Collaborative Body
Meeting Summary

Meeting Information			
Date:	July 8, 2021	**Location:**	Zoom; Meeting ID: 946 0656 9885
Time:	12:00 – 1:30 PM ET	**Note Taker:**	Neha Agrawal
Facilitator:	John Lumpkin	**Attendees:**	See attached

Agenda Item	Time (ET)
1. **Call to order and roll call** – John Lumpkin	12:00 pm
2. **Agenda review & approval, welcome new members, and COI declarations** – John Lumpkin	12:05 pm
3. **ExeCC workgroup update and subsequent discussion –** John Lumpkin & Joe Rogers	12:10 pm
4. **Adding new member organizations to Digital Bridge – SAS & NCHC** – John Lumpkin a. Vote to approve new members - All	12:35 pm
5. **eCR & eCR Now Update** – John Loonsk	12:45 pm
6. **Public health API white paper update** – Walter Suarez	1:00 pm
7. **IZ workgroup update**	1:15 pm
8. **Updated policy and procedures item** – IPHI staff	1:20 pm
9. **Announcements and Next Steps** – John Lumpkin	1:25 pm
10. **Adjourn** – John Lumpkin	1:30 pm

Decisions

The Collaborative Body approved the following organizations to join the Digital Bridge Collaborative Body: SAS and National Coalition on Health Care.

Meeting Summary

1. **Call to Order and Roll Call** – Quorum was met.
2. **Agenda Review and Approval and COI Declarations**
   A. John Lumpkin, MD, MPH welcomed the Digital Bridge Collaborative Body to its July 2021 meeting. Dr. Lumpkin welcomed the new organizations and representatives since the last Collaborative Body meeting: OCHIN, SHIEC, American Cancer Society (ACS), NAACCR, The Sequoia Project.
      - North American Association of Central Cancer Registries (NAACCR)
        - Sector: Public Health
        - Representatives: Betsy Kohler – Executive Director (Primary), Randi Rycroft - President of NAACCR (Alternate), and Stephanie Hill – Associate Director (Alternate)
      - OCHIN
        - Sector: Healthcare
        - Representatives: Jennifer Stoll - EVP Government Relations & Public Affairs (Primary), Paul Matthews – CTO and CISO (Alternate), and Sylvia Trujillo - Director, Advocacy and Policy (Alternate)
      - Strategic Health Information Exchange Collaborative (SHIEC)
        - Sector: Healthcare
        - Representatives: Lisa Bari – CEO (Primary) and Melissa Kotrys - SHIEC's Board Chair and the CEO of Health Current (Alternate)
      - The Sequoia Project
        - Sector: Public Health
        - Representatives: Didi Davis – VP, Informatics (Primary), Debbie Condrey – CIO (Alternate), and Mariann Yeager – CEO (Alternate)
      - American Cancer Society
        - Sector: Public Health
        - Representatives: Hyuna Sung - Principal Scientist, Cancer Surveillance Research (Primary)
        - Note, American Cancer Society will be a non-voting member

   B. Jeff Engel has retired from CSTE and the Collaborative Body. Annie Fine (Sr. Director for Science, Surveillance and Data Modernization) will serve as a new Alternate representative for CSTE.
   C. Dr. Oscar Alleyne has left NACCHO. Lilly Kan (current alternate representative) will replace Oscar as primary representative.
   D. Due to COVID-19 pandemic constraints, eClinicalWorks has elected to become a non-voting member of the Collaborative Body to help with achieving a quorum at Digital Bridge meetings.
   E. There were no abstentions or changes to the agenda. There were no conflicts of interest declared.

