson HIE – Southern Oregon, mid-Columbia River Gorge region
  - Central Oregon HIE – Central Oregon
  - Coos Bay, Corvallis, others in development
- Direct secure messaging within EHRs is beginning
  - CareAccord, Oregon's statewide HIE
- Epic Care Everywhere
- Other organizational efforts by CCOs, health plans, health systems, independent physician associations, and others
  - including HIE and HIT tools, hosted EHRs, etc. that support sharing information across users

# HIT/HIE exists in Oregon, but gaps remain

Many providers, plans, and patients do not have the HIT/HIE tools available to support a transformed health care system, including new expectations for care coordination, accountability, quality improvement, and new models of payment.

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# The Role of the State in Health IT



Community and  
Organizational  
HIT/HIE Efforts

# State-Level Health IT Services

- Why provide some health IT services at the state-level?
  - Connecting and supporting providers across the state
  - Administrative simplification and efficiencies where multiple systems would be duplicative and burdensome
  - Fill gaps where there are no services available
  - Bring significant federal Medicaid investment to state-level health IT services

# 2015 HIT Legislation – HB 2294

At a high level, the legislation seeks three things:

- 1) The authority for OHA to provide statewide health IT services beyond Medicaid/OHA programs, including charging fees to users
- 2) The authority to participate in partnerships or collaboratives to implement and provide statewide health IT services
- 3) To update and refine the role of the Health IT Oversight Council (HITOC)

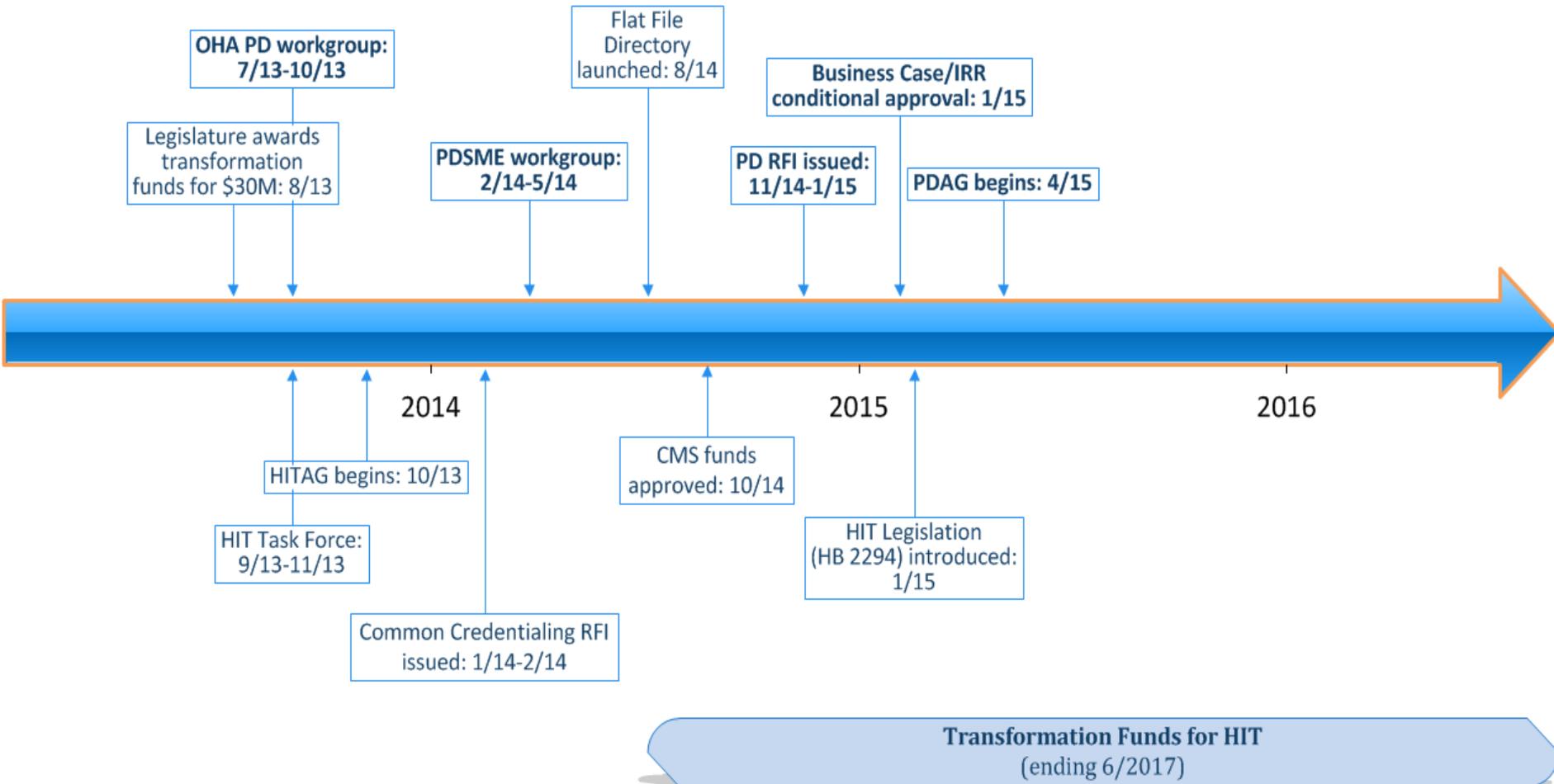
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# Provider Directory re-orientation and group discussion

