Meeting Minutes

Digital Bridge Interim Governance Body

Meeting Information

Objective: Concluded work on eCR Digital Bridge phase 2 objectives with approval on all products critical to eCR implementation (project Phase 3), specifically: (1) eCR Technical Architecture and Requirements; (2) Legal and Regulatory Guidance; (3) Implementation site schema, and evaluation plans.

Date:	1/18/2017	**Location:**	Task Force for Global Health 325 Swanton Way, Decatur, GA 30030
Time:	10:30 AM – 5:00 PM EST	**Meeting Type:**	In-Person
Called By:	Project Management Office	**Chairperson:**	John Lumpkin
Facilitator:	Charlie Ishikawa	**Note Taker:**	Jelisa Lowe, Hoa Truong
Attendees:	See attached		

Agenda Items		Speakers	Time Allotted
1	Call to order and roll call	John Lumpkin, Charlie Ishikawa	5 min
2	Agenda review and approval	John Lumpkin	2 min
3	eCR Digital Bridge Technical Architecture	Benson Chang	80 min
4	Digital Bridge Communications	Jessica Cook	30 min
5	eCR Legal and Regulatory Assessment and Recommendations	Rick Hogan, Jim Jellison	120 min
6	eCR Implementation: Plan, Sites and Evaluation	Jim Jellison	75 min
7	Candidates for the Governance Body vacancy	Charlie Ishikawa	30 min
8	Meeting Adjournment	John Lumpkin	5 min

Decisions

1 Since Digital Bridge aims to establish bi-directional information exchange for eCR, promote practice advancement by learning about what it will take to successfully adopt eCR nationwide during the 2017 implementation phase, and recognizing a reportability response standard is developing, the Digital Bridge shall select Digital Bridge eCR implementation sites based on criteria previously approved (12/2016) and recommend that sites implement both eICRs and reportability responses. We will accept, however, sites that are only able to implement eCR exchanges of eICRs and technical ACK messages.

- Motioned by James Doyle (Epic); seconded by Oscar Alleyne (NACCHO). Decision passed unanimously; no dis… or abstentions.

2 Approve the flow and functional requirements document with the intent to regularly revisit to ensure mechanisms to receive an acknowledgement from public health to provider and enhance the capabilities to provide bidirectional flow.

- Motioned by Walter Suarez (Kaiser); seconded by Bill Mac Kenzie (CDC)

3	Model I and II will be provided as options for eCR implementation sites to use. Digital Bridge intends to explore technical and legal solutions that address feasibility and scalability issues. The trust framework and the HIE network will have to be embedded in Models I and II. • Scott Becker (APHL) motioned, Walter Suarez (Kaiser) seconded.

New Action Items

		Responsible	Due Date
1	Make final updates to eCR business process flow diagram and technical requirements for coorespondance with governance body decisions made	PMO	1/30/2017
2	Notify Jessica Cook if willing to sign-up for a Digital Bridge speakers bureau, and/or ad hoc, informal communications advisor	Governance Body	Open
3	Complete replacement candidate list and poll Governance Body to identify the top three.	PMO	Next Governance Body meeting

Other Notes & Information

1 – Call to Order

A quorum of Digital Bridge Governance Body Representatives were present.

2 – Agenda Review and Approval

No additions to the agenda made. No disagreement with the agenda voiced.

3 - eCR Digital Bridge Technical Architecture

Benson Chang presented a full review of the Technical Architecture Workgroup's (TAW's) products. These products are: eCR Technical Architecture Diagram, Technical Architecture Diagram Narrative, and eICR Trigger Sequence Diagram. An eCR Requirements Business Process Task Flow Diagram revised to correspond with the TAW's eCR technical scheme is a related TAW product.

Discussion

- Version 1.0 of the electronic initiate case report (eICR) messaging standard has been approved by HL7. Approval of an improved, more mature version of the eICR standard, Version 1.1, is expected in May 2017. Digital Bridge eCR implementation sites that are scheduled to begin work in March 2017, will use eICR message version 1.
- The eICR standard includes specification for an acknowledgement message (ACK). This ACK communicates: a.) that a given eICR message was delivered; b.) that it was received and opened; c.) whether the content was complete and executable; and d.) whether something was done with the message. Notably, this ACK does not provide data that are useful in clinical work or patient care; i.e., this ACK it is not meaningful feedback to clinicians from public health.
- That Digital Bridge promotes bi-directional information exchanges that are mutually beneficial is essential. The eICR ACK, while important from a technical perspective, is not a message that provides clinicians with beneficial public health or clinical information.