3. **ExeCC workgroup update and subsequent discussion** *(John Lumpkin & Joe Rogers)*
    A. Since the last Collaborative Body meeting, the Digital Bridge Executive Committee team and ExeCC workgroup co-Chairs have explored integrating the cancer registries use case with the expanding eCR architecture use case. Through this exploration have concluded that moving cancer registries forward is not dependent on generic enhancements to the eCR architecture. Therefore, the proposal and recommendation brought forth to the Collaborative Body is to bifurcate the ExeCC project into two streams of work; one is cancer registries and the second is the development of a white paper exploring the idea of a generic enhancement to the current eCR architecture to support other conditions of interest and across different types of recipients. This would be an extension and amendment of the current workgroup charge.
    B. CDC has been providing trigger codes to RCKMS for case ascertainment and cancer reporting specifications will be available in RCKMS soon. The cancer registries group hopes to leverage Digital Bridge's partnership with healthcare and industry organizations to obtain additional data elements for a more complete cancer longitudinal record for the patient / tumor. Additionally, team is planning to pilot with a few central cancer registries and look for ways to expand bidirectionality of data exchange.
    C. The second group would develop a white paper, instead of full implementation, on expanding the current eCR architecture to support other kinds of conditions in the future, for example if filtering necessary, where should filtering occur, and what are privacy concerns once you extend beyond public health purview.
    D. Joe Rogers, CDC, ExeCC co-Chair reviewed a high-level overview of the first two phases of the cancer registries project plan. Over the past few years CDC and the National Program of Cancer Registries have worked with various stakeholders to identify cancer codes that are used for case finding by data reporters to the state-based central cancer registries. These code sets are vetted by national standard setters to meet the needs of programs. RCKMS will use these trigger codes for the initial case report in EHRs or the healthcare systems they serve. The core code sets are primarily complete, with a few remaining updates needed for the expanded code lists. The core code set should be ready for testing soon. Keep in mind that the cancer surveillance community update and coordinate these reporting requirements each year through NAACCR. These code lists need to be updated each year. Also work is underway on an updated cancer surveillance position statement with CSTE as the current one is out of date. RCKMS should be able to implement the core code set soon. In the meantime will develop a test plan to ensure that implementation at pilot sites will be successful. These organizations will provide feedback on the reports and utility to their organization.
        - Phase 1 (current + ~6 months)
            - Finish and refine all cancer trigger codes required by standard setters
            - Work with CSTE and RCKMS to fully implement all cancer trigger codes
            - Cancer specifications become available in RCKMS tool
            - Testing RCKMS cancer specifications
            - Pilot test with eICRs related to cancer specifications (minimum of 1 university and 1 state). Requirement that site has worked with eCR:

- Review and refine test RCKMS cancer specifications based on pilot testing results

- Phase 2
  - Evaluation and Implementation
    - Evaluation of pilot sites
    - Establish baseline measurements at pilot sites
    - Create best practices guidance for implementation
    - Defining project sustainability

E. Member Discussion

- Do we need three-legged stool (i.e. healthcare system, EHR vendors, and state), as was used in eCR? When will there be more details on pilot sites?
  - California and Kentucky have relationships with vendors and healthcare organizations.
- Several members expressed support for bifurcation of workgroup into two streams of work.
- Will there be a legal/policy group for this work?
  - eHealth Exchange is a network network which has 300 gateways to exchange data between federal and non-federal entities; partnered with APHL and have in production exchange of data (specifically lab reports). If eHealth Exchange would be considered as a partner, there is already a policy in place. Connected to four federal agencies currently.
  - Because cancer reporting is required by law at state level and HIPAA supports it in conjunction with that, and policy framework aligns with eCR, there is a great fit with trust networks already in place which includes eHealth Exchange. A distinction is between non-reportable conditions and reportable conditions.
  - Add to cancer registries task list: how are security concerns addressed?
- What does implementation look like for cancer registries? Would this be a requirement or effort to have all cancer registries participate?
  - There is a project underway that is moving reporting to a cloud-based system. Those reports would be used for case finding and consolidating into the longitudinal record. The goal is to move towards that direction. Most or all cancer information will end up in EHRs; to utilize the EHR as much as possible will be very beneficial.
- Regional and statewide HIEs can participate in this work as well, in addition to the national networks and frameworks.
- Many cancer registries/immunization registries are connected to their local HIE or statewide HIEs. This creates great synergies for those HIEs that are also part of a national network like the eHealth Exchange and CommonWell.
- Experience with cancer registries that staff have access to the HIE medical record and can look records up one at a time, but data do not flow automatically.

