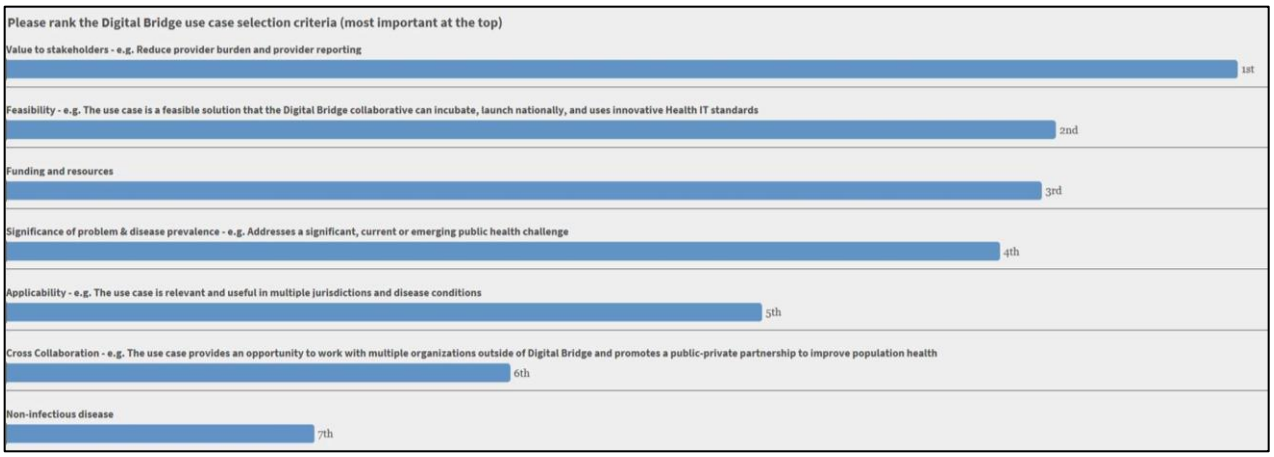
digital bridge

In-Person Governance Body Meeting Summary

January 23-24, 2019

Contents

Grouping	"Digital Bridge will enable me to…"	Attribution
Promoting adoption	… *ASTHO members to participate in a national effort to advance population health*	Mary Ann Cooney
	… *Promote the adoption of eCR and future use cases among Cerner clients and beyond*	Bob Harmon
Connecting disparate systems and cross-sector collaboration	… *Connect multi-sector partners to work on solving problems in health IT*	Vivian Singletary
	… *Enable eCR via simplified universal interconnected to a single entity to reach all public health agencies*	Richard Hornaday
	… *Make data exchange more efficient and feasible*	Bill Mac Kenzie
	… *Engage with all stakeholders to work with and learn from one another to develop a scalable approach to public health initiatives*	Dan Chaput
	… *Contribute to building an infrastructure to enable the collection of interoperable health care data to improve public health*	Monique van Berkum
	… *Showcase our organization's contribution to a broader public health and clinical interaction*	Scott Becker
	… *Work more efficiently with healthcare and health IT developers*	Bill Mac Kenzie
Providing better care and improving public health	… *Improve the public's health, unlock the data*	Brian Castrucci
	… *Provide better care to my patients*	Rich Paskach
	… *Collaborate across boundaries to improve healthcare and be confident someone is herding the cats.*	James Doyle
	… *Find mutual needs and solutions with my peers in public health*	Rich Paskach
	… *Feel like we have made a positive contribution to public health in the US*	Andy Wiesenthal
	… *Meet our goal that public health, health care work together to meet people's goals and needs*	John Lumpkin
Reducing burden/efficiency	… *Reduce provider burden*	Shan He
	… *Improve health data without increasing burden*	Chesley Richards
	… *Improve the reporting burden and experience for healthcare providers*	Monique van Berkum
	… *Provider perspective: find more efficient and effective ways to exchange health information with public health*	Walter Suarez
Policy and systems	… *Advance the use of policy and systems-driven solutions in health technology*	Oscar Alleyne
	… *Better support development of new policies*	Dan Chaput
	… *Better support eCR certification for eCR incentive programs*	Dan Chaput
	… *Improve local public health departments' work and capacity in public health technology*	Oscar Alleyne
	… *Show the stakeholders what modernization of public health systems can do for services*	Jeff Engel



Executive Meeting Summary

On January 23-24, 2019, the Digital Bridge governance body met at the Task Force for Global Health (Decatur, GA) to capture lessons learned from the eCR demonstration sites, determine how to transition efforts for eCR scale-up, and decide what scaling the Digital Bridge initiative may entail. The outputs from this meeting will inform next steps for supporting eCR adoption, identifying the next Digital Bridge use case, and determining Digital Bridge governance structure transitions. Representatives from every governance body organization and special guests from the Task Force for Global Health, the Centers for Disease Control and Prevention (CDC), and Davis Wright Tremaine, LLP participated in the meeting.

Meeting presentations, discussions, and work focused on 1) realizing and applying lessons learned from the eCR demonstration sites and governance coordination to date, and 2) scaling eCR and Digital Bridge efforts, including identifying potential new use cases and determining potential transitions in roles and organizational structure. Participants learned about implementation process, lessons learned, and preliminary evaluation findings from two live sites (Houston and Utah), as well as implementation progress at six other demonstration sites. Representatives from the Digital Bridge attorney-client group presented four legal framework options for eCR services. The group also reflected on successes and opportunities for change related to use case incubation and governance coordination. Participants discussed a proposed eCR transition plan and identified key tasks and timelines related to governance, operations, communications and marketing, and workforce training. Finally, the group prioritized parameters for selecting the next Digital Bridge use case.

The meeting produced the following key items that will be used to support transition efforts for scaling eCR and Digital Bridge:

A. Priorities and interests driving participation in Digital Bridge for 2019
B. Use case incubation and governance successes and opportunities for change
C. Proposed tasks and timelines for eCR transition to scale
D. Actions governance body members will take by April 2019 to support eCR and Digital Bridge scaling and transition

In addition, the governance body preliminarily endorsed the proposed eCR transition plan (with revisions generated during the meeting) and discussed the potential addition of a new advocacy workgroup or sub-workgroup of the legal, policy, and regulatory workgroup. Discussion of new Digital Bridge use cases was limited.

As a next step, the governance body will vote on the finalized eCR transition plan in March 2019. The transition workgroup will also develop use case recommendations based on prioritization input from the meeting. Additionally, the governance body will continue defining roles and structure as Digital Bridge scales, including identifying and implementing strategies related to marketing, advocacy, and workforce.

The purpose of this document is to provide the governance body and Digital Bridge stakeholders with a record of the information presented during the meeting and a summary of meeting conversations and work. The Digital Bridge Project Management Office (PMO) will also use this document to revise the eCR transition plan and propose strategic changes to the Digital Bridge governance body organizational structure as efforts scale up.

Suggested Next Steps

Throughout the two-day governance meeting, participants suggested next steps and action items for demonstration site evaluation, eCR scaling, and scaling the Digital Bridge. These suggestions were sorted into the following three tables by the PMO after the meeting to identify tentative action timeframes and tentative ownership.

eCR Demonstration

Area	Suggested action / next step	Time frame	Tentative owner
Evaluation	Document what made it difficult for eCR demonstration sites that could not implement eCR during the demonstration period	Pre-Aug '19	Evaluation Committee

eCR Scaling

Area	Suggested action / next step	Time Frame	Tentative owner
eCR Transition	Update the Transition Workgroup eCR recommendations based on in-person meeting discussions and small group work	Pre-Aug '19	Transition Workgroup
Operations	Adapt the eCR onboarding guide that will be developed eCR implementation workgroup for various stakeholder groups, including healthcare/vendors and public health agencies	Pre-Aug '19	DSI partners and CDC
	Release a schedule for how RCTC will roll out; i.e., getting from six conditions to 74, releasing trigger codes for vendor implementation in parallel, and having public health author the rules for those conditions in summer 2019	Pre-Aug '19	CSTE
	Obtain a landscape analysis of HIEs to inform clarification of their role in Digital Bridge and onboarding guidance	Post-Sept '19	Gov. body
Legal	Create description of post-demonstration phase legal approach	Pre-Aug '19	Attorney Client Group

	Create new agreement(s) supporting post-demonstration phase legal approach		
Workforce	Consider change management approach to addressing workforce aspect of eCR scaling, including identifying competencies and communications strategy	Pre-Aug '19	DSI partners and CDC
	Include an updated applied public health epidemiologist job description in communications for eCR workforce change management approach	Pre-Aug '19	DSI partners and CDC
Communications and advocacy	Create an eCR communications suite with materials about eCR that may be used for education during opportune moments. This suite should include: A. A single source of truth website for eCR by spring 2019 (DSI) B. A business case for eCR for healthcare and public health stakeholders (PMO) C. Success stories that highlight and emphasize the business case from live sites (PMO)	Pre-Aug '19	PMO, DSI partners and CDC
	Augment the eCR marketing and communications strategy to draw in customers; i.e., parties interested and eager to implement eCR	Pre-Aug '19	DSI partners and CDC
	Develop an advocacy strategy to promote public health data policy to Congress and other stakeholders in the short term.	Pre-Aug '19	DSI partners and CDC
	Conduct an inventory of non-traditional public health partners to assist with advocacy efforts	Pre-Aug '19	DSI partners and CDC

Digital Bridge Scaling

Area	**Suggested action / next step**	**Time Frame**	**Tentative owner**
Use Case Selection	Update use case recommendations, considering input from prioritization exercise during meeting and focusing on how public health and clinical care can work together for the benefit of people	Pre-Aug '19	Transition Workgroup
	Consider using demonstration sites as testbeds for how to extend existing eCR architecture to address new use cases (e.g., Parkinson's)	Pre-Aug '19	Gov. body

Communications and advocacy	Determine whether the Digital Bridge brand can be used by other organizations for marketing and advocacy purposes	Pre-Aug '19	Gov. body
	Develop a Digital Bridge mission statement that expresses the partnership's benefits and goals	Pre-Aug '19	Gov. body
	Identify critical partners and health data connection initiatives for the partnership to engage as Digital Bridge scales	Pre-Aug '19	Gov. body
	Develop plan for a federal infrastructure fund for long term sustainability	Post-Sept '19	Gov. body

Meeting Overview

Background

The Digital Bridge is an innovative collaborative that brings together key decision makers in health care, public health and health IT to solve information exchange challenges. The vision of the Digital Bridge is to ensure our nation's health through a bidirectional information flow between health care and public health. Since its creation, many of the Digital Bridge's accomplishments have been met; one of the greatest being forming the governance body and working together. As its first project, Digital Bridge has designed a nationally scalable, multi-jurisdictional approach to electronic case reporting (eCR), the automated generation and transmission of case reports from the electronic health record (EHR) to public health agencies for review and action.