Reportability response

Mr. Chang revisited the TAW's reportability response issue. Although discussed by the Governance Body on 1/12/2017, a specific solution was not decided. There are two TAW recommended solutions: Option A

– Require eICR ACK messaging of Digital Bridge eCR implementation sites and leave implementation of reportability response messaging (RR) optional; or Option B – Require that implementation sites exchange both eICR ACKs and RRs.

Discussion

- This issue highlights a tension between two Digital Bridge aims: 1.) promote novel and meaningful bi-directional exchanges of health and public health data between public health agencies and health care delivery; and 2.) promote standardization and interoperability. Whereas eCR implementation must progress rapidly to demonstrate public health readiness for Stage 3 meaningful use attestations, doing so in the absence of a national RR standard may work against standardization and undermine interoperability.
- Since a RR standard is being developed in HL7 and is anticipated to be ready for use in May 2017, Digital Bridge will be will positioned to learn about what works and does not work for both eICR and RR communications. Lessons about the later will be helpful in maturing standards for reportable case reportablility data exchange. Therefore, the Digital Bridge should not exclude applicant implementation sites that are unable or unwilling to produce RRs, because there is opportunity to learn and ultimately support public health and health delivery systems in establishing eCR nationwide.

Governance Motion: *The Digital Bridge shall select Digital Bridge eCR implementation sites based on criteria previously approved (12/2016) and recommend that sites implement both eICRs and reportability responses (RRs). We will accept, however, sites that are only able to implement eCR exchanges of eICRs and technical ACK messages. Motioned by James Doyle (Epic); seconded by Oscar Alleyne (NACCHO). Passed with unanimous agreement; no objections, no abstensions.*

Reconciled Functional Requirements

- The eCR Requirements Business Process Taskflow Diagram and all other related products need to be updated to reflect and correspond with ideas discussed and decided above.
- As the Digital Bridge initiative proceeds, diagrams and requirements documentation will need to evolve as lessons are learned and best practices identified.

Governance Motion: *Approve the flow and functional requirements document with the intent to regularly revisit to ensure mechanisms to receive an acknowledgement from public health to provider and enhance the capabilities to provide bidirectional flow. Motioned by Walter Suarez (Kaiser); seconded by Bill Mac Kenzie (CDC). Passed with unanimous agreement; no objections, no abstentions.*

4 – Digital Bridge Communications

During lunch, Jessica Cook spoke about the accomplishments and challenges of Digital Bridge communications. Ms. Cook also asked for Governance Body representative help in future communication efforts.

Digital Bridge communication efforts have focused on establishing a visual identity, executing communications strategies and tactics, and securing webinars and presentations. Accomplishments include:

- Launched new website with 1,341 total visits from Dec. 14-Dec.31
- Designed a new logo and templates
- Built a comprehensive communications plan with detailed audience descriptions and messaging
- Drafted talking points and developed fact sheets
- Secured six presentations on association webinars (since November 2016) as well as secured presentations at relevant meetings
- Held successful question and answer session for implementation sites with 57 participants
- Secured media coverage in *Health Data Management, Georgia Health News, Public Health Reports* and *Healthcare Informatics*

Communication challenges include:

- difficulty addressing the needs and concerns of each large sector involved and reflecting those issues in the communications strategy; the complex and fragmented nature of public health with the differing levels of eCR capability and adoption rates; and
- creating messaging that highlights the value case for health care.

For next steps, communications will continue nurturing a community of practice around eCR by working with associations on communications. The team has also submitted abstracts to a number of conferences (i.e., HIMSS, NACCHO, CSTE, and Preventive Medicine). In closing, Jessica suggested creating a communications advisory group to review materials, act as spokespeople and help develop messaging for particular sectors.

Discussion

- Look into small medical practices, such as the American College of Family Physicians. Include them in the value proposition because there are unique differences, and we can consider how we want to address that in marketing campaigns.
- PMO should put together a speakers' bureau where the SMEs share their expertise and availability for speaking engagements.
- There is a need for a communications strategy to hit multiple audiences. Use Google Analytics to pinpoint who those audiences are through to address and amplify the commitment around this effort.
- The governance body should also use their networks to help communications get through to their channels. Keep policymakers in mind. We need to know what kind of messaging would resonate with them.