Karen Hale & Group

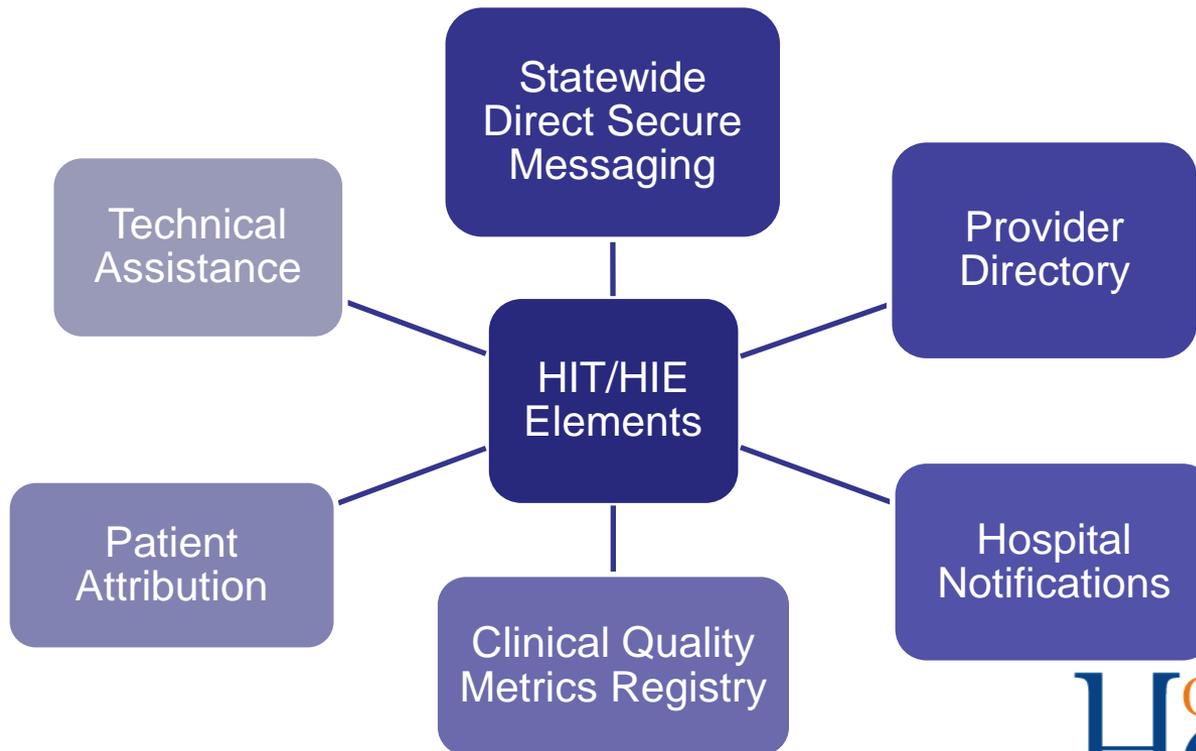


# Timeline to today



# Provider Directory origination

- In 2013, the Provider Directory was identified as one of six HIT/HIE foundational and high-priority initial elements to support Oregon's health system transformation.
- The CCO HIT Advisory Group (HITAG) provides advice and guidance over these elements.



# Why tackle the work of a provider directory?

Create efficiencies for HIE, operations, and analytics

- 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:
  - Multiple, isolated provider directories in use today – costly to maintain the same information across directories
  - Limited in scope (e.g., missing HIE addresses), data accuracy, and timely updates
  - May not meet national provider directory standards
- Question for group:
  - Which ones resonate with you? Are there others?

