

HIN User Group Meeting Minutes
May 12, 2005
Arlington, VA

Introduction

The HIN user group, chaired by Doug Clark, met on May 12, 2005 at 9:00 am. After introductions, the minutes from the December meeting were reviewed and approved. Attendees included: Barbara Broadbent and Colleen O'Hare of Neoforma, Marv Cowan of Covansys, Bill Graham and Karolyn Suszynski of C R Bard, Inc., Victor Kruchows of Johnson and Johnson, and Claude Ritman of Coler-Goldwater Specialty Hospital.

Clark reported the HIN productivity statistics for the period since December 10, 2004:

Source	HIN Requests	Assignments	Cross-References	Cancels
Human Health	51,293	24,020	7,984	9,462
AHI Project	27,779	17,461	4,903	5,415*
Total	79,072	41,481	12,887	14,877*

* 1600 cancels were initiated due to an incorrect file that was submitted by AHI.

Co-Chair Volunteer needed

Another Co-Chair for the Group is needed to share the responsibilities for coordination, content development and administration of the meetings.

HIN Implementation Guide

No further comments were received for the HIN Implementation Guide update. The full document will be made available for review. It was agreed that the guide would be circulated for comments by each new subscriber to continue the improvement/development of the document.

iHIN Hierarchy update

Additional upgrades to the iHIN Hierarchy application are being implemented based upon comments received from users. During upgrades, the site will be intermitently unavailable. Full access will be restored by May 22. A User Guide has been developed and is available to any interested party. Please contact HIBCC to receive a guide.

Public Health Service

Sub-Group:

With the notable increase in the submission and processing of PHS associated HIN records, the User Group has decided to form a sub-group to address issues related to the enumeration of Public Health Service entities. CR Bard and Amgen indicated that they would like to lead the group. Any interested subscribers should contact HIBCC if they

would like to participate. The HIBCC office will make contact to arrange a teleconference once the sub-group is established.

Processing/Rules Change:

Novartis Pharmaceuticals and Merck have requested that In Patient Pharmacies (Disproportionate Share) be added as qualifying PHS locations. The Office of Pharmacy Affairs does not include In Patient Pharmacies as qualifying entities currently. Historically, HIBCC does not add them unless they are listed by OPA.

The User Group considered if an exception should be made, and if so, should In-Patient Pharmacies be added to the HIBCC list as a qualifying PHS location? Several points and options were discussed:

- the creation of duplicate records to identify 1 for private and 1 for PHS;
- who would decide which entities qualify;
- what are the drivers for identifying such entities as part of the CE subset;
- whether the creation of a new Subset Code or Market Segment would better serve the purpose, allowing the integrity of the OPA designation to remain intact.
- users maintain their own classifications or exception codes to identify these In Patient Pharmacy locations.

It was agreed that the companies requesting the update would be contacted by the PHS sub-group to further understand their requirements.

Position statement re: Prescriber merge

The Position Paper was reviewed (see below for full document) and discussed. The fundamental question is whether prescribers should be physically integrated into the facility superset or whether they should be maintained in their own superset with some sort of visibility permissions to human health subscribers.

Essential elements include:

- Do prescribers need to be enumerated for human health supply chain transactions?
 - Need more detail, assume yes
- What percentage of the prescriber population will eventually be enumerated?
 - Don't know but subscribers would need to be surveyed.
- How should prescribers be enumerated?
 - Allow prescribers into the facility database, but maintain separate identification that they are prescriber type record
 - Allow broader access to the prescriber DB
- Control distribution with an access code?
- How should relationships between prescribers and facilities be maintained?
 - Not initially necessary but worthwhile in the long run.

The two most favored options were enabling broader access to the prescriber database along the lines of the Animal Health model, or incorporating specifically required

prescribers into the facility database and identifying them via a new subset code. This would preserve the prescriber structure wherein the base HIN identifies the prescriber and the suffix identifies the various locations of the prescriber. This assumes the prescriber data structure would fit in the facility format, but otherwise requires the fewest changes by subscribers to leverage the data. It does, however, create apparent duplicates at a location.

The Animal Health Group resolved this problem by using both subsets and maintaining a cross reference between the prescriber and facility databases. This implementation is perhaps the most clean, but access to the prescriber databases may impede its adoption. The group agreed the record types, prescriber vs. facility, should not be co-mingled, so the subset code option may be necessary. HIBCC will review this option and the topic will be further developed and finalized at the next meeting.