5 – Legal and Regulatory Assessment and Recommendations

Jim Jellison and Rick Hogan spoke about the Legal and Regulatory Workgroup's products. Options for the transactional relationships between a healthcare delivery systems, a public health eCR decision intermediary, and a public health agency were presented as three models. The models were compared and contrasted to identify and describe key eCR legal and regulatory issues, and facilitate a Governance Body discussion regarding how best to approach eCR implementation by Digital Bridge and for national scalability.

The models were described as::

- **Model I:** The decision support intermediary (DSI) acts on behalf of a healthcare provider. In this model:
    - Healthcare provider and DSI enter into a business associate agreement in which services and service expectations and conditions are described. Between the DSI and public health agencies, legal tools such as memoranda of understanding (MOU), or data use agreements (DuAs) may also be necessary.
    - The benefits of Model I are that it is commonly used for Health IT services, and effectively houses patient data on potential cases within the umbrella of the covered, healthcare provider entity.
    - The problem with Model I is that establishing a BAA is a time and resource intensive process.
    - Although a familiar legal tool, the necessity of BAA use for Model I type eCR presents a significant feasibility challenge to nationwide implementation. Whereas DSI services and public health case reporting logic would best be provided by a single or handful of parties, a national rollout of eCR would thereby require those DSI parties to form BAAs with each and every healthcare provider or delivery system. The total would be hundreds of thousands of agreements; expensive and cost prohibitive work that would present a nearly insurmountable barrier to nationwide eCR.
- **Model II:** The DSI provides services on behalf of the public health agency. In this model, the DSI provides its services on behalf of a public health authority and does so under the laws and regulations of a governmental jurisdiction. This is a common model used by state and local public health agencies to deliver certain public health and public health information services; e.g., immunization registries, cancer registries, etc.
    - A benefit of this model is that the DSI can receive and process eICR messages under the authority granted to a PHA for reportable conditions surveillance
    - An barrier to this model is that governmental procurement rules and procedures may make it difficult or impossible for some PHAs to "sole-source" with the DSI
    - Rather than the thousands of agreements that a DSI would need to establish under Model I, Model II would require hundreds of service agreements with state and/or local health agencies.

While less expensive and more feasible than Model I, Model II would nonetheless require significant resources to implement nationwide

- **Model III:** The DSI provides services within a trust framework that healthcare delivery systems have joined. The Sequoia Project is an example of such a framework. Data USA and Reciprocal Support Agreements (DURSAs) are the legal tool used.
    - This Model has the benefit of requiring fewer "one-off" agreements for establishing DSI services. It is, however, a relatively new approach.

Discussion

- The immediate goal is to both prepare what is needed for the pilots and for the long-term solution.
- The Legal and Regulatory workgroup wanted to point out that whatever model is used, there will be new relationships and the necessary legal resources will need to be available.
- Although there are concerns and issues in each model, the Legal and Regulatory Workgroup favors Model I for near-term implementation. They also believe, however, that Model III—if successful—would be better suited for a nationwide implementation of eCR
- Regardless of which model Digital Bridge uses during the 2017 implementation phase there will be lots to learn.
- The three models aside, the planned use of a comprehensive, nationwide trigger set for eICR provisioning may present legal challenges in those instances where a healthcare provider sends an eICR for a case that is not reportable in a neighboring jurisdiction, and not reportable in their clinic's jurisdiction.
- It should be said that any model that would have the DSI sign thousands to millions of documents is not scalable. The Digital Bridge needs to explore how this burden can be reduced. Exploring technical and legal options for Model II, as well as learning more about Model III are necessary steps moving forward.

Governance Motion: *Model I and II will be provided as options for eCR implementation sites to use. Digital Bridge intends to explore technical and legal solutions that address feasibility and scalability issues. Scott Becker (APHL) motioned, Walter Suarez (Kaiser) seconded. Motion passed unanimously; no objections, and no abstentions.*

- Notably, there may be technical solutions for the legal and regulatory challenges inherent to the present Digital Bridge approach to eCR. For example, trigger code sets could be native to healthcare data systems, or processes could be used to anonymize an eICR and identify an eICR record if and only if case criteria are met, or query methods could be used. The legal and regulatory implications for different technical approaches to eCR should be investigated during the Digital Bridge eCR implementation phase in 2017 just in case it should be learned that the selected technical approach is not feasible for nationwide implementation. .