# What is the opportunity

- Medicaid Coordinated Care Organizations (CCOs) have told us a statewide provider directory is needed for foundational near term needs
- Common credentialing efforts that place standards for data are underway in Oregon
- Emerging national standards for data models and protocols IHE Profile for Healthcare Provider Directory (“HPD” or “HPD-Federated”) have recently been adopted
- State sources of data such as DHS facilities, Patient Centered Primary Care Home (PCPCH) clinics, All Payer All Claims (APAC) are currently being explored to also be included

# Project principles

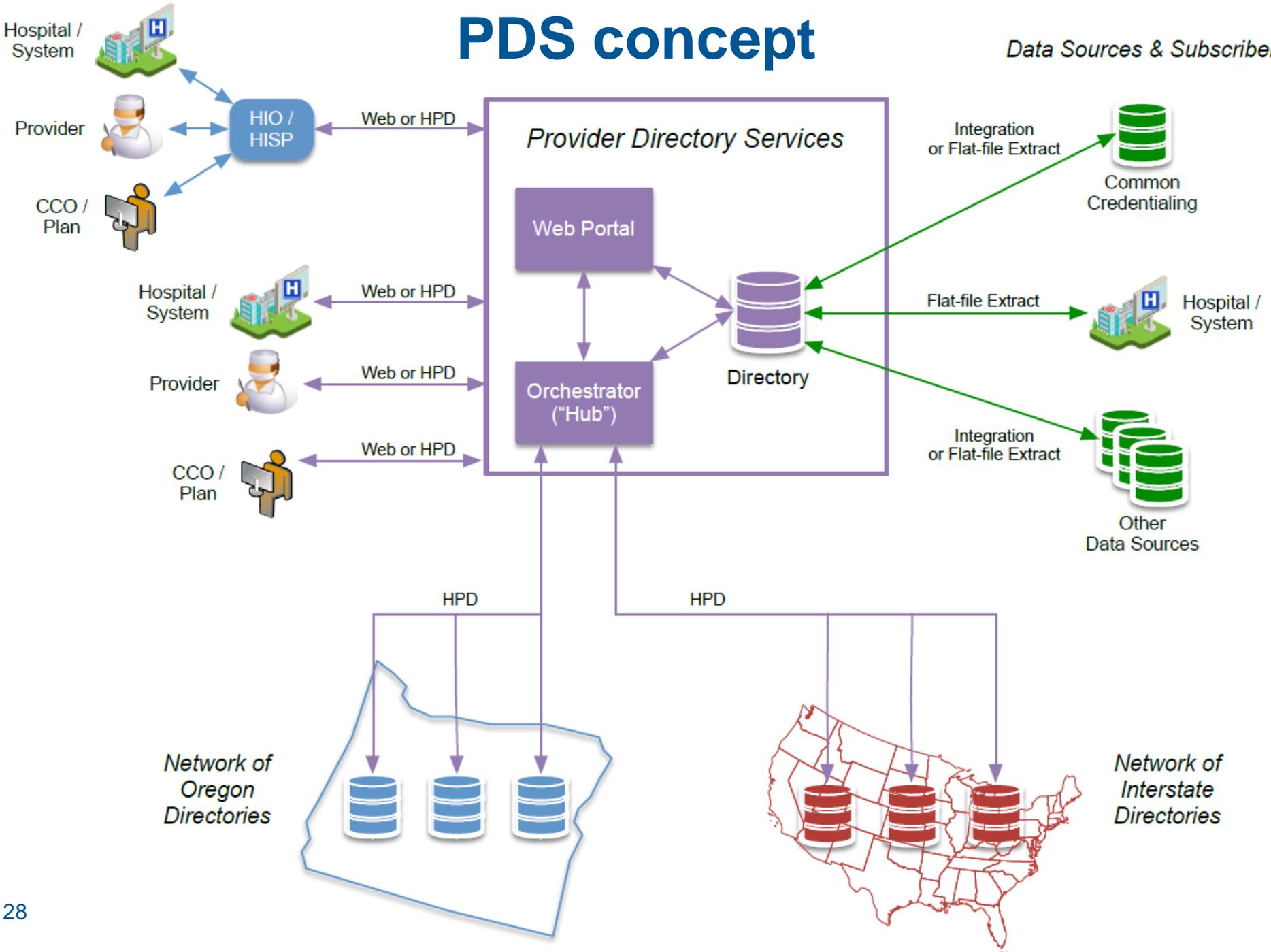
- Build incrementally to ensure success, but must have value right out of the gate
- Establish clear expectations regarding quality of provider information
- Contract for both implementation and operations
- Work in collaboration with Common Credentialing database/program (under development)
- Centralize where needed but allow for federation of existing provider directories

# What is our approach

- Procure for Provider directory services (PDS) that will allow healthcare entities access to a statewide directory of healthcare provider and practice setting information.
- The project comprises design, development, implementation, and maintenance of the technical solution as well as operations and ongoing management and oversight of the program.
- PDS will leverage data existing in current provider databases and add critical new information and functions.