September Meeting

The next meeting will be held September 15, 2005 in Chicago at the Renaissance Chicago O'Hare Suites Hotel. Agenda items will include: the identification of a new co-chair, the PHS sub-group report, and the further identification of a solution for the Prescriber data set requirements.

Prescriber Enumeration in the HIN Database
HIBCC White Paper
May 3, 2005

The primary HIN database used in human health supply chain contract administration transactions is the HIN facility database. Since its inception, the HIN facility database has enumerated *establishments* because the establishment is the predominant contracting entity in the health care supply chain. However, individuals are now being recognized in some GPO membership lists, adding an additional layer of complexity to end-user identification. As a result, HIN subscribers have begun to request the enumeration of prescribers (persons) in the HIN database. The purpose of this paper is to describe the existing HIN database structure and outline alternatives for managing prescriber identification.

Since 1994, the HIN database has comprised two *supersets* – facilities and prescribers. Only the facility superset has been widely distributed and used for customer identification in contract administration. The prescriber superset enumerates medical doctors, dentists, veterinarians and other health care professionals and, except for veterinarians, has had only limited distribution. The HIN database management system maintains separation and limits visibility between the two supersets. Only establishments are enumerated in the facility superset and individuals in the prescriber superset.

With the need to enumerate prescribers for contract administration, the issue is not whether, but how to go forward. Simply adding the prescriber superset to the facility superset would not be practical because it would approximately double the size of the HIN database and add many entities that have not been subject to the same maintenance practices as the facility superset. In addition, some prescribers have been enumerated in the facility database at the request of subscribers, so there is a danger of duplication. Ignoring the prescriber superset altogether is also not a viable option. The veterinarian subset within the prescriber superset is an actively maintained database for animal health. Many other prescriber records in the superset have been updated within the past year.

The fundamental question is whether prescribers should be physically integrated into the facility superset or whether they should be maintained in their own superset with some sort of visibility permissions to human health subscribers. The following considerations should be noted.

Enumeration policies

There are different HIN assignment rules for facilities and prescribers. For facilities, HINs are randomly assigned without regard to organizational relationship. In other words, HIN assignments to an organization's facilities at several different locations (addresses) are unrelated. (Locations within a facility are associated with the facility's base HIN, however.) For prescribers, a base HIN is assigned to the prescriber and each practice location for that prescriber is assigned the base HIN plus a two-character suffix.

HIBCC does not publish base HINs for prescribers, since the base HIN is only a “tie” for locations.

This relationship would not be retained if prescribers were physically integrated into the facilities superset. The few prescribers that have been enumerated in the facilities superset have been enumerated as “locations” of the establishments where they work, which obfuscates the identification of physical locations within facilities.

Double counting

Recognizing prescribers adds another layer of complexity to customer identification and, in some respects, represents a different “view” of the customer. Product may be ordered and shipped to a person or an establishment, and the view may often depend on the originator of the transaction. Animal health subscribers faced this issue when HIN was first adopted by the AHI EDI Special Project. Here, manufacturers recognized that some trading partners identified veterinarians as their customers, while others recognized animal clinics. Rather than convert one set of distributors, the project decided to identify both facilities and veterinarians and permit trading partners to link their customers to whichever HIN was appropriate. Animal health subscribers have visibility to all animal health facilities and all veterinarians. Relationships between veterinarian and facility HINs are maintained in a separate cross-reference table (not at HIBCC) to resolve to internal customer numbers. Similar cross-references would probably be necessary in human health to align establishments and persons to each subscriber’s customer view.

Identification standards

Identification standards for establishments and prescribers are slightly different, though not incompatible. Establishment identification follows standard business naming practices, along with a postal standardized address and class of trade code (or activity code for locations). Prescriber identification adopts a standard format for name (last, first, middle, generation suffix, credentials) and uses a credentials code list for “class of trade”. (UPIN specialty codes are no longer supported.) Prescriber identification standards would be maintained if prescribers were physically integrated into the facility database.

The HIN User Group needs to weigh in on this issue, particularly with respect to the following questions.

- Do prescribers need to be enumerated for human health supply chain transactions?
- What percentage of the prescriber population will eventually be enumerated?
- How should prescribers be enumerated?
- How should relationships between prescribers and facilities be maintained?

This topic will be a major agenda item at the next HIN User Group meeting.