6 – eCR Implementation: Plan, Sites and Evaluation

Jim Jellison described the preliminary plan for phase 3 implementation, and summarize the applicants for Digital Bridge eCR implementation. Implementing the eCR approach that Digital Bridge has characterized and documented will the the focus of project phase 3. The timeline, February 2017- January 2018, is highly aggressive. Adjustments will likely need to be made as the realities of implementation are revealed and lessons are learned., Evaluation will be a key component of phase 3. Seven applicants submitted complete applications by the deadline: two local and five state jurisdictions; site application presented with different vendors and health care providers types (e.g., hospital systems, outpatient, etc.). Based on a cursory review of the applications, rural settings and mixed jurisdictional sites seem to be under represented. A second round of applications may need to be opened in order to obtain a sufficiently diverse and representative cohort for generalizability purposes.

Discussion of applicants and timeline

- The timeline should be sensitive and perhaps leverage the opportunities that national conferences offer for convening the implementation sites

- Evaluation data collection should happen throughout phase 3; from beginning to end. It should That would help us to learn what it costs to implement eCR. Data collection doesn't have to be highly detailed or intensive, but it does need to be deliberate and calibrated to answer useful questions.
- There may be as many as another dozen or so sites that would have liked to submit applications—based on inquires PMO received before and during the application period. When considering whether to open for another round of applicants there are two things to consider: 1.) The goal is to get a representative collection of sites that would include state/local, urban/rural and HIE/no HIE; and 2.) The capacity the DSI (which is planned to be hosted on APHL's AIMS Platform) will have for on-boarding, testing and production.
- As it regards the legal and regulatory aspects of on-boarding, the most APHL is presently prepared to handle up is ten sites, but this could be much less if the legal and regulatory agreements delay or require extensive negotiations. Notably, the applicant set are mostly agencies that APHL has already worked with.
- Deciding whether to have a second round of applications based on an impulse to be inclusive maybe misguided. Given the need we are looking at and striving to fulfill, the decision should be made by what ultimate success in establishing eCR will look like.
- We will try to hold ten sites; we will accept these seven; we will open up a second round targeted to partners on the governance body; and we will recognize that while we have a tight timeline, learning is a critical component of this, so if there is some learning we could do on a less aggressive timeline, it's worth doing. What we would see as success is that we will have ability to apply trigger codes in the EHR, and it would identify a record sent to the DSI. The DSI can adjudicate that based on the trigger code; the messages can go back to the health department and then back to the health care provider.
- The application process is already an opportunity to learn: For example, the impediments to applying include:
    - The jurisdictional health department had already finalized their priorities for FY 2017.
    - The health-care systems maybe limited in resources due to dramatic business re configurations; e.g., mergers and acquisitions.
    - From a vendor perspective, the challenge was aligning their work with the proposed timeline. They're not at a point of readiness to meet the current timeline.
    - The biggest issue is timing both in terms of internally being able to achieve the level of support to do the implementation, and also the time that it would take for us to incorporate into their system and installing that process in one of our regions.
- Regarding evaluation:
    - The evaluation needs the governance body's input on the goals, objectives and methods.
    - The evaluation could be divided into categories: process evaluation metrics (process of on-boarding an entity, steps, what can be simplified, the legal aspects, etc.) and then the actual execution itself of triggers and other elements intrinsic to the system (process of feeding in and consuming triggers).
    - A possible metric or observation to make: What cases we captured that we wouldn't have in our current system of reporting?
    - PMO will outline detailed evaluation plan for governance body feedback.

7 – Candidates to fill Governance Body Vacancy

Charlie Ishikawa reviewed the charter amendments made as a result of the 1/12 governance body decision regarding processes for filling vacancies on the governance body and workgroups. University of Nebraska Medical Center recently withdrew from the Digital Bridge project, and the governance body discussed criteria and candidates for a replacement.

Discussion and feedback

- Because the criteria will be ongoing, don't exclude places that serve smaller populations, and don't exclude places that are not implementation sites because they could be beneficial to guiding the governance body. It would be good to have their feedback with challenges from not being able to implement eCR.
- We could include organizations that are more safety net-focused (e.g., the National Association of Community Health Centers, primary care organizations)—particularly those that represent a larger population of communities in global health.

- Retail clinics like CVS could be helpful. There is value in getting support whether it is AFP or whoever because that could help marketing efforts. Also consider groups that could help with congress (like the American Academy of Pediatrics).
- One large clinical group that could be part of the safety net is OCHIN. There is also a benefit in including trust networks like Sequoyah, etc.
- The next step is to poll the governance body. The PMO will send out a survey and everyone will vote for their top three choices. We will distill that list to a final three to do some outreach to determine interest. A decision on the selection will be made at the next meeting.