The Digital Bridge Governance Body In-Person Meeting summarized in this report was held on January 23-24, 2019 at the Task Force for Global Health (Decatur, GA). This meeting marks significant progress for Digital Bridge. In January 2018, the group was discussing the concept of the first pilot, and now stakeholders have been engaged and there are two live pilot sites. In-kind contributions from members now reflect over 20,000 hours (2.3 years) since June 2016.

Future milestones include the upcoming transition to scale-up eCR efforts and evolving Digital Bridge to support the next use case. The purpose of this in-person meeting is to capture lessons learned from eCR pilot sites and focus on transitioning to scale, both with eCR and Digital Bridge. Additional topics for future discussion are summarized in the "Bike Rack" table (Appendix 6).

Meeting Objectives

1. Identify and document lessons learned from the eCR pilot sites
2. Determine what the Digital Bridge will do to further promote eCR adoption post-pilot work
3. Determine what sponsors and stakeholder groups to engage for the next Digital Bridge use case
4. Identify issues to consider in redesigning governance given transitional eCR and use case decisions

Meeting Preparation

Meeting participants were asked to prepare for the meeting by completing the following tasks:

1. Revisit the pledges made during the in-person meeting in January 2018
2. Come prepared to share lessons learned from the initial use case, and what their organization will do for scale-up
3. Review and comment on the preliminary eCR Transition Recommendations
4. Complete brief pre-meeting survey on expectations and use case prioritization criteria

Attendance

Name	Organization
Sponsors	
Laura Conn	CDC
Michael Iademarco	CDC
Bill Mac Kenzie	CDC
Chesley Richards	CDC
Brian Castrucci	de Beaumont Foundation
John Lumpkin	Robert Wood Johnson Foundation
Public Health	
Scott Becker	APHL
Michelle Meigs	APHL
Patina Gagne	APHL
Mary Ann Cooney	ASTHO
Priyanka Surio	ASTHO
Jeff Engel	CSTE
Meredith Lichtenstein Cone	CSTE
Daniel Chaput	HHS/ONC
James Daniel	HHS
Oscar Alleyne	NACCHO
Health Care	
Monique van Berkum	American Medical Association
Shan He	Intermountain Healthcare
Richard Paskach	HealthPartners
Walter Suarez	Kaiser Permanente
Health IT	
Richard Hornaday	Allscripts
Monica Coley	Cerner
Bob Harmon	Cerner
Tushar Malhotra	eClinicalWorks
Pallavi Tummala	eClinicalWorks
Christopher Alban	Epic
James Doyle	Epic
Joe Wall	Meditech
Special Guests	
Kathy Bruss	CDC
Charles Shepherd	CDC
Adam Greene	Davis Wright Tremaine
Patrick O'Carroll	Task Force for Global Health

Name	Organization
Dave Ross	Task Force for Global Health

PMO	
Rob Brown	Deloitte
Benson Chang	Deloitte
John Stinn	Deloitte
Andy Wiesenthal	Deloitte
Charlie Ishikawa	Kahuina Consulting
Lura Daussat	PHII
Piper Hale	PHII
Jim Jellison	PHII
Jelisa Lowe	PHII
Jim Mootrey	PHII
Vivian Singletary	PHII
Natalie Viator	PHII

Note: All participants were present for both days of the in-person meeting.

Meeting Agenda

Wednesday, January 23, 2019 - Day 1

"Realizing and applying lessons learned."

TIME	AGENDA TOPIC
8:30 AM	Breakfast
9:15 AM	Welcome and meeting orientation
9:30 AM	Big Picture Refresh *Revisit accomplishments, and refresh the partnership's motives and interests*
10:00 AM	eCR Demonstration Insights • *Live implementation experience: Houston and Utah* • *Early evaluation findings (Jeff Engel and Lura Daussat)* • *Discussion of live implementations (John Lumpkin)* • *Demonstration progress at all sites (Laura Conn, Rob Brown, and Benson Chang)*
12:30 PM	Working lunch [eCR Demonstration Insights cont'd] • *Lessons applied to completing demonstrations (APHL and CSTE)* • *Legal framework for eCR services (Adam Greene and Natalie Viator)*
2:00 PM	BREAK (30 MINUTES)
2:30 PM	Lessons learned for the Digital Bridge mission *For future efforts, identify what has worked well, and what should change to improve or enhance use case incubation and governance work*
4:00 PM	Scaling eCR discussion – Part 1: Response to preliminary report *Review and discuss governance body responses to the Transition Workgroup's preliminary eCR transition recommendations in preparation for day 2 work*
5:00 PM	Day 1 wrap-up, and preview day 2
5:30 PM	End meeting day 1
6:15 PM	DINNER RECEPTION| Location: Parker's on Ponce, 116 E Ponce de Leon Ave, Decatur

Thursday, January 24, 2019 - Day 2

"Deciding a transitional course and strategizing on the next problem to solve."

TIME	AGENDA TOPIC
9:00 AM	Breakfast
9:30 AM	Reconvene
9:45 AM	Scaling eCR discussion – Part 2: Closing gaps and reaching consensus *Working session to close gaps in the recommendations, reach consensus on focal issues, and endorse a plan for what the Digital Bridge will do to transition from demonstrating eCR to scaling-up eCR*
12:00 PM	Lunch Break
1:00 PM	Scaling Digital Bridge: The next use case *Working session to revise Digital Bridge use case selection criteria, and identify feasible use cases*
2:15 PM	Discussion of emergent topics on the Bike Rack
2:30 PM	Meeting summary, next steps, and closing remarks
3:00 PM	Meeting concludes

Digital Bridge Motivations and Interests: A Big Picture Refresh

Description

The objective of this 45-minute session was to reflect on interests and motives that bring Digital Bridge governance organizations together and determine how they have evolved since January 2018.

Prior to the meeting, participants prepared for this exercise by reviewing the interests and motives collected at the January 2018 in-person governance body meeting. During the meeting, participants revisited the statement, "Digital Bridge will enable me to ____." and completed the sentence on a Post-It note. Meeting guests then grouped the motives by theme (see Table 1). They shared observations and similarities and reflected on how their motivations have changed since January 2018.

Key Discussion Points

After expanding on their individual statements, participants identified and discussed the following themes across Post-It notes:

Promoting Adoption

A. State health officials need to be informed on Digital Bridge efforts, and participating sites want to know more
B. Widespread adoption of eCR and other use cases will require large effort

Cross-sector Collaboration

A. Digital Bridge as a platform to bring different sectors together to solve data problems together; a unique opportunity to collaborate in advance to establish a working infrastructure the first time; Come together to think big picture across sectors
B. Governance is essential to solving unforeseen technological problems
C. Working together can solve immense problems and make progress
D. Someone needs to do this; we should
E. If endeavor is not taken on together, it won't be successful
F. Health system is fragmented and shouldn't be; need to work together to fix the system
G. Opportunity for lab community to connect with clinical care in pursuit of a broader goal, instead of being isolated in a lab sending data
H. Expand collaboration to include health plans and other sources for public health data exchange

Providing Better Care and Improving Public Health

A. Common goal of wanting to improve healthcare
B. Foundation of eCR is providing better care to patients – need to see the faces, not just the numbers; look beyond the clinical to keep the humanity in sight
C. Vendors also want to make customers happy
D. Unlock the data to put taxpayers' investment to use and realize value
E. All three sectors have similar missions and visions; need to look at each other as peers working together on a common mission, leveraging respective strengths to improve health

Reducing Burden/Increasing Efficiency

A. Economic efficiency as well as technical efficiency
B. Reduce providers' time spent on administrative actions; provider experience affects the patient experience, and providers are frustrated with EHR
C. All stakeholders need health data, and need it to be pertinent and timely
D. Increase effectiveness of achieving better ways and better exchanges of health information with public health
E. Efforts may feel inefficient in short-term, but overall outcomes are efficient in the long-run; time investment up-front to achieve efficiency