# PDS concept

Data Sources & Subscribers



# Key use elements for “HIE”, Analytics, Operations

## Users and Sources

Providers

Groups

Clinics/Clinic Sites

Hospital

Health System

State programs

Plans/CCOs

Local HIEs

## Value

Meet meaningful use

Care coordination

Administrative simplification

Data available for research and analytics

## Required Data

Demographics, contact information

Licensing information

State program participation

Affiliations

HIE Addresses

# HPD data model

## Credentials

- Information about where a provider is credentialed (includes credentialed date and expiration)
- Can also represent professional qualifications (e.g., degrees, certifications)

## Memberships

- Indicates affiliations between individuals and organizations
- Includes contact and Services information for the individual specific to the affiliation

## Organizations

- Represents organizational entities
- Includes identifying information such as name, legal address, and contact, plus items such as languages supported pointers to Services

## Providers

- Represents individual healthcare professionals
- Includes identifying information such as name, profession, specialization, addresses (legal, billing, postal), and contact information, plus items such as status (primary, other, inactive)

## Services

- Contains health information exchange information for an individual or organization, including Direct address and query endpoint

| Element  | Common Credentialing | Federated HPD | Potential “Gaps”  |
|--|----------------------|---------------|---|
| Identifying/Practitioner Address Information             | X                    | X             | In Common Credentialing, not HPD:<br><ul style="list-style-type: none"> <li>• Birth date and place, SSN, Citizenship, VISA</li> <li>• Additional status types (full time, part time, telemedicine, etc.)</li> <li>• Other professional actives (administration, research, teaching, retired)</li> <li>• Department name (hospitals)</li> <li>• Federal Tax ID, SSN</li> <li>• Professional liability carrier</li> <li>• Work history</li> </ul> |
| Practice Information/Practice Call Coverage              | X                    | X             |   |
| Specialty Information                                    | X                    | X             |   |
| Board Certification/Recertification/Other Certifications | X                    | X             |   |
| Education/Residencies/Fellowships                        | X                    | X             |   |
| Health Care Licensure, Registrations, Certificates       | X                    | X             |   |
| Hospital and Health Care Facility Affiliations           | X                    | X             |   |
| Professional Practice/employment                         | X                    | X             | In HPD, not Common Credentialing:<br><ul style="list-style-type: none"> <li>• Direct Address</li> </ul>   |
| Peer References  | X                    |               |   |
| Continuing Medical Education (CME)                       | X                    |               |   |
| Professional Liability Insurance                         | X                    |               | Not in either:<br><ul style="list-style-type: none"> <li>• Office hours</li> <li>• PCPCH designation and tier</li> <li>• Accepting new patients</li> </ul>  |
| Attestation Questions/Professional Liability Actions     | X                    |               |   |
| Direct Address   |                      | X             |   |

# Uses – specified by SME workgroup

## HIE

- Facilitate transitions of care
  - 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)
- Find Direct addresses
- View affiliations and insurance,
- Identify who is in the Trust Community
- Identify if referring doctor is “in network” or part of a CCO

## Operations

- 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
- Eligibility or audit information

## Analytics

- Produce quality metrics:
  - Claims by group
  - Adolescent well-care
  - EHR – hypertension
  - PCPCH designation and tier
- To identify
  - how care varies across practice sites, within/outside of PCPCH’s, CCOs, etc.
  - targets/deficiencies based on availability of EHRs

# PDS uses translated into needs in the Request for Information (RFI)

- Technical solution
  - Data types, data access, and storage
  - Data standards
  - Data quality
  - Future stage (after-hours tracking, PCPCH tier, geo-coding, data entry interface)
- Operations
- Information security

# PDS Functions from November 2014 Request for Information

- 10 total responses
- Objective – learn what's in the market, identify where more research and analysis is needed, refine needs/adjust how we've framed our needs
- Some responses were for the solution only, consulting only, operations only
- For those offering a technical solution, versions of HPD were in existence

# Discussion questions

- How many PDs does your organization maintain?
- What are the primary or mandatory uses of your PDs today?
- What are the pain points with your current state?
- What would change once you have an accurate statewide directory (staffing, workflows, processes)?
- Regarding value out of the gate, what would you consider minimum level of functionality to get value?
- What will drive the adoption of PD, what would it take for your organization to use the PD as a primary verification source?

