Meeting Minutes

Digital Bridge Collaborative Body

Meeting Information

Date:	September 10, 2020	**Location:**	Zoom; Meeting ID: 868 8707 9223
Time:	12:00 – 1:30 PM ET	**Meeting Type:**	Virtual
Called By:		**Facilitator:**	John Lumpkin
Timekeeper:	Samantha Lasky	**Note Taker:**	Neha Agrawal
Attendees:	See attached		

Agenda Items		Presenter	Time Allotted
1	Call to Order and Roll Call	John Lumpkin	12:00 PM
2	Agenda Review, Approval, and Conflict of Interest Declarations	John Lumpkin	12:05 PM
3	Consent: January virtual meeting	John Lumpkin	12:08 PM
4	Background information on Use Case Project Statement Forms and evaluation	Vivian Singletary	12:10 PM
5	Newly Reportable Conditions using eCR Infrastructure Workgroup Use Case Project Statement Form presentation • Discussion and Q&A • Vote to approve workgroup moving forward	Priyanka Surio (ASTHO) and Lesliann Helmus (CDC)	12:15 PM
6	Immunization Registries Workgroup Use Case Project Statement Form presentation and update • Discussion and Q&A	Malini DeSilva (HealthPartners)	12:45 PM
7	Discussion – capacity for workgroups moving forward	John Lumpkin	1:00 PM
8	eCR update	Laura Conn	1:10 PM
9	Announcements and next steps	Laurie Call and John Lumpkin	1:25 PM
10	Adjournment	John Lumpkin	1:30 PM

Decisions

1	The Digital Bridge IZ Workgroup will not move forward with its use case at this time; Workgroup will continue to monitor progress of IZ Gateway project and reduce its cadence of meetings. Motion by Malini DeSilva; seconded by Bob Harmon; verbal vote taken, all “ayes,” no “nays” or abstentions.
2	The Collaborative Body will provide a recommendation to the Newly Reportable Conditions workgroup at its November 5 meeting, after hearing from the remaining two workgroups. The Newly Reportable Conditions workgroup will pause its work until then.

New Action Items		Responsible	Due Date
A.	Feedback form on Digital Bridge communications	Collaborative Body	9/21/2020

Other Notes & Information

1. **Call to Order** – Quorum was met.
2. **Agenda Review and Approval and COI Declarations** *(John Lumpkin)* –
    A. John Lumpkin welcomed the Digital Bridge Collaborative Body to its third meeting of 2020.
    B. There are no abstentions or changes to the agenda.
3. **Consent: January virtual meeting** *(John Lumpkin)* –
    A. Executive Committee decided that the safest approach is to have a virtual Collaborative Body meeting in January, as most likely travel will not be safe at that time, regardless of a vaccine release.
    B. There was no further discussion and this item is documented as approved by the Collaborative Body.
4. **Background information on Use Case Project Statement Forms and evaluation** *(Vivian Singletary)* **–**
    A. During the January 2020 in-person Collaborative Body meeting, participants incubated potential use case ideas and identified 4 potential use cases for scoping including:
        - Newly Reportable Conditions using eCR Infrastructure;
        - Immunization Registries;
        - Cancer Registries; and
        - NHSN Reporting of Healthcare Acquired Infections by Skilled Nursing Facilities