Policy and Systems

A. The overall outcome is advancement for all our partnerships, which are health systems driven by policy and strategic thinking; these are important solutions that can help advance the state of the health system
B. Impact from vendors and public health working together upfront instead of both sides complaining after a new system is implemented
C. Digital Bridge outcomes represent technical assistance and capacity building elements to enhance local public health departments' share of the market and overall outcomes
D. Gaps in public health agencies need to be addressed to achieve scalability
E. Change from paper-based system in public health agencies is essential for monitoring the health of the population, investigating diseases early and eliminating them quickly
F. Make it easy to connect disparate health agencies with different use cases in a repeatable way; increase ease with which vendors can connect to state and local health departments, not just for eCR, but for expansions to new use cases (e.g., connecting to immunization registries)

General Observations

A. Themes address "how," "why," and "remember that too"
B. No longer a question of "if" eCR adoption will happen; rather, a question of how, how much, and how much more
C. Consider overarching Digital Bridge statement, such as, "promote human health by facilitating clinical-public health collaboration via modern ICT, as effected through a three-way partnership among clinical care organizations, public health agencies, and health technology developers/vendors"
    - Use this statement to help define future use cases instead of focusing too much on eCR
D. Adoption takes time; 50 independent states that have to agree to adopt a common infrastructure (e.g., immunization information system took states a decade to agree on one way to share data); eCR progress in two years has been much faster than immunization system implementation (similar progress over 15 years)
E. Enthusiasm and attitudes towards improving population health and individual patient health is encouraging and propels efforts forward
F. Describe Digital Bridge and eCR as a "population health" initiative, as this term is used more frequently among provider systems than "public health"

Table 1: Governance body representatives' and ex officio members' responses to the statement, "The Digital Bridge will enable me to ____." (grouped into motivations and interests)

Grouping	"Digital Bridge will enable me to…"	Attribution
Promoting adoption	*… ASTHO members to participate in a national effort to advance population health*	Mary Ann Cooney
	… Promote the adoption of eCR and future use cases among Cerner clients and beyond	Bob Harmon
Connecting disparate systems and cross-sector collaboration	*… Connect multi-sector partners to work on solving problems in health IT*	Vivian Singletary
	… Enable eCR via simplified universal interconnected to a single entity to reach all public health agencies	Richard Hornaday
	… Make data exchange more efficient and feasible	Bill Mac Kenzie
	… Engage with all stakeholders to work with and learn from one another to develop a scalable approach to public health initiatives	Dan Chaput
	… Contribute to building an infrastructure to enable the collection of interoperable health care data to improve public health	Monique van Berkum
	… Showcase our organization's contribution to a broader public health and clinical interaction	Scott Becker
	… Work more efficiently with healthcare and health IT developers	Bill Mac Kenzie
Providing better care and improving public health	*… Improve the public's health, unlock the data*	Brian Castrucci
	… Provide better care to my patients	Rich Paskach
	… Collaborate across boundaries to improve healthcare and be confident someone is herding the cats.	James Doyle
	… Find mutual needs and solutions with my peers in public health	Rich Paskach
	… Feel like we have made a positive contribution to public health in the US	Andy Wiesenthal
	… Meet our goal that public health, health care work together to meet people's goals and needs	John Lumpkin
Reducing burden/efficiency	*… Reduce provider burden*	Shan He
	… Improve health data without increasing burden	Chesley Richards
	… Improve the reporting burden and experience for healthcare providers	Monique van Berkum
	… Provider perspective: find more efficient and effective ways to exchange health information with public health	Walter Suarez
Policy and systems	*… Advance the use of policy and systems-driven solutions in health technology*	Oscar Alleyne
	… Better support development of new policies	Dan Chaput
	… Better support eCR certification for eCR incentive programs	Dan Chaput
	… Improve local public health departments' work and capacity in public health technology	Oscar Alleyne
	… Show the stakeholders what modernization of public health systems can do for services	Jeff Engel

eCR Demonstration Insights

Description

The objective of this four hour session was to review status of live sites (Houston Methodist and Utah), including evaluation efforts, and discuss lessons learned from live sites and APHL/CSTE. In addition, review implementation progress at all demonstration sites and discuss legal framework options.

Meeting participants listened to a series of presentations, with group discussion following each.

1. Live Site Updates – Houston Methodist (Tai Tennessee and Josh Sol, Biru Yang) and Utah (Shan He)
2. Preliminary Evaluation Findings – Evaluation Workgroup (Jeff Engel and Lura Daussat)
3. APHL and CSTE Lessons Learned – APHL (Patina Gagne) and CSTE (Meredith Lichtenstein Cone
4. All Site Implementation Progress – Laura Conn and Rob Brown
5. Legal Frameworks – Adam Greene Following the presentations and discussion, meeting participants engaged in a "confidence check" exercise to share their thoughts on how long it will take to reach 80% of states with eCR implemented.

Updates from Live Demonstration Sites

Houston Methodist and Houston Health Department

eCR Implementation Process Details

The presenters shared the following details in response to questions from the governance body:

- For LOINC codes, the soft lab maintained codes over time; manual effort would be duplicative. Issues could be generated downstream after both Houston Methodist and soft lab make updates. Houston

Methodist was not able to implement all LOINC features in Epic; instead, they are pulling item numbers with LOINC codes embedded in them. Quest and Lab Corps were not sending information via the hospital's interface. Houston Methodist is looking to update their interface to enable use of that report and, therefore, pulling LOINC codes out of individual items and using them to trigger response.

- Houston has improved upon reporting speed and want paper to be processed the same way; it is difficult to quantify how volume has changed, but with RCKMS, the last number was 5,000 reports that went to RCKMS and AIMS, and 150 were reported to the health department.
- Houston was implementing eLR in parallel to eCR. On the eLR side, mapping to lab results, and on the other, providing technical assistance in a successful partnership.

Lessons Learned

Lessons learned were presented by Houston Methodist. Additional observations made by governance body members include:

- For legal agreements, Houston Methodist utilized their Center for Innovation as a conduit to obtain approvals and accelerate the contract. The implementation team participated in writing the standard language for the agreement.
- If the site makes eCR implementation a priority, especially on the provider side, documents will be able to move along quickly.
- No barrier due to customization; used existing infrastructure to facilitate sending messages; even though there was customization for long-term sustainability, the essential product was the same

Next Steps

Houston Methodist is working to address limitations related to interfaces with two vendors who cannot report their LOINC codes. Systems must be updated to send labs with LOINC codes and claim workflows. In addition, Houston site is planning to expand triggers and code sets, expand to other counties who can receive this info as well, and respond and update eICRs managed within EHR workflow

Long-Term Goals

Houston aims to continue expanding the system and working together to identify trigger codes impactful for public health. Their ultimate goal is to cover all of Houston and surrounding areas and truly go paperless.

Utah

eCR Implementation Process Details

The presenters shared the following details in response to questions from the governance body:

- Uses XDR to securely process all messages and log them in a structural way to monitor all events

Lessons Learned

Additional observations made by governance body members include:

- Invested in enterprise architecture that allows expanding capabilities; did not experience issues with customization because they were able to build one infrastructure to serve multiple projects with similar needs

Next Steps

Utah is currently staging messages in the production feed and mapping them to surveillance system. In addition, the site plans to process interoperability response to be able to indicate out of state reporting.

Long-Term Goals

Utah is trying to design a solution to monitor the current eCR process and wants to establish a mechanism to detect system abnormalities. In addition, the site is designing and developing time-driven methods with current event-driven approach. Utah also wants to design a scalable architecture for trigger code mapping using existing terminology server.

Preliminary Evaluation Findings

Meeting participants discussed the evaluation findings and reflected on lessons learned; observations are included in the Overarching Lessons Learned section below.

Overarching Lessons Learned

A. **Benefits from eCR implementation are worth the effort**
   - Reduces physician burden and interoperability burden
   - Enables real-time reporting and improves consistency

B. **Accelerating factors for implementation**
   - Leadership support to prioritize eCR implementation project above other initiatives
   - Low cost
   - Opportunity to be innovative

C. **No immediate impact to reducing manual reporting** – Both live sites are expanding their trigger codes and creating a seamless user experience (i.e., confirming that our LOINC, SNOMED and ICD-10 codes are accurate, and that the cases are coming in as they should and triggering automatically) before implementing workflow changes for providers

D. **Auditing is important** – Utah's system went down temporarily; they used AIMS' auditing service, and their own auditing component service supporting eICR to track what's sent out, and what AIMS is receiving. When the system was down, the messages were queued up and were recovered and processed when the system came back online. Utah's site also has system logs of what's waiting and what didn't process. Messages can be re-processed if they fail

E. **Provider experience and reportability response** – Providers can see the electronic reporting and are working in parallel with their regular workflow; not exchanging data currently, although reportability response data do exist in a chart

F. **LOINC code mapping** – Using LOINC mapping and distribution from manufacturer in labs would aid implementation and allow lab orders to work out a common solution. In addition, having information on timeline for LOINC to be updated if implementation sites fund development of something that's missing. In addition, system integration of existing mapping resources would increase efficiency

G. **Scalability of support**
   - **Live site support** – Level of resources and one-on-one demand provided to two live sites is not sustainable; need to determine how to apply lessons learned to the next five sites as a trial period for scaling
   - **RCKMS team support** – Need to determine if one scalable solution can be applied to all sites to reduce burden on support team

H. **Collaboration and communication** – Need to continue exploring approaches and tools to help various stakeholders prioritize onboarding, provide consistent information, and gather metadata to inform onboarding improvements (e.g., "single source" informational website, communication tools such as Slack)
   - **Cohort approach** – Considering a cohort approach for sites with similar attributes or implementation pace to increase efficiency and reduce support burden
     - E.g., Epic staff helping Houston will also work with UC Davis (California site), Kansas site partners are working closely with Utah for lessons learned