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# Implementation of the Oregon Common Credentialing Program

Melissa Isavoran  
Credentialing Project Director  
OHA



# Background

- ***What is credentialing?***

***Credentialing*** is the process of assessing and confirming the qualifications of a licensed or certified health care practitioner in an effort protect patients and facilities by lowering the risk of medical errors caused by incompetent practitioners.

- ***Why is credentialing a problem?***

Credentialing is currently done independently by health care delivery systems and carriers resulting in duplication

# Oregon's efforts

- Oregon created a common credentialing form for use by all health plans and hospitals established by the Advisory Committee on Physician Credentialing Information
- The Oregon Health Leadership Council's Executive Committee on Administrative Simplification began the process for assessing and building support for a common credentialing solution
- SB 604, Sponsored by Senators Alan Bates and Elizabeth Steiner-Hayward, passed in 2013 mandating OHA to develop a common credentialing solution

# Main tasks of SB 604

- Establish a program and database to provide credentialing organizations access to information necessary to credential or recredential health care practitioners
- Convene an advisory group to review and advise the authority on the implementation
- Develop rules on application and submittal requirements, the process of verification, and fees
- Issue a Request for Information and Request for Proposals
- Report to the Legislature on progress

# Common Credentialing goals

- Reduce time practitioners spend on credentialing applications and responding to requests for information
- Reduce the time carriers and other organizations spend on redundant credentialing processes
- Leverage Health Care Regulatory Board information
- Build from past efforts to simplify credentialing
- Establish a fair and equitable fee structure

# Common Credentialing Program

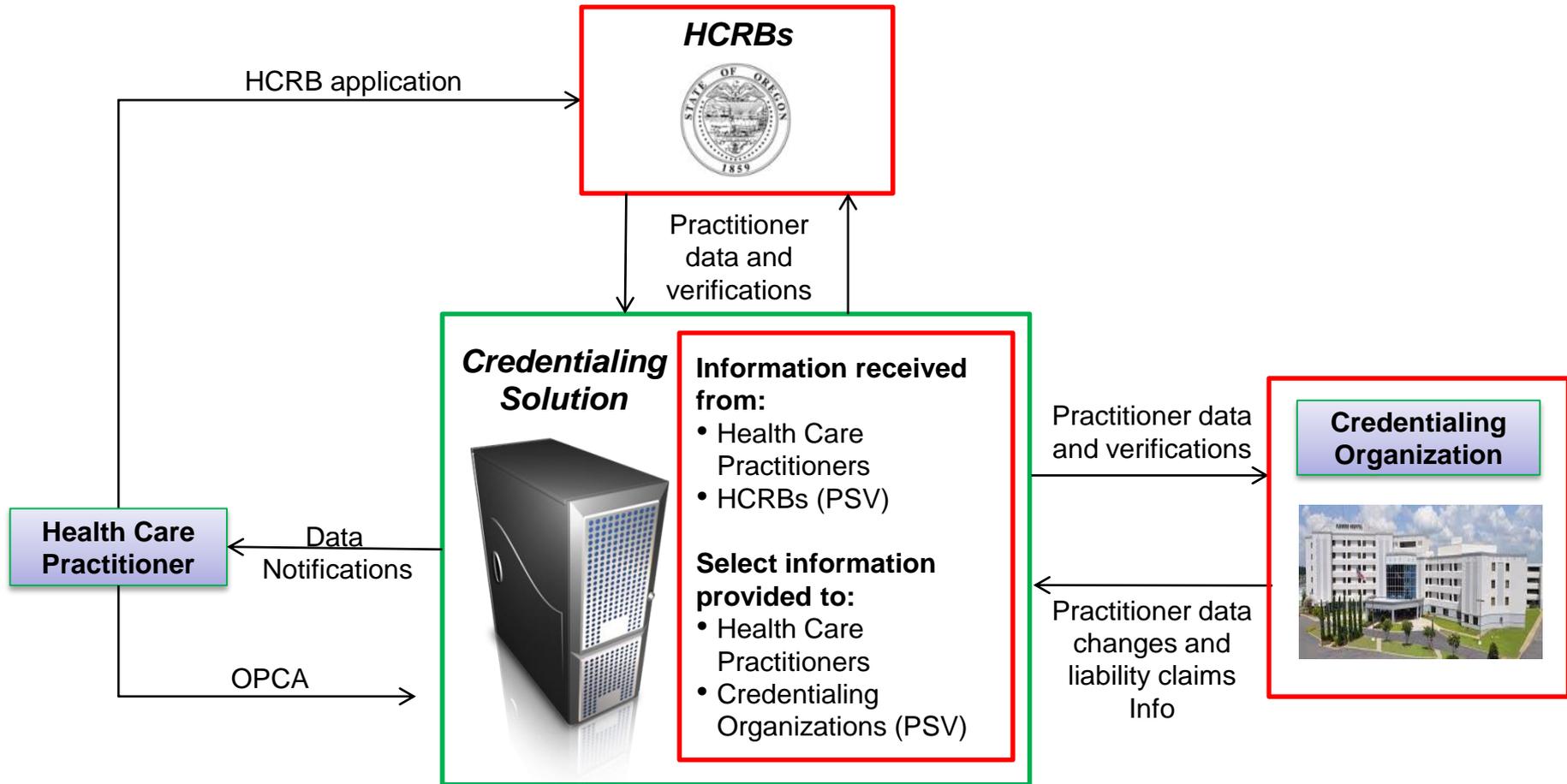
## The Program will include...