    B. A fifth workgroup was formed to develop a white paper on Public Health Application Programming Interfaces (API).
    C. From February through April 2020, the Scoping Methods Workgroup convened to propose a method/template for new use case development that resulted in the Use Case Project Statement Form. The form includes the use case name, statement of problem, description of the basic elements of the use case and data flow, users, technical standards and interoperability, inputs, outputs, stakeholders, benefits and value of use case, critical milestones and timeline, evaluation approach, costs, lists of risks, and sponsor information.
    D. In May 2020, the Collaborative Body approved charges for each workgroup. Per the bylaws, in June Dr. Lumpkin appointed workgroup Chairs and in July workgroup members were appointed. The intention was for all workgroups to use the Use Case Project Statement Form to "scope" the potential use case and present the proposed use case to the Collaborative Body for consideration.
    E. The Executive Committee provided an initial review of the draft Use Case Project Statement Forms prior to the workgroups presenting them to the Collaborative Body. Workgroups were asked to submit the Project Statement Forms to the Executive Committee at least one week prior to the Executive Committee meeting preceding the Collaborative Body meetings.
    F. Based on work done by the Scoping Methods Workgroup, an evaluation form was developed. The Executive Committee used this form to evaluate clarity and completeness of each section of the Use Case Project Statement form.
    G. Feedback from all Executive Committee members is then compiled by IPHI and discussed at the Executive Committee meeting. Results of the discussion and feedback on the Project Statement Form drafts are shared with the workgroups to consider and finalize their work prior to submitting one week prior to the Collaborative Body Meeting.
    H. Workgroups presenting to the Collaborative Body receive a PowerPoint template to complete to present to the Collaborative Body. Following the presentation to the Collaborative Body, discussion will be open followed by voting to accept and advance the use case as is, accept and advance the use case with modifications, or decline to advance the use case.
    I. If workgroups wish to make amendments to the Use Case Project Statement Form, they should send recommended changes to staff for discussion at the next Executive Committee meeting.

5. **Newly Reportable Conditions (NRC) using electronic case reporting (eCR) Infrastructure Workgroup Use Case Project Statement Form presentation** *(Priyanka Surio, ASTHO and Lesliann Helmus, CDC)* **–**
    A. The proposed scope is to use eCR infrastructure for newly reportable and non-reportable conditions of public health importance.
    B. Define the requirements of a centrally maintained decision support tool to filter reports from EHRs based on event, data type, and authorized recipient. Examples of how we could leverage eCR (not use cases):
        - Reporting of Parkinson's disease to Parkinson's disease registries
        - Reporting of attempted suicides or actual suicides to State Mental Health Authorities
        - Post marketing surveillance of adverse effects from COVID-19 vaccine
    C. Scenarios for Consideration
        - Only reportable or newly reportable conditions within the Public Health purview
            - Understand there is an existing infrastructure for this with adding new conditions and authorizing them in Reportable Condition Knowledge Management System (RCKMS) but would want to make sure that is rapid. And if conditions are reported to other entities like registries, this use case would expand to include that.
        - Additional reporting within the Public Health purview
            - These could be conditions that are reported to other agencies within a state, but would have significance to public health
        - Conditions to be reported to non-Public Health authorities
            - Would get outside public health here and explore reporting to a federal level; e.g. post-marking surveillance of adverse effects from COVID-19 vaccine could get reported to the FDA.

Discussion:

A. **Priyanka Surio:** Should the scope of this workgroup be reportable conditions within the public health purview, additional reporting (non-reportable that are currently collected through registries or other means) within the public health purview, or conditions to be reported to non-public health authorities? These are not necessarily exclusive. We also welcome feedback on looking at multiple layers.
B. **John Lumpkin:** When I saw the architecture in slide 17, I was struck by including the new filter function once the data had been sent. There is a notice of reportability that is sent back from the DSI that goes back to the provider. Had you considered if that would trigger the specific data that would be required rather than it all sent in the initial data dump?
C. **Richard Hornaday** *(Allscripts)***:** Already included in the initial capabilities. Providers would be focused on what is reported. When we do the requirements, we will make it seamless on the backend.
D. **Lesliann Helmus:** All of the decision support is on the public health side.
E. **Laura Conn** *(CDC CSELS)***:** Parkinson's is reportable and already using the current eCR infrastructure.
F. **Priyanka Surio:** Parkinson's is not reportable in all states.
G. **Laura Conn:** If it's not reportable then the jurisdictions don't have a Parkinson's rule so it would be determined "not reportable" for those jurisdictions.
H. **Priyanka Surio:** Our intent is to explore that option and what we would do for non-reportable.
I. **Scott Becker** *(APHL)***:** There may be liability for whoever does the "filtering."
J. **Priyanka Surio:** This is something that has come up in terms of who would champion this use case.
K. **Hilary Heishman** *(RWJF)***:** What implications might these 3 options have for information that could be fed back to the healthcare settings/EHRs?
L. **Priyanka Surio:** There is an opportunity to explore what could be generated as a reportability response.
M. **Richard Hornaday:** Right now, not expecting anything to come back to the healthcare setting/EHR, from the three scoping options. Those actions are driven by actions from the public health agency. Seeing that data coming from eICR is robust enough that there is not a need to get additional clinical information that was needed when it was coming from a fax. If there is something needed by one of

these other recipients, it would be an end-to-end application rather than intermediary management. Keep in mind that this is all happening behind the scene for the clinician.