I. **Data routing through HISP** – HISP connection to AIMS presents issues when testing production – may end up testing in a test server or production environment (encountered with Houston Methodist, and now with New York City)

- With HISP, instead of sending data directly to AIMS, providers send data to a third-party HISP

J. **Enabling simultaneous state and local reporting –** For New York City implementation, FIH will be sending reports to New York City and New York state; need to gather ZIP codes to enable this capability. Exploring a method where ZIP code rules will be encoded, so the same reports will be sent to both jurisdictions, and they discard data if it doesn't apply

K. **California Parkinson's Disease reporting** –
   - Determined to be possible, with technical limitations. Digital Bridge decided to explore this addition in part due to a recent Act requiring CDC to conduct national neurologic conditions surveillance (Michael J. Fox Foundation was a primary driver for the legislation). This use case serves as an opportunity to resolve several technical issues related to a diagnosis trigger that will be applicable to other conditions, such as:
     - **Need ability to trigger from diagnosis,** since Parkinson's is not reportable
     - **Need ability to exclude out-of-state residents,** as requested by California due to the related reporting requirement
     - **Need to add ICD-10 codes**; determined to be minor barrier to add two codes
   - Interim solution proposed is to manually trigger an eICR to be sent to public health; some members expressed concern over this option
     - The goal for Parkinson's, MS, and other conditions may not be about public health notification; rather, about monitoring incidence and prevalence in the community. Other potential use would be for enrolling individuals in registries to join clinical trials – another potential opportunity for Digital Bridge
     - Alternate option is to add Parkinson's as the 7th condition (hepatitis C being the 6th) and add trigger codes and rules appropriately (Nevada and Utah also want Parkinson's reporting, so the additional infrastructure could be applied at these sites as well)

All Site Implementation Progress

See presentation slides for implementation progress updates for each demonstration site.

Legal Frameworks

Current Status

- DSI is in the middle, set up as a BAA under HIPAA and subject to a pilot participation agreement with providers
- No agreement set up between public health agency side and APHL because without DSI there is no contract in place between the hospital and public health authority
- Two legal agreements:
  - Pilot Participating Agreement (PPA) – specific to the pilot sites but can be modified for scale-up.
  - Business Associate Agreement (BAA) – there are requirements defined by HIPAA—the idea that APHL is acting as a service provider and will be handling information

Lessons Learned

- **Liabilities are limiting** – Discussion of legal terms around security breaches: if something happens on the APHL side, providers want indemnification, but on the APHL side, can't provide that for every provider. The issue was addressed by offering an indemnification during pilot phase that places a cap. Intermountain Health and Houston Methodist will have X amount of indemnification today, but if Digital Bridge eCR grows past 10 sites, that number will go down so APHL doesn't exceed the cap
- **Non-network agreement and a trust exchange increase efficiency** – will establish structure such that adopters check a box for eCR and another for an additional capability, and building that into the system now rather than having to develop new legal documents for each specific use case
- **Consider legal efforts related to state rules and regulations** – need to put a pattern in place for addressing this aspect

Framework Options

Legal support looked at alternate frameworks to best address different types of conditions that may raise unique issues that are not national in scope, and also considering varying reporting rates across the two live sites as well as distinguishing between what is reportable and what is not. Four options were identified discussed by meeting participants. Option 4 – keeping APHL as a BAA and join a trust network or have EHRs provide agreements – was proposed by legal support.

eHealth exchange and CommonWell have expressed interest in the trust network model. This model would mostly alleviate the indemnification issue because parties are not acting on behalf of one another and are once removed from indemnification. Regarding impact of state legislature, the greatest impact from policy change would be to require reporting; if there are no laws to require reporting conditions, then a jurisdiction reporting data to CDC or its contractors is illegal. With influence from TEFCA, the various existing trust networks are connecting together, such that if an organization joins one trust network, it will eventually also be connected to others.

In the future, Option 3 (distributed RCKMS reporting logic) will be a more ideal option once viable. In the future, alternate models will exist that won't require signing agreements or disclosing PHI, but rather directly consuming the rules from the CDS/RCKMS engine and executing them locally. FIHR or CDS hooks provide an engine that allows EHRs to consume external CDS rules.

After discussion, meeting participants agreed to continue exploring all four options, as the indemnification issue is not fully resolved by any one solution. It is possible that a fifth solution combining elements from the existing four may lead to an optimal option.

Confidence Check Exercise

Process

Participants moved themselves into four quadrants across the room based on how long they believe it will take to reach 80% of states with eCR implemented (0-4 years, 5-8 years, 8-10+, never).

Key Assumptions Driving Timeline Assessments

A. Consideration of barriers to entry and effort required to initiate participation
B. Time required for investments, infrastructure and system build-out in local public health organizations
C. Desire to understand incentives ("carrots" and "sticks") for organizations to participate, and how quickly they will act based on various motivations (e.g., financial incentive, legislation requiring action)
D. Ability to replicate products developed during demonstration as an accelerator for expanding eCR to additional conditions and sites
E. Impact of policy, politics and legislation on feasible timelines
F. Level of demand from providers and the concept of the adoption curve (i.e., easier to market product and sign on additional sites after early adopters concretely demonstrate success and benefits)
G. Importance of policy and communications strategies in fostering growth
H. Importance of sustainability and funding to maintain growth
I. Comparison of timeline for progress with other technological adoption (e.g., Meaningful Use, care quality data, HIPAA standard mandate for administrative transactions)

Supporting Points

<u>0-4 Years (2 participants)</u>

A. The hardest step is done; building scalable infrastructure. All the fundamental work, connections and technical software pieces are done in the two live sites; other hospitals and vendors can follow the same approach and adapt based on lessons learned
B. If examples of successful implementation exist and there are no cost barriers, providers will be incentivized to adopt eCR. The system can use a trust network where the organization essentially checks a box. There will be technical onboarding, but if the options are a check-the-box action to implement eCR or to do it manually it's likely that many organizations choose checking the box
C. Incentives drive behavior; when funding or legislation requires action, organizations have shown they can move very quickly (e.g., implementation of changes required by Meaningful Use in 36 months)

5-8 Years (8 participants, with 2 additional participants ½ voting for this option)

A. Assumption that the underlying question is "how soon can vendors scale up?" Seven to eight years was reasonable because there are currently a lot of requests for eCR from customers today. Considering that the technological barriers have been crossed, and vendors don't have to reinvent the wheel, the main action required is vendors getting on board to implement
B. Eight years – Once vendors receive demands for eCR, the next step is establishing regulations, which can take up to two years for some states. Following that action, time is required for organizations to wait for their contracts to be up before transitioning from current EHRs to new systems including eCR to wait for their contracts
C. Policy and politics will require additional time
D. Set high goals and timeline expectations to incentivize rapid action; part optimism, part expectations. For example, Houston Methodist said it needed to be done in three and a half weeks, and it was
E. Eight to 12 years, based on thinking about local health jurisdictions' ability to report or do something with this system. Investments, infrastructure and system build-out that fit their collaborative process would be needed within that time frame
F. Considering patterns with similar adoptions in the industry, e.g., care quality data requirements launched in 2013. After three years, all vendors are adopting the existing framework one way or another, but not all vendors and not all practices have completed adoption yet. There's still only 30% adoption without any cost to providers posing a barrier; the process requires education and it takes a while for customers to see value. It will take at least 8+ years to get to that critical juncture.
G. As a "stick" incentive, what about the first entity sued and held liable for not transmitting life-saving information?

8-10+ Years (14 participants, with 2 additional participants ½ voting for this option)

A. Without a state mandate requiring action, and without grant funding (e.g., from the Robert Wood Johnson Foundation and the de Beaumont Foundation), adoption progress will be very slow
    - It has taken us more than 10 years to implement administrative transactions, even with a HIPAA standard mandate to do so
    - It has taken eight years to adopt EHRs, even with a $37 million incentive program and many requirements
    - Realistically, the health care industry is known to wait until pushed to change
B. Sustainability and interoperability concept are important
C. Ten years is lightspeed in the public health sector
D. Nothing succeeds like success; now that Digital Bridge has live sites, it will be easier to market to states
E. A major incentive for providers is better care for patients. If the next use case lets providers care better for diabetic population or hypertensive population, for example, that will be a major force driving acceleration of uptake
F. Quality and effectiveness of policy and communication strategy will greatly influence pace of progress
    - Create a communications packet with policy documents that can be deployed during an opportune "policy window"; simplification and reduction of work or outbreak response could both be incentives to get greater momentum and/or rapid policy change during a public health emergency

- For example, two years ago when the opioid epidemic was everywhere, reporting of overdose deaths and overdose reporting could have been better using Digital Bridge

G. Expectation for providers to work in EHR and demand from patients for access to their own health data are motivators for eCR adoption

Never (2 participants)

A. No discussion was conducted for this option

Digital Bridge Lessons Learned

Description

The objective of this 90-minute session was to capture lessons learned related to use case incubation and governance.

Participants formed four groups and spent 45 minutes brainstorming positives ("pluses") and potential improvements ("deltas") for Digital Bridge use case incubation and governance, respectively. Participants used voting dots to indicate their top pluses or deltas. Each small group reported out following the activity, and the full group shared general observations.

Results of the exercise are summarized in Appendix 2. The lessons learned will be used to inform identification of the next Digital Bridge use case and decisions about changes to governance organizational structure.