- A centralized web-based electronic solution that will collect, store, and maintain practitioner credentialing information
- A process for collecting and verifying credentialing information
- ***A process for practitioners or designees to access the Solution to submit information necessary for credentialing upon initial application, providing attestations every 120 days***
- A process for credentialing organizations to input, access, and retrieve practitioner credentialing information
- A process for Health Care Regulatory Boards to input and access practitioner credentialing information

## The Program will **NOT** include:

- The decision to credential a practitioner
- The process of privileging a practitioner

# Baseline solution diagram



# Implementation challenges

- State IT procurement process has contributed to implementation delays
- Change management for participants
- Risk and liability concerns regarding verifications process
- Interfacing capabilities for the use of HCRB data and other interoperability
- Collecting fees from credentialing organizations and practitioners must be delicately balanced

# Current progress

- Established a Common Credentialing Advisory Group
- Engaged other subject matter experts for advice
- Developed clarifying definitions for “Credentialing Organization” and “Health Care Practitioner”
- Identified accrediting entity requirements
- Determined common credentialing solution functionality
- Developed and released a Request for Information
- Established fee structure principles and guidelines
- Finalized credentialing rules on July 1, 2014

# Expected health care practitioners

“Health care practitioner” means an individual authorized to practice a profession related to the provision of health care services in Oregon for which the individual must be credentialed.

This includes, but is not limited to the following:

- Doctor of Medicine
- Doctor of Osteopathy
- Doctor of Podiatric Medicine
- Physician Assistants
- Oral and Maxillofacial Surgeons
- Dentists
- Acupuncturists
- Audiologists
- Licensed Dietitians
- Licensed Marriage & Family Therapists
- Licensed Professional Counselor
- Psychologist Associate
- Speech Therapists
- Physical Therapists
- Occupational Therapists
- Registered Nurse First Assistant
- Advanced Practice Registered Nurses
- Psychologists
- Licensed Clinical Social Worker
- Optometrist
- Chiropractor
- Naturopathic Physician
- Licensed Massage Therapists

# Common Credentialing rule provisions

- Definitions to clarify participants and concepts
- *Practitioner requirements (includes 120 day attestations)*
- Health Care Regulatory Boards to provide data with waiver option
- CO's requirements to use data available in the solution
- Advisory Group membership and responsibilities
- Practitioner information uses (hold harmless language)
- Intention to impose fees (will be adjusted later)

# SB 594: implementation date flexibility

SB 594 (2015), sponsored by Senator Alan Bates, provides implementation date flexibility with these provisions:

- Health care practitioners will not be required to submit information to the Program until an electronic system is established and until the date the OHA requires it by rule
- OHA must consult the Common Credentialing Advisory Group
- Notice of the implementation date to credentialing organizations and Health Care Regulatory Boards must be provided at least six months prior
- OHA must report to the Legislature by February 1, 2016

# Moving forward

- RFP anticipated to be released by the fall of 2015
- Rule revisions via a Rulemaking Advisory Committee
- Stakeholder outreach planned for all stakeholders through publications, professional associations, and other forums during implementation
- Implementation process begins and will include:
  - Contract negotiations
  - Quality assurance planning and reviews
  - Build out of the solution and system testing
  - Policy development and marketing strategies
  - Population by select Health Care Regulatory Boards/practitioners
  - **Go live date established by rule**