N. **Bob Harmon** *(Cerner)***:** Spoken to IMH and right now they are holding those and not getting them out to the clinician level. Perhaps sharing them with infection prevention/control. The Utah DOH is also filing those reportability responses and working otherwise from the eICR. For our clients, their top priority is the required reporting conditions since they have many competing priorities. Other opportunities are important but may be a harder sell.

O. **Laura Conn:** Program level filtering would vary within PHAs so not sure how to handle centrally.

6. **Immunization Registries Workgroup (IZ) Use Case Project Statement Form presentation and update** *(Malini DeSilva, HealthPartners and Dan Chaput, ONC)* –

A. Malini DeSilva provided an initial overview of the workgroup's decision. This workgroup is pausing discussion at this time due to work loads, time constraints.

B. The initial charge of the IZ workgroup was to investigate, deliberate, and recommend collaborative work that advances information exchange capabilities for clinical immunization practices (e.g., alerting clinicians to vaccines due for pediatric patients) in alignment with the Digital Bridge mission.

C. The importance of having bi-directional data sharing was talked about at the January 2020 in-person meeting. The idea was to see what they could do to further this data exchange across jurisdiction lines.

D. During the initial workgroup meeting on July 13, the group discussed a high-level overview of the workgroup's tasks over the next two months. Workgroup members decided to meet weekly in order to accomplish tasks. The next two meetings were dedicated to hearing from stakeholders currently working on immunization registry data exchanges including the IZ Gateway and the Immunization Integration Project (IIP) as well as to identify gaps in existing projects where Digital Bridge may be of best use. After the first three meetings workgroup members had decided that currently, supporting existing work of the IZ Gateway made the most sense for the use case because that project is doing much of what this workgroup had been charged with. The group also discussed future ideas about how Digital Bridge may be able to improve the provider-initiated multi-jurisdictional data exchange. After the August 10 meeting a subgroup worked on the draft use case and it became clear based on feedback from other workgroup members that what had been written was not representative of the entire group. During the August 17 meeting the workgroup discussed how to alter the use case.

E. Malini reviewed the use case that was submitted to the Executive Committee. A brief overview of the scope includes:

- Ensure provider-initiated multi-jurisdictional data exchange can be successfully operationalized by providers (including EHRs) by:
  - Supporting the CDC IZ Gateway, by serving as a convening body to assist in the coordination and advancement/implementation of public-private immunization data exchange efforts, in particular, efforts to exchange data across multiple jurisdictions in order to increase utilization of IZ Gateway.
  - Supporting existing collaborative efforts to advance IIS-EHR exchange
  - Supporting provider and EHR implementers of IZ Gateway submission and queries by recommending standardized onboarding to ensure best practices are followed and allow for ease of integration into clinical workflows.
  - Continue to identify gaps left unaddressed by IZ Gateway in order to support use and uptake of multi-jurisdictional Immunization data exchange.

F. It was noted by the Executive Committee that the use case did not address a specific problem or provide a rationale for the value that Digital Bridge would have at this time. The Executive Committee requested that the workgroup further explore IZ Gateway's interest in Digital Bridge. The workgroup focused on supporting the work of IZ Gateway and collaborating with existing efforts. During its meeting on August 24, the workgroup decided to wait until IZ Gateway is operationalized and explained this decision to the Executive Committee.

G. Dan Chaput (ONC) provided a brief overview of the IZ Gateway project. IZ Gateway has a portfolio of projects including connecting national provider organizations to multiple IIS'. It was originally conceived

to form this share function, IIS to IIS. A newer function is the Provider-initiated Multi-Jurisdictional Data Exchange. Limited capacity to take on additional work due to the work on COVID-19 vaccinations.

Discussion:

A. **John Lumpkin:** Recommend pausing work pending a review of IZ gateway progress and evaluation of work once implemented.
   - Motion by Malini DeSilva; seconded by Bob Harmon; verbal vote taken, all "ayes," no "nays" or abstentions.