Key Takeaways

Use Case Incubation

Pluses

A. **Shared Value for All Participants** – Mutually beneficial impact from eCR implementation for all sectors
B. **Taking Initiative** – Initiated pilots quickly, stakeholders acted without waiting on each other to move work forward, members were passionate about the eCR use case
C. **Persistence** – Pushed through challenges to continue efforts, challenges were treated as hurdles rather than barriers, worked through difficult items together as a partnership
D. **Flexibility** – Balance of optimism and realism and flexibility allowed for a diversity of models instead of just one way of doing things (e.g., one type of health system)
E. **Prior Investments** – Significant prior investment from CDC and other partners led to high prioritization of the eCR use case and implementation efforts; allowed for decisions around the use case to be realized and successful demonstrations to be stood up
F. **Project Management** – Support for site selection process and obtaining legal guidance
G. **Live Sites** – Two sites are currently live

Deltas

A. **Timeline Delays** – Reduce timeframe for use case participants' onboarding and implementation, avoid commitment and work creep/scope creep, develop an easier approach to next use case
B. **Legal Guidance** – Engage legal support from day one for new use cases, implement a thorough legal analysis from the beginning, develop legal case and business case together
C. **Dependencies across Organizations** – Decouple parts of the onboarding process, identify dependencies between organizations that make project management difficult and streamline where possible
D. **In-kind Structure** – Determine if possible to reduce heavy reliance on volunteers and time in-kind
E. **Use Case Selection Criteria** – Establish clearly defined criteria, conduct more end-to-end discovery and research prior to use case selection
    - Want next use case to be bidirectional, minimize complexity, emphasize population health values

- Data-driven selection is about focusing on the next problem to be solved and not the abstract

F. **Lessons Learned** – Formalize lessons learned from less successful sites, and organizations who dropped out

Governance

Pluses

A. **Consistency** – Strong leadership, vision, commitment, dependability and trust at every level of Digital Bridge
B. **Collaboration** – Cross-functional participation and sponsorship, consensus-driven, equal voices among sectors
C. **Decision-centric Approach** – Governance decisions required to move forward
D. **Focus on eCR** – Maintained focus on eCR use case to ensure its success, instead of looking to next use case in early 2018
E. **Structure** – Ability to delegate to workgroups to execute tasks, learning organization, objective chairperson and excellent facilitation
F. **Project Management** – Third party support to coordinate process moved work forward, adhering to timeline

Deltas

A. **Health Care Presence** – Continue increasing this sector's presence in Digital Bridge collaboration
B. **Advocacy** – Increase preeminence for policy and communication in membership to develop advocacy strategy and broaden partnerships to new stakeholder groups and organizations
C. **Complex Decision Making** – Think about how to solve problems quickly and reach decisions among the large membership group, transition from informational meetings to a focus on decision-making, understand the implications of decisions being made, focus in-kind time on solving complex barriers for greatest value
D. **Values and Perceptions** – Confirm Digital Bridge values are reflected in the value-based proposition of use cases and in broadening representation, address perceptions through an advanced communications strategy (e.g., "pay to play," possibly leaving less advanced public health organizations behind)
E. **Pilot Participation** – Consider governance body member organizations participating in pilots; this approach would avoid the challenge of recruiting other organizations for demonstrations
F. **Funding** – Identify a stable, long-term funding source; without funding and sustainability, Digital Bridge may not move forward

eCR Scaling Conversation

Description

The objective of this session, which took a total of 5 hours on meeting days 1 and 2, was to determine how to transition efforts for eCR scale-up; review and comment on the eCR Transition Recommendations executive summary and report and seek to tentatively endorse the recommendations; and discuss what functions the governance body will serve in the eCR scaling transition.

Meeting participants began discussion of eCR scaling by reviewing results from the pre-meeting survey on support for the eCR scale-up transition plan and discussing gaps and clarifications needed. Meeting participants then discussed key eCR transition plan edits requiring consensus agreement and reviewed the executive summary from the eCR Transition Recommendations report to provide feedback for updating the document, including identifying tasks and owners. Following full group discussion,

participants engaged in a "World Café" exercise, in which members broke into small groups to clarify details and identify tasks and timelines for each of four categories:

- eCR governance and scale-up
- Events that affect scale-up and operations
- Needs for advocacy, marketing and communications
- Needs for workforce and training

Participants had the opportunity to rotate through and comment on each of the four categories, building on previous small groups' content.

Outputs from the discussions and World Café exercise will be updated in the executive summary and reconciled in the rest of the eCR Transition Recommendations report ahead of the March 2019 governance body meeting. The governance body will meet in-person in June (tentative) to make decisions about the organizational structure of Digital Bridge.

Key Discussion Points

Pre-Meeting Survey Results

A. All but three governing organizations responded to survey prior to meeting.
B. Four respondents disagreed with completeness of the draft report; 11 agreed with completeness. Some important gaps remain in the draft, which need to be addressed.
C. Only two voices (of fourteen total responses) cannot support transition recommendations as drafted prior to the in-person meeting.
D. Three participants who did not respond to the survey and had reviewed the recommendations agreed they could support them. Two participants had not yet reviewed the draft recommendations.

Key Edits

Meeting participants reviewed and discussed five key transition plan edits requiring agreement. Key points on each topic are summarized below.

<u>September 1st as Key Date</u>

A. The eCR Transition Recommendations document outlines a demonstration phase, an interim phase and a scale-up phase. The target is to have infrastructure in place to transition from the demonstration phase to the scale-up phase by September 1st.
B. September 1st may be an internal date, not communicated externally – need to transition PMO activities and manage transition for demonstrations by that date and be ready to start the process of educating, communicating and getting the policy out so organizations can begin thinking about how to prepare. A roll-out will follow afterwards.
C. Consider September 1st as a closeout date rather than opening date. For example, aiming for a non-pilot legal agreement to be available in March with organizations starting to sign up by March, rather than waiting for a pilot agreement in July.
D. August 31st is last day that PMO function is funded. Activities will need to be transitioned to other group(s) by then (ideally earlier).
E. Funding for legal support is time-limited through August.

<u>Timeline for Transition Management Activities and Scale-up Phase Start</u>

The group discussed edits to the proposed timeline for transition of management activities and the start of the scale-up phase (see Appendix 12) and agreed on a revised timeline. Key points from discussion are included below.

A. Complete activities required to open up scale-up between now and September
B. For external audiences, need to identify the date at which Digital Bridge tells stakeholders they can begin signing up and onboarding and craft related communication. At that point, vendors and health systems can begin encouraging customers to connect.
C. Evaluation will continue through to scale-up phase, and may need to be restructured. Evaluation report is due to governance body in August 2019.

Centralized DSI as the Primary Scale-up Structure

A. The assumption is that use of a central DSI infrastructure is more efficient than the high cost and long-term limitations of developing one-off solutions
B. Using DSI doesn't preclude an HIE being included in the architecture; some jurisdictions may feel their HIEs are not high cost and may be an adequate approach
C. Onboarding documents should include guidance for a direct DSI connection, for HIEs and possibly other options
D. Interest in obtaining a full comprehensive analysis of the HIE landscape, the role of HIEs in Digital Bridge, and how the HIE landscape will evolve in five years

Continuation of Digital Bridge Governance Partnership through eCR Scale-up

A. The Digital Bridge partnership that includes all three sectors (public health, health care, health IT vendors) must continue through the eCR scale-up phase
B. Potential to broaden the partnership to additional sectors during scale-up, as relevant
    - Consider including education or social services
    - Some of the best outcomes are achieved when social services, health care and public health work together
    - Think about what's achieved with registries to achieve health outcomes, as opposed to a cancer registry, which is only for surveillance

Transferring of eCR Demonstration PMO Functions

A. Two questions:
    - How are we going to move eCR functions management to new owner(s) by September 1st?
    - What is the role of governance for eCR?
B. eCR use case has been incubated, and now it's time to transition ownership to a new operational group. Need an operational governance element for eCR scale-up, rather than the strategic Digital Bridge governance body currently in existence
    - Consider each use case as an individual "digital bridge"; the governance body established a "bridge" for eCR and is now done owning it, and needs to turn focus to building the next "bridge" (i.e., use case)
    - The Digital Bridge governance looks at the need for "bridges" and incubates them
    - The governance of a Digital Bridge-built initiative is operational in nature
C. Digital Bridge serves as the overarching initiative to support the exchange of data and creation of useful information about population health and health promotion. As instances of value are created, such as eCR, an operational sub-committee or a sub-group within the same community of stakeholders needs to take ownership
    - The same parties participating in Digital Bridge will want to be aware of or involved in "governance lite" for each use case
    - The organizations involved in Digital Bridge may need to provide governance and comment on things changing on an existing use cases, because the same three sectors' voices are needed to provide guidance on use case evolution
    - Consider bringing in individuals with different skill sets – strategic thinkers versus operational leaders – from the same set of organizations
D. Digital Bridge owns intellectual property and has created a platform—AIMS—and a set of software solutions—RCKMS and eCR solutions; Digital Bridge needs to maintain some governance of this property.

The sub-committees would need a reporting relationship to the Digital Bridge governance body, at least for the foreseeable future

Gaps Noted During Discussion

A. What does it mean to be a Digital Bridge standard?
   - Consider the element of standards and related maintenance and requirements; consider developing best practices in place of standards.
   - Variance is tolerable; not acceptable – too much state-to-state variance isn't the goal
   - Is Digital Bridge like HL7 or not like HL7?

B. As eCR scales up, gaps arise in architecture, operations and enablers.

C. Within operations, need to address recruitment strategy and onboarding and the approval for use process.
   - Need to discuss the relationship of the approval for use process to the opening of onboarding work and how all that works together to be clear in recommendations about AFU and its relationship in bringing in new implementations in the scale-up system.