**More information can be found at:**  
**[www.oregon.gov/oha/OHPR/occp](http://www.oregon.gov/oha/OHPR/occp)**

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# OHA HIT Project Governance Structure and Procurement Process

Rachel Ostroy  
Implementation Director  
OHA



# What we intend to procure

- Project Management and Risk Management
- Solution Selection and Procurement
  - Provider Directory (PD)
  - Common Credentialing (CC)
  - Clinical Quality Metrics Registry (CQMR)
- Operational Services
  - Outreach/marketing
  - Technical operations
  - Program operations
- Systems Integrator Services, Interfaces and Common Access Mechanisms, Fiscal Services

# Key considerations for procurement

1. Solution Quality “goodness of fit”
2. Creating the most advantageous balance of risk and time
  - Reduce the burden of administrative oversight
  - Move as quickly as possible
3. Cost



# Prime procurement: “Leverage” approach

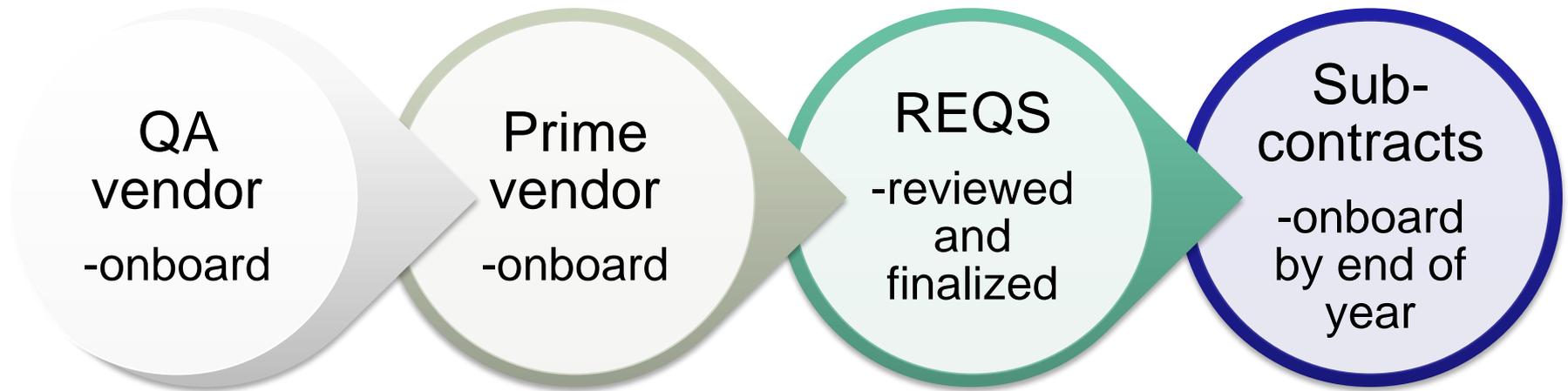
Use contract amendment to extend existing Prime services to other HIT initiatives, including PD, that were included in the Scope for the Oregon HIE Services RFP

1. Prime is a proven partner with high quality service
2. Accelerates timeline: Allows OHA to move to procurement of HIT Services
3. Maintains open procurement for HIT solutions that allows for stakeholder feedback and complies with state and federal requirements for selecting the sub-contractors
4. Consistency: Portfolio of services managed and operated by the same Prime

# Prime procurement: current action

- Continue exploring the Leverage approach
- Open procurement for sub-contracts of HIT Services
- Follow DAS Stage-Gate for sub-contracts of HIT services
- Follow advice to keep the procurement as transparent as possible

# HIT portfolio milestones



# HIT portfolio governance

- HIT Executive Steering Committee
  - Decisions around scope, timeline or budget
- CCO HIT Advisory Group
  - Guide the development of HIT services, including two projects in the portfolio: PD and CQMR
- CC Advisory Group
- PD Advisory Group