B. Digital Bridge IZ Workgroup will pause with moving forward with its use case; workgroup will work at low production and ask IZ Gateway liaison to provide updates.

7. **Discussion – Capacity for workgroups moving forward** *(John Lumpkin)* –
   A. **John Lumpkin:** We have two additional workgroups that will be reported at the November Collaborative Body meeting. We also have a work product from the API workgroup. Many of our members have been actively engaged with COVID-19 response work. We thought last January that having 4 potential use cases and a paper on the public health API was something we could handle. Do we feel the same? Or should we reduce this list down?
   B. **Bob Harmon:** Agree that reducing the number of projects/workgroups is a good idea.
   C. **Walter Suarez** *(Kaiser Permanente)***:** Recommend having time-limited and task-oriented workgroups that can be transitioned out to an operationalized and implemented project.
   D. **John Lumpkin:** What we hope comes out of the November 5 meeting is a prioritization of the work and which of the three workgroups we will focus on.
   E. **Priyanka Surio:** At this time, bandwidth is a concern. If we receive the recommendation to proceed from the Collaborative Body and have support from partners, we can pick this work up at a later time.
   F. **Lesliann Helmus:** Agree we are ready to pause.
   G. **John Lumpkin:** Barring some specific issues, the one outstanding issue is how much external entities would be willing to work on and fund this.
   H. **Walter Suarez:** Important to consider the appropriate sequencing and timing of moving the different components forward. Work should be time-limited and task-oriented.
   I. **John Lumpkin:** This will be our task in November.

8. **eCR Update** *(Laura Conn)* –
   A. Laura Conn provided an update on the accelerated implementation of eCR for COVID.
      - During the May Collaborative Body meeting she introduced the eCR Now initiative, which has become a critical tool for reporting COVID cases to state and local public agencies. Data includes travel history, medication and vaccines, patient identity and contact information, race and ethnicity, occupation, pregnancy status, and other clinical data.
      - There has been a rapid cohort-based COVID-19 eCR implementation within provider sites that have eCR enabled EHRs. In addition, the eCR Now FHIR app can be utilized for electronic case reporting. Almost everyone in the country is connected to one of these frameworks, including eHealth Exchange, Care Quality, and Commonwealth members.
      - Laura provided an update on new production implementers since the last update and ones in process, and a summary of the numbers as of September 3, 2020. 4800 facilities have implemented eCR for COVID-19. By the middle of July had all states, DC, and a number of large jurisdictions connected to AIMS to receive case reports.

Discussion:

A. **John Lumpkin:** Infrastructure that is being put in place will enable us to further interoperability as we think about pipelines for eCR.

B. **Priyanka Surio:** How are the public health agencies using that data from the COVID-19 reports in tandem with other data (e.g., from syndromic, labs)?
    - The pairing of the case reports with the lab reports have been a key activity as part of COVID. Heard from Utah that case reports are coming in real time and can immediately begin contact tracing and public health work.
C. **Kathy Turner** *(CSTE)***:** It has been great to get additional clinical data in a digital form. Epidemiologists are incredibly busy and not having to make calls and conduct data entry has helped them. Also focused on the social determinants of health of the COVID burden.
D. **John Lumpkin:** Do we have a feel for how much those 1.65 million reports are coming in via eCR-enabled EHRs versus through the FHIR eCR Now app.
E. **Laura Conn:** Currently all those are coming in from eCR-enabled EHRs. Working with eCR Now vendors as well.
F. **Walter Suarez:** Has there been issues with matching accuracy within public health between lab and clinical reports?
G. **Laura Conn:** Has not heard of that issue in the eCR implementation space.

9. **Announcements and Next Steps** *(John Lumpkin and Laurie Call)* –
    A. The next Collaborative Body meeting will be November 5. Will prioritize which use cases. Will hear from SNF and Cancer Registries and determine which of the 3 use cases to move forward and in what capacity.
    B. IPHI is developing a feedback form on Digital Bridge communications, specifically the internal and external newsletters, the website, and strategic communications going forward.

10. **Adjourned.** *(John Lumpkin)*