D. Need conversation around funding for eCR scaling governance and operations.

E. Think about volume of early adopters; is there a natural limit or a strategic target number?
   - In parallel, consider tracking future possibilities and how they could support policy and legal work.

F. Consider mentioning ONC within transition plan.

G. Add the word "burden" — e.g., provider burden — in the document.

Review of Draft eCR Transition Recommendations

Key Decisions Reached

A. Preliminary endorsement of the proposed eCR transition plan (with revisions generated during the meeting)

B. eCR Transition Recommendations executive summary to include the significance of September 1st date

C. Refine how an eCR community of practice will work with the DB governance body to govern eCR during scale-up, and discuss during the March Digital Bridge governance body meeting

D. Potential to add an advocacy sub-group to the Policy, Legal and Regulatory Workgroup (other options for advocacy ownership: PMO, governance body)

Closing the Gaps – World Café Exercise

Summary of Tasks and Timelines

Table 2 is the outcome of the small group work completed during the World Café exercise.

Table 2: Tasks and timelines identified to inform updates to the eCR Transition Recommendation report

eCR Scale-up Governance	eCR Scale-up Operations[1]
• Transition eCR work to a management body or community of practice where guidance for eCR continues, with responsibility for onboarding new sites, by September • Refine how an eCR community of practice (or "center of excellence") will work with the Digital Bridge governance body to govern eCR during scale-up, and discuss during the March Digital Bridge governance body meeting • Determine what infrastructure would be needed to support the eCR community of practice concept (e.g., the new operations	• Identify and join a trust network by February 2019 (APHL) • Develop a single source of truth website for eCR by March 2019 (APHL) • Develop the final non-network agreement draft by March 2019 (DWT) • Validate PHAs connection to DSI in April-June 2019 (APHL) • Release a schedule for how RCTC will roll out; i.e., getting from six conditions to 74, releasing trigger codes for vendor implementation in parallel, and having public health author the rules for those

group would run the community to manage participation levels by volunteers) • Determine whether the community of practice would be a sub-group to the overall Digital Bridge, a separate group that would operationalize eCR, or in between (may be dependent on onboarding and operational scale)	conditions in summer 2019 (CSTE) • Operationalize AIMS/DSI help desk (e.g., formal agreements and other resources) by June 2019 (APHL) • Develop onboarding documents for various stakeholder groups, including healthcare, vendors, public health by July 2019 (APHL) • Finalize the legal non-network draft and complete pilots' adoption of them over the next few months • Map terminology on healthcare and vendor side, and incorporate into onboarding guidance • Develop and socialize the business case for eCR with healthcare and public health stakeholders • Document what made it difficult for eCR demonstration sites that could not implement eCR during the demonstration period, so new sites can avoid pain points
eCR Advocacy, Marketing and Communications	**eCR Workforce and Training**
• Develop advocacy strategy for eCR (including consideration of a partner-driven approach to advocacy, determining governance structure and defining new governance body role) to promote public health data policy to Congress and other stakeholders in the short term by June 2019 (CSTE/APHL/HIMSS/NAPHSIS) • Develop marketing content highlighting live sites' successes and their business case for eCR by June 2019; distribute at convenings (CSTE/APHL/HIMSS/NAPHSIS) • Conduct an inventory of non-traditional public health partners to assist with advocacy efforts • Develop plan to propose to Congress creation of a digital infrastructure fund in the long term (CSTE/APHL/HIMSS/NAPHSIS) • Determine how Digital Bridge brand will be used/loaned to other organizations for marketing and advocacy purposes	• Determine how workforce efforts to be incorporated into eCR scaling and transition; to be discussed further at March 2019 meeting • Consider change management approach to addressing workforce aspect of eCR scaling, including identifying competencies and communications strategy • Review "centers of excellence" opportunities for eCR scale-up capacity across sectors (e.g., practicum development, cross-jurisdictional sharing, repository for expertise, governance model, strategy (service, delivery, and funding), incentives) • Include an updated applied public health epidemiologist job description in communications for eCR workforce change management approach

[1]Events assume that priority is for all 50 states to be onboarded with six diseases (APHL/CSTE)

General Comments

A. **eCR scale-up governance –** In the future, the Digital Bridge governance body will focus more on strategy, and less on operational leadership and eCR onboarding. The current Digital Bridge governance body should exist for new use cases, standards and harmonization. There would be a dynamic relationship between the governance body and a new operational body and community of practice. Any matters with legal, changing technology, architecture, and other broader issues should go up to the governance body.
    - By the time the community of practice is up and running, the guidance on how to engage and onboard will be clear, so all comers will be able to participate and site selection would atrophy.
    - How will the operational body get input from clients, vendors and providers who are still implementing eCR well? How will that influence come into operations? The community of

practice should help the operational body and provides input on onboarding messages, even if they disagree with the operational body.
    - The governance body would be an independent voice. It would not be advisory to the CDC. The CDC would be a member at the table.
    - One example of the community of practice model working is open source software. You get true believers who share and grow information and get real benefit from it.

B. **Including demonstration sites –** What happens with the five demonstration sites that are s till implementing during this transition period, and what if some of them don't go live before August? Will we roll them into the next process? The eCR scale-up operations small group agreed on Yes.
C. **Onboarding documents –** It's self-service, do-it-yourself, so what boxes do eCR participants have to check to get approval for the use term? The onboarding document would ask, what are the ways we connect with AIMS? What are options for legal documents? What about operations level assumptions?
    - Onboarding information to include AIMS and RCKMS expectations for operations and specific steps needed to onboard. Over the next few months, AIMS and RCKMS will be working with public health organizations throughout the country to get public health authoring six conditions and making sure an eCR coming into AIMS can function with these six conditions by June 2019.
    - Considering the appropriate term for agreement document (not Service Level Agreement (SLA), because no exchange of money).
    - Pilots can use the non-network final draft to avoid challenging transitions.
D. **Enterprise architecture –** Assess similar data connectivity efforts and identify repeatable patterns to inform how the various public health systems work together, including IT, business views and stakeholders and staff
    - Consider connecting to similar initiatives, such as HHS' new immunizations record system gateway, and EHR connectivity projects led by chronic conditions groups
    - Use case for Digital Bridge is, at the highest level, bidirectional exchange of data and information; Digital Bridge adds value to the data elements in eCR through RCKMS – information is exchanged, not only data elements; value is in converting data into information, into knowledge, and finally, into better outcomes
E. **Advocacy in the short-term –** Promote public health data policy going forward; already launched with CSTE, NAPHSIS and others, HIMSS, etc., who teamed up to work with a lobbyist in Washington, D.C. who represents CSTE.
    - CSTE launched a public health data campaign, which seeks to fund local, state and federal public health to have capacity to do things for 21st century data exchange with healthcare. The timeline for a short campaign is now to June 30. If CSTE receives funding, the campaign may extend to full calendar year, depending on the tempo of Congress this year. CSTE launched the campaign in mid-January and is convening a larger advisory group.
    - What is Digital Bridge advocating for? Need to define this and have bullet points and appropriate connections to vendors.
F. **Congressional fund –** Advocate for a public health data fund or similar trust fund. Maybe a public health information and technology modernization act to fund and support improvement in tech for public health. Congress would fund it, and states would apply to fund public health infrastructure, just like with highways. Rather than money going to CDC and distributed from there, like anthrax, it's more of a pull mechanism of states applying for funding, demonstrating how they'll spend it, and then building infrastructure with standards guidance from CDC.
    - There are lobbying rules on funders, and we should keep within those rules going forward.
    - Are public health stakeholders ready to consume data from vendors? Vendors saw a need for public health data capacity. CDC agreed, because of their data/infrastructure needs. Once the state campaign leads the way, the federal agencies are invited to comment, and they reiterate, yes, these are our needs.
    - Consider a trust fund as an alternate structure.
    - Each participating organization will need to pull in individuals with relevant expertise part-time to support advocacy activities.

G. **Marketing –** Need an active plan for vendors to identify customers who may want eCR and how to engage potential customers; approach needs to be more active in bringing in public health agencies to implement the product that vendors have ready

H. **Non-traditional partner inventory –** Identify non-traditional public health partners to assist with advocacy, such as CHIME, the Electronic Health Records Association, the National Governors Association. Look at the non-public health partners in Digital Bridge and ask if they do policy and advocacy work, and do they do it directly or indirectly?

    - A partner-driven approach through that inventory is more strategic than pulling an abstract list from an internet search.
    - The inventory would be used to track activities and present progress to the partnership to identify challenges, progress and opportunities for synergy.
    - How does Digital Bridge want to structure a partner inventory? For example, use a one-time liaison who outlines common actions, or have a shared activity that drives this effort?

I. **Workforce and training –** Digital Bridge can't deal with the full scope of this problem; rather, consider how Digital Bridge connects to larger training efforts.
    - Governance does impact workforce, which is a necessary component of eCR scaling. A platform, use case, etc. will face implementation challenges without individuals skilled and trained to manage that system. There are core competencies required for eCR implementation, which include skills beyond informatics (e.g., legal).
    - How are we incorporating training into our existing workforce efforts? There may be a component of marketing Digital Bridge to health departments.
    - Which workforce will efforts focus on – vendor, health care, or public health?
    - Need to leverage the pilot site evaluations to strengthen roles needed for implementation and provide guidance related to competencies for future sites. Need to assess where positions fall, e.g., through job descriptions, and how to support informatics-savvy health departments. For example, CSTE state epidemiologists having a manual for eCR implementation. Not all jurisdictions have this.
    - How do you convince a leader, whether a public health commissioner or otherwise, that they need to hire or develop specific competencies in their staff and how they need to do it? The small group proposed using a change management approach, including showing how this strategy will fit a larger picture in the provision of services from public health agencies.
    - The applied public health epidemiologist job description should be updated, as well as the data science component description. Epidemiologists do not need to be data scientists, but they should have some related knowledge as part of their roles.
    - CDC is tallying and categorizing informatics training.
    - To retain talent, staff in these roles need to feel they have purpose, are being paid fairly, and are doing interesting work. Trained informaticists are mission-driven and need engaging work.