# High level governance context

State Leadership

Internal stakeholder groups

HIT Executive Steering Committee

Legislature

Project Steering Committee

External advisory groups and stakeholders

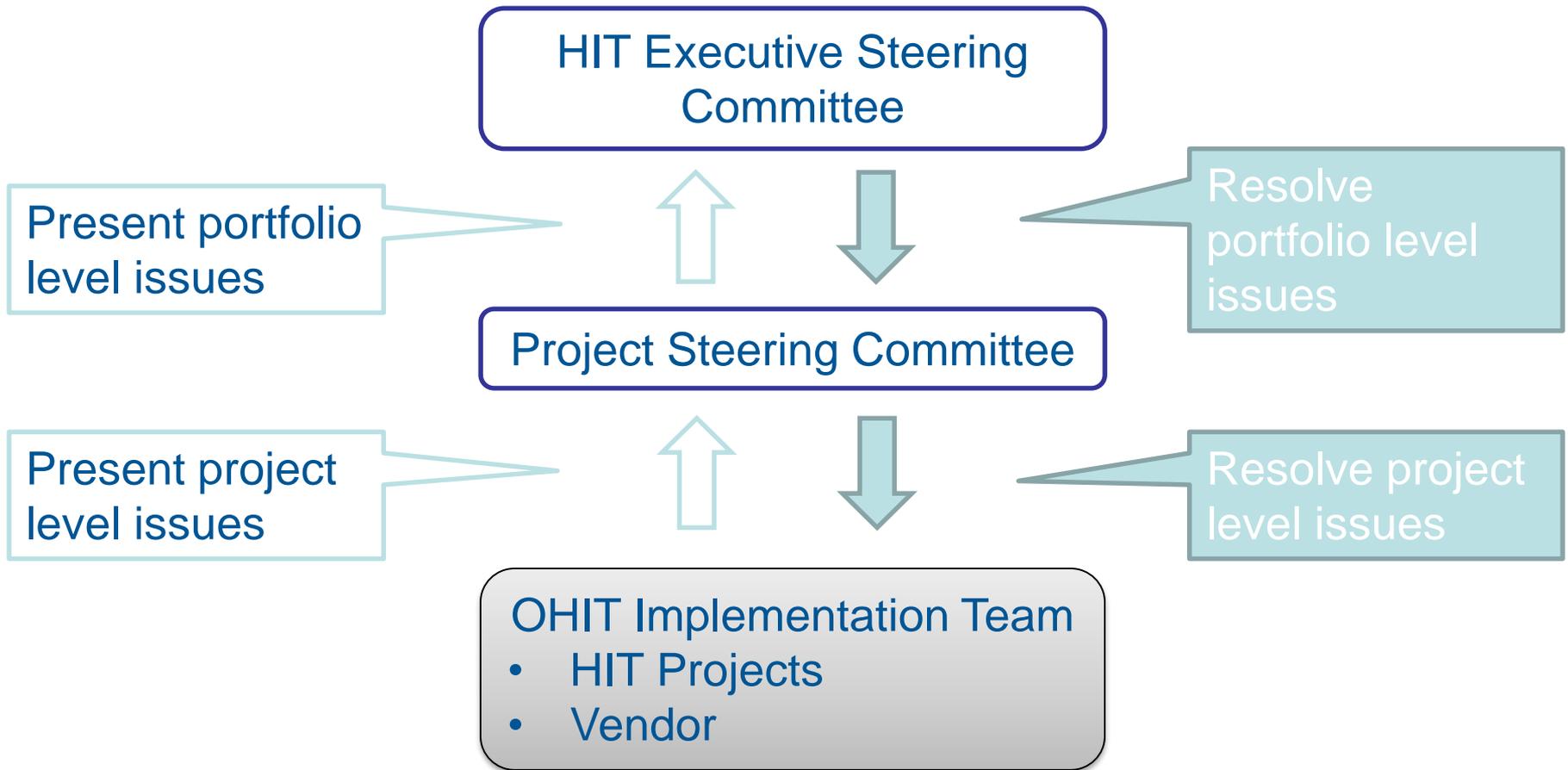
OHIT Implementation Team

- HIT Projects
- Vendor

PDAG



# Provider Directory project governance



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# Wrap up and Next steps

Karen and Susan



# Wrap up and next steps

Feedback on process today

- What worked well?
- What could be improved?
- What could we do better?

Meeting frequency

- Preference for meeting length, frequency, other thoughts?

# May PDAG meeting

May 13<sup>th</sup> from 10-12pm in Salem, Oregon State Library,  
Room 103, 250 Winter Street NE, 1st Floor

Other thoughts, questions, concerns?

- Karen Hale, Lead Policy Analyst, Office of Health Information Technology, OHA, [karen.hale@state.or.us](mailto:karen.hale@state.or.us), 503-378-1767
- Nick Kramer, Policy Analyst, Office of Health Information Technology, OHA, [nicholas.h.kramer@state.or.us](mailto:nicholas.h.kramer@state.or.us), 503-373-0791

**More information can be found at:**  
**[healthit.oregon.gov](http://healthit.oregon.gov)**