- Next step: will bring revised workgroup charge to the Collaborative Body for a more formal approval at the next meeting.

4. **Adding new member organizations to Digital Bridge – SAS & NCHC** *(John Lumpkin)*
   A. SAS reached out to IPHI recently with the potential to collaborate or become a part of the Digital Bridge. Dr. Lumpkin nominated SAS for Digital Bridge membership.
      - SAS is the leader in analytics. Through our software and services, we inspire customers around the world to transform data into intelligence. Our curiosity fuels innovation, pushing boundaries, challenging the status quo and changing the way we live. SAS is committed to providing epidemiologic subject matter expertise on nationally-notifiable conditions, as well as technologic knowledge on developing exchanges with EHR systems for integration into public health registries. SAS has prioritized Public Health Modernization as a key initiative among its US government divisions. SAS technology has expanded to support enterprise data solutions, investigative case management, and of course, analytics. SAS' mission is to empower and inspire with the most trusted analytics.
   B. Bob Harmon met with NCHC to discuss potential collaboration and nominated NCHC for membership.
      - The National Coalition on Health Care (NCHC) was formed more than two decades ago to help achieve comprehensive health system change and was led by John Rother until his recent retirement. While a CEO search is being developed, it is currently led by Interim CEO Shawn Martin, CEO of the American Academy of Family Physicians, and Board Chair Jack Lewin MD, CEO of Lewin and Associates LLC. The NCHC aims to be a leader in promoting a healthy population and a more effective, efficient and responsive health system that provides quality care for all. NCHC is a nonpartisan, nonprofit organization of organizations. Our growing Coalition represents more than 80 participating organizations, including medical societies, businesses, unions, health care providers, faith-based associations, pension and health funds, insurers, and groups representing consumers, patients, women, minorities and persons with disabilities. Collectively, our organizations represent, as employees, members or congregants, more than 150 million Americans.

The Collaborative Body approved the following organizations to join the Digital Bridge Collaborative Body: SAS and National Coalition on Health Care. Motion by Bob Harmon; seconded by Walter Suarez; verbal vote taken, all "ayes," no "nays" or abstentions.

5. **eCR & eCR Now Update** *(John Loonsk)*
   A. See slide deck for corresponding presentation.
   B. 8880 reporting facilities and growing. All Digital Bridge industry partners are working on implementation.
   C. Member Discussion:

- Encourage the group to evolve the thinking to refer to "health IT" data or something similar; seeing more data sources than EHRs and it will rate-limit the growth and dissemination of eCR for syndromic surveillance.
- There are several options to report through eCR. To what extent should these options be limited to standardize how this is done? Do you think that is a good goal?
    - It is a laudable goal and target. One of the advantages of architecture is that variability does not impact healthcare system. APHL/AIMS platform can take content that is presented from clinical care, and give flexibility to public health as technologies are evolving e.g. from CDA to FHIR. Public health agencies will be in different states for some time to come and eCR team wants to accommodate all to help with migration.
- Is there a sense of the distribution between FHIR-app and native implementation of CDA?
    - There is one data standard. Clinical world moving to FHIR. All eICRs are HL-7, CDA 1.1. Some are done natively within EHRs and some are done via FHIR app.
- To what extent are there still barriers to public health agencies leveraging eCR data or prioritizing using eCR for their reporting?
    - eICR can be delivered via HTML. That is not the goal for access; integration into surveillance system is next level. In ideal world, all data from eICR are usable in native form. Some have achieved this but not all. Coming out of COVID, there are a number of PHAs rethinking systems.
- Trying to work with healthcare systems to minimize interfaces.
- Health departments are at very different stages in terms of being able to use the eCR data and integrate them into their surveillance systems so that they can be used/analyzed/managed. It is not necessarily simple for all jurisdictions.
- The reporting via a HIE to a registry may not remove the provider burden of mandatory reporting to the jurisdiction. The HIE may not be contractually obligated to report to PH on behalf of the provider. This is an area that we have found is not always clear in HIE participation agreements.
- Staff at health departments are so stressed and overworked due to COVID that I think it has been hard to find enough trained staff time to do the authoring that is needed for the 108 conditions. Additional funding is needed for a sustained public health workforce to be able to do this work.
- Centralizing the development and maintenance of rules will create a larger pool of trained staff and improve the consistency of data delivered.
- Early on in implementation, rapid conversion predominantly came from larger healthcare systems. Has there been a change in that pattern?
    - EHRs prominent in ambulatory care have been coming to table and are part of hub-based model where many ambulatory providers come together. Still it is more larger providers versus smaller ones.