Scaling Digital Bridge: The Next Use Case

Description

The objective of this 75-minute session was to gather input from voting members to prioritize use case selection criteria and inform the Transition Workgroup's recommendations for the next Digital Bridge use case.

Previously, Alana Cheeks-Lomax and Ben Stratton prepared information regarding use case selection process, criteria, etc. At that time, the governance body reviewed and decided to set the criteria aside and focus on eCR. During the in-person meeting, participants reviewed the criteria again and discussed how to prioritize them. The group used Poll Everywhere technology to take a live poll on how to rank the criteria (see Appendix 4 for full results).

Key Discussion Points

Ranking and Discussion of Criteria

The criteria are listed in the order they were ranked by 20 survey respondents.

1. **Value to stakeholders** (e.g., reducing the health care personnel burden)
    - Think about placing value on clinicians
    - Need value to engage people and organizations
2. **Feasibility of the use case** (i.e., is it something that can launch nationally?)
    - Thinking about the interaction of policies that promote adoption
    - Where is inclusion and MU located within the criteria? – an important consideration
3. **Funding and resources**
    - Important to consider where new resources will come from?
    - Site selection and use case selection should be strategically thought out regarding funding and resources from Congress
4. **Significance of problem** (i.e., emerging public health challenges)
5. **Applicability**
6. **Cross-collaboration** (i.e., does it promote cross-sector and multi-organizational collaboration?)
7. **Non-infectious disease** (see notes immediately below)

Discussion of Non-Infectious Disease as Next Use Case

- Agreement from most that the next use case should be a non-infectious disease
    - Capturing data for non-infectious diseases is critical, as the leading cause of death in the country
    - An area where Digital Bridge can bring value to stakeholders – difficult for health care to address
    - Addressing top-ranked criteria will naturally lead to a non-infectious disease use case
    - eCR covers all infectious diseases, and Digital Bridge has already dealt with notifiable conditions
    - Addressing a non-infectious disease will allow the Digital Bridge concept to expand beyond the current conceptual framework to bridging, not just exchanging—i.e., opportunities to exchange with health plans, social providers, education and others
        - Potential for legal and policy issues to be more difficult with non-infectious disease, due to new legal and regulatory frameworks in many jurisdictions
        - Requires true partnership with care delivery
        - Potential to push need and policy and technical and practical solution together to demonstrate value to provider community
    - Think of a use case as not just the technology, but as the concept of working with boards of health to make a condition reportable (e.g., how birth record reporting began)
    - Consider if you want the intervention to be personal
    - Consider the implications for health insurance status when reporting non-infectious diseases

General Points on Organizing Criteria

- What is the end goal, and how does that inform prioritization of the criteria?
- As a starting point, ask the question: how can public health and clinical care work together for the benefit of the people who are under care? Allow the answer to direct use case toward infectious or non-infectious disease
    - Points to multi-sector work
    - Health care doesn't always have to house the data; provides value to stakeholders in this way, especially with the long arc between health care providers' work and long-term health benefits
    - As increasingly health care is going to value-based purchasing, health care systems are on the hook for outcomes with external influences. This structure relies on a partnership that will really drive Digital Bridge forward
    - Electronic health records are just one of many data sources to address potential use cases
- Consider grouping criteria together in to higher-level categories to reduce the number of options. For example, combining value, problem, and cross-collaboration into one category of "the right thing to do"

- Consider criterion of “strategic” (e.g., high reporting volume); we picked STDs so we have a high volume
- Value to stakeholders and significance of stakeholders were split out during polling
- The top five criteria are musts; the last two are traits

Closing Remarks and Outputs Summary

Closing Remarks

The meeting closed with final remarks from Charles Ishikawa, Vivian Singletary and John Lumpkin. The group revisited the purpose of the meeting – applying lessons learned to determine how eCR efforts and Digital Bridge will go to scale, and clarifying conceptions of eCR governance and Digital Bridge governance to inform upcoming transitions. In closing, the group reflected on the following concepts:

- Perseverance through challenges, and amazing progress made by the demonstration sites in one year
- Readiness and renewal of the participants and the collaborative effort to move forward
- Attention to ensuring a smooth transition of eCR and related PMO activities, as well as marketing and advocacy to support eCR scaling
- Transition of efforts from vision to fact – after decades of envisioning an operational eCR system, two live sites are active; seeing this come to life is transformational
- Impact of eCR efforts on the health of the nation, with the potential to have an upcoming outbreak be rapidly controllable

All meeting objectives were met and closed. In one final activity, meeting participants wrote down their commitments and pledges of actions they will take in the next 90 days to continue moving efforts forward.

Outcomes

- Preliminary endorsement of the proposed eCR transition plan (with revisions generated during the meeting)
- Potential addition of a new advocacy workgroup or sub-workgroup of the legal, regulatory and policy workgroup
- For next use case selection, most agree on using a non-infectious disease
    - Proposed alternate starting point for selection: ask the question, how can public health and clinical care work together for the benefit of the people who are under care? Allow the answer to direct use case toward infectious or non-infectious disease

Outputs

- Priorities and interests driving participation in Digital Bridge for 2019 (Appendix 1)
- Use case incubation and governance successes and opportunities for change (Appendix 2)
- Proposed tasks and timelines for eCR transition to scale (Appendix 3)
- Actions governance body members will take by April 2019 to support eCR and Digital Bridge scaling and transition (Appendix 5)

Appendix

Meeting Outputs

Appendix 1: Affinity Grouping of Motives and Interests

Grouping	"Digital Bridge will enable me to…"	Attribution
Promoting adoption	… *ASTHO members to participate in a national effort to advance population health*	Mary Ann Cooney
	… *Promote the adoption of eCR and future use cases among Cerner clients and beyond*	Bob Harmon
Connecting disparate systems and cross-sector collaboration	… *Connect multi-sector partners to work on solving problems in health IT*	Vivian Singletary
	… *Enable eCR via simplified universal interconnected to a single entity to reach all public health agencies*	Richard Hornaday
	… *Make data exchange more efficient and feasible*	Bill Mac Kenzie
	… *Engage with all stakeholders to work with and learn from one another to develop a scalable approach to public health initiatives*	Dan Chaput
	… *Contribute to building an infrastructure to enable the collection of interoperable health care data to improve public health*	Monique van Berkum
	… *Showcase our organization's contribution to a broader public health and clinical interaction*	Scott Becker
	… *Work more efficiently with healthcare and health IT developers*	Bill Mac Kenzie
Providing better care and improving public health	… *Improve the public's health, unlock the data*	Brian Castrucci
	… *Provide better care to my patients*	Rich Paskach
	… *Collaborate across boundaries to improve healthcare and be confident someone is herding the cats.*	James Doyle
	… *Find mutual needs and solutions with my peers in public health*	Rich Paskach
	… *Feel like we have made a positive contribution to public health in the US*	Andy Wiesenthal
	… *Meet our goal that public health, health care work together to meet people's goals and needs*	John Lumpkin
Reducing burden/efficiency	… *Reduce provider burden*	Shan He
	… *Improve health data without increasing burden*	Chesley Richards
	… *Improve the reporting burden and experience for healthcare providers*	Monique van Berkum
	… *Provider perspective: find more efficient and effective ways to exchange health information with public health*	Walter Suarez
Policy and systems	… *Advance the use of policy and systems-driven solutions in health technology*	Oscar Alleyne
	… *Better support development of new policies*	Dan Chaput
	… *Better support eCR certification for eCR incentive programs*	Dan Chaput
	… *Improve local public health departments' work and capacity in public health technology*	Oscar Alleyne
	… *Show the stakeholders what modernization of public health systems can do for services*	Jeff Engel

Appendix 2: Pluses and Deltas for Use Case Incubation and Governance

Use Case Incubation Pluses	Dot Count
Persistence and willingness to push through challenges	12
Balance of optimism and realism	3
Built on existing work (research and standards)	3
Legal guidance	3
Challenges faced as hurdles vs. barriers	2
Diversity of models chosen	1
Emphasis on pilots/demonstration (in production)	1
Finding sites process	1
High prioritization (issue-based)	1
Project management (essential)	1
Shared value for all participants	1
Successful demonstration	1
Doesn't have to be perfect	0
Level of passion to do eCR was present	0
Significant prior investment (CDC, RCKMS, AIMS) and health care providers	0
Taking initiative (don't wait for all participants to be ready)	0
Two sites live	0
Use Case Incubation Deltas	**Dot Count**
Sustainability	12
Legal engagement from day 1	4
Well-defined use case selection criteria	4
More efficient and speedy	3
Bidirectionality	2
Population health value	1
Recognize parallel efforts	1
Stakeholder engagement improvements	1
Work creep; commitment time	1
Better communication within participating organizations	0
Better coordination and awareness of dependencies	0
Complexity (minimize)	0
Data-driven selection	0
Enough discovery/research done upfront	0
Formalize lessons learned from the less successful sites	0
Have right people at table	0
Need roles and responsibilities of parties clearly defined upfront (project charter, clear communication, etc.)	0
Scalability	0
Too heavy reliance on volunteers or time in-kind	0