- There is a list of smaller organizations that want to participate in eCR; there is demand, but in phase where vendors are building their technological capacities.

- Now that CSTE has over 100 reportable conditions, is there good uptake from healthcare and public health?
  - Matter of coordinating interest on healthcare system and principal public health agency to do it. Public health agencies are in different stages of authoring process. Healthcare systems that use app have to make a configuration change, which can happen fast. For others they have to add codes. 108 number includes nationally notifiable conditions and conditions that are specific to select states.

6. **Public health API white paper update** *(Walter Suarez)*
   A. The purpose of this workgroup is to develop a Public Health Application Programming Interface (API) white paper to serve as a reference and provide information to public health professionals as they investigate developing and implementing a Public Health API strategy for their organizations. The Collaborative Body approved the paper as version 1.0 at its 2021 January meeting and a second round of public comments concluded in June.
   B. Did not receive a lot of comments from second call for public comments, but did receive positive feedback from those that did submit. Workgroup will meet on Thursday, July 15th to discuss the comments and finalize the paper.
   C. Next steps: profiling a few examples of API implementation from public health agencies.

7. **IZ workgroup update**
   A. The Immunization Registries workgroup was started in 2020, prior to the COVID-19 pandemic. This workgroup was charged with investigating and recommending collaborative work that advances information exchange capabilities for clinical immunization practices (e.g., alerting clinicians to vaccines due for pediatric patients) and promoting bidirectional data exchange between state immunization information systems (IIS) and healthcare provider's electronic health records. One of the areas the Immunization Registries workgroup identified as important was interstate IIS data transfer. Although there were initially a number of barriers identified, COVID-19 vaccine reporting requirements combined with the IZ Gateway have addressed a number of these barriers. This workgroup has been meeting bi-monthly since January 2021 to stay abreast of the progress of IZ Gateway and other immunization information system initiatives. Workgroup members will identify potential gaps they could fill in the future, but active work is on pause for now. IZ Gateway management has changed, and the ownership now resides with CDC. Have requested to CDC for an update on IZ Gateway this Fall.

8. **Updated policy and procedures item –** *(IPHI staff)*
   A. The origin of this agenda item comes from a request we received from a Digital Bridge member for a letter of support for its organization's application to a grant. As there is nothing in the

Digital Bridge bylaws on letters of support from Digital Bridge as a collective group, we discussed this with the Executive Committee. The discussion was that to preserve collaborative, Digital Bridge should remain neutral. Digital Bridge works on consensus and members may be competing on grant opportunities. And there was consensus amongst the EC that Digital Bridge should not write letters of support for individual members' grant applications but can verify / document that member is a member in good standing. This change would not be part of the bylaws, but rather an updated policy and procedures item.

B. The intent of IPHI and Digital Bridge will be to operate with this new policy item moving forward.

9. **Announcements and Next Steps** *(John Lumpkin)*
   A. Next Collaborative Body Meeting: October 7.

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