Governance Pluses	Dot Count
Equal voices across the necessary sectors (and all voices; structure worked)	8
Consistency (longevity/commitment)	5
Multi-stakeholder collaboration	5
Strong leadership	3
Consistency (low turnover/trust)	2
Chair was objective/excellent facilitation/it was money well spent	1
Decision-centric	1
Most people remained engaged (vendor collaboration c/w PHCP)	1
Supportive PMO	1
Vendor reps are a "critical mass" of lives covered	1
Ability to delegate to groups to get work done	0
Collaborative environment and discussion/civil	0
Consensus-driven	0
Decision to focus on first use case instead of talking about the second use case	0
Funding/sponsorship	0
Operations support	0
Participation--multi/cross sector	0
Representation	0
Shared decision making	0
Strong vision	0
Governance Deltas	**Dot Count**
Health care presence	8
Need broader representation	5
Need stable and long-term funding	4
Sustainability	3
Articulating the business case (identifying outcomes of value)	2
Preeminence of policy and communications	2
Governing more participation in pilot itself from governance body members	1
More streamlined/ "right-size" process and communications (better tools for collaboration)	1
Need better approaches for related complexities	1
Need to understand ramifications before making a decision (and understanding the work necessary to support the decisions)	1
Balance of 20K hours	0
Clinical care representation (amount and type)	0
Decision/problem solving orientation	0
Improved targeted marketing (value-based leadership support)	0

Less exclusion/broader engagement with partners and implementers	0
More deliberate communication strategy	0
Need to expand focus	0
Perception of "pay to play"	0
Perception of potentially leaving less advanced public health jurisdictions behind	0
Workgroup philosophy vs. practical	0

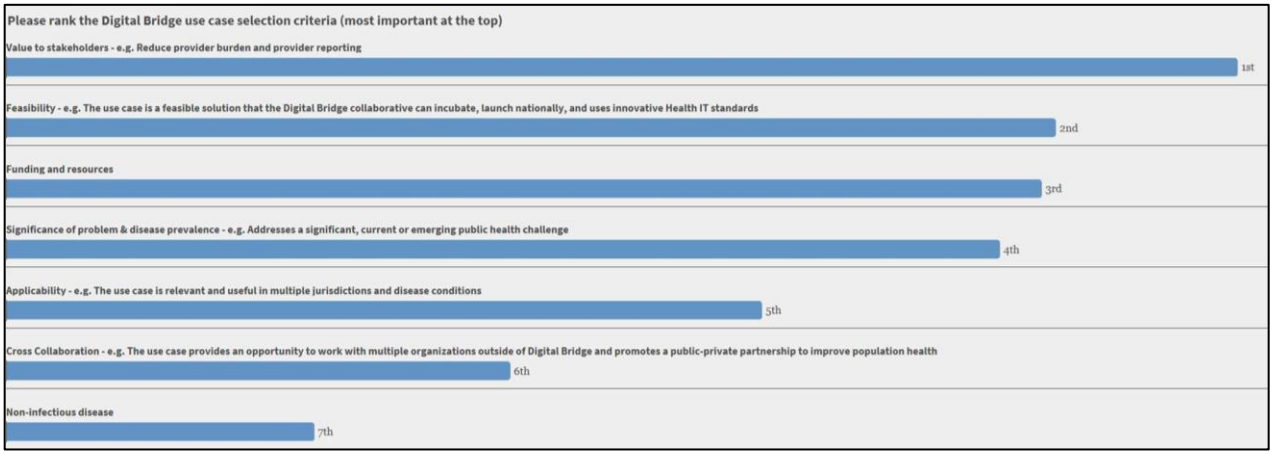
Appendix 3: World Café Exercise Outputs – Tasks and Timelines

eCR Scale-up Governance	eCR Scale-up Operations[1]
• Transition eCR work to a management body or community of practice where guidance for eCR continues, with responsibility for onboarding new sites, by September • Refine how an eCR community of practice (or "center of excellence") will work with the Digital Bridge governance body to govern eCR during scale-up, and discuss during the March Digital Bridge governance body meeting • Determine what infrastructure would be needed to support the eCR community of practice concept (e.g., the new operations group would run the community to manage participation levels by volunteers) • Determine whether the community of practice would be a sub-group to the overall Digital Bridge, a separate group that would operationalize eCR, or in between (may be dependent on onboarding and operational scale)	• Identify and join a trust network by February 2019 (APHL) • Develop a single source of truth website for eCR by March 2019 (APHL) • Develop the final non-network agreement draft by March 2019 (DWT) • Validate PHAs connection to DSI in April-June 2019 (APHL) • Release a schedule for how RCTC will roll out; i.e., getting from six conditions to 74, releasing trigger codes for vendor implementation in parallel, and having public health author the rules for those conditions in summer 2019 (CSTE) • Operationalize AIMS/DSI help desk (e.g., formal agreements and other resources) by June 2019 (APHL) • Develop onboarding documents for various stakeholder groups, including healthcare, vendors, public health by July 2019 (APHL) • Finalize the legal non-network draft and complete pilots' adoption of them over the next few months • Map terminology on healthcare and vendor side, and incorporate into onboarding guidance • Develop and socialize the business case for eCR with healthcare and public health stakeholders • Document what made it difficult for eCR demonstration sites that could not implement eCR during the demonstration period, so new sites can avoid pain points
eCR Advocacy, Marketing and Communications	**eCR Workforce and Training**
• Develop advocacy strategy for eCR (including consideration of a partner-driven approach to advocacy, determining governance structure and defining new governance body role) to promote public health data policy to Congress and other stakeholders in the short term by June 2019 (CSTE/APHL/HIMSS/NAPHSIS) • Develop marketing content highlighting live sites' successes and their business case for eCR by June 2019; distribute at convenings	• Determine how workforce efforts to be incorporated into eCR scaling and transition; to be discussed further at March 2019 meeting • Consider change management approach to addressing workforce aspect of eCR scaling, including identifying competencies and communications strategy • Review "centers of excellence" opportunities for eCR scale-up capacity across sectors (e.g., practicum development, cross-jurisdictional

(CSTE/APHL/HIMSS/NAPHSIS) • Conduct an inventory of non-traditional public health partners to assist with advocacy efforts • Develop plan to propose to Congress creation of a digital infrastructure fund in the long term (CSTE/APHL/HIMSS/NAPHSIS) • Determine how Digital Bridge brand will be used/loaned to other organizations for marketing and advocacy purposes	sharing, repository for expertise, governance model, strategy (service, delivery, and funding), incentives) • Include an updated applied public health epidemiologist job description in communications for eCR workforce change management approach

[1]Events assume that priority is for all 50 states to be onboarded with six diseases (APHL/CSTE)

Appendix 4: Use Case Selection Criteria Prioritization Poll Results (20 Responses)



Appendix 5: Commitment and Pledge Forms
"What Will I Commit To In the Next 90 Days?"

Name	Commitment	Actions
Adam Greene	Assist in putting in place the legal tools to scale eCR up and assist APHL with its privacy and security compliance	1. Provide a non-trust network agreement for providers to participate in eCR on a non-pilot basis (Marcg 2019) 2. Assist with onboarding APHL and the eCR use case into a trust network 3. Work with APHL to further strengthen HIPAA compliance document
Bill Mac Kenzie	Do good and avoid evil; continue optimism; I feel more confident that I will die in peace	1. Discover CHIME the potential for engagement in Digital Bridge 2. Work with PHII, Deloitte and RWJF to understand priorities and transition associated activities 3. Overview (?) communications about demonstration projects and their success 4. Providing vetted onboarding documents for review
Bob Harmon	Promote DB eCR; help resolve legal issues; seek optimal RCKMS trigger code selection; survey Cerner clients about readiness to adopt eCR	1. Continue marketing and presenting on DB and eCR; help Lawrence Memorial have successful eCR production 2. Arrange DB Webex call with Commonwell Health Alliance 3. Continue pursing SMART-FHIR-CDS hooks etc. solutions for RCKMS trigger codes
Brian Castrucci	Continue conversation with Vivian at PHII on the need for a non-technical strategy meeting	
Charles Shepherd	Thanks for opportunities to observe and participate in this meeting and for generosity of the TFGH for hosting. I commit to work with Digital Bridge under direction of the CDC/CSELS division to further polic-related objectives of scale-up and transition	1. Participate as asked in workgroups to move forward on policy effort that Digital Bridge prioritizes 2. Make available to Digital Bridge information and resources that possibly interfere between Public Health Data Strategy and the upscale of Digital Bridge eCR efforts
Christopher Alban	Explore Epic's lobbying and advocacy opportunities with respect to Digital Bridge	1. Discuss with Epic PR reps 2. Discuss with Houston Methodist team

Name	Commitment	Actions
	roll-out efforts	
Dan Chaput		1. Meet with ONC and OCTO partners to review and discuss meeting and meeting outcomes 2. Provide consensus feedback on documentd 3. Document any additional needs, risks, issues from ONC/OCTO view 4. Push on idea/concepts of EHR certification criteria
Dave Ross	Volunteer my time to work with APHL, CSTE, ASTHO, NACCHO and CDC on advocacy for new federal funding to support public health agency adoption of modernized information infrastructure, including eCR	1. Will follow up with Jeff and Scot, et. al
James Doyle	Investigate how Epic can increase eCR interest and adoption among our clients and make that process easier	1. Propose lab-driven workaround to resolve mapping challenges 2. Make sure Houston Methodist and other Epic pilot sites share the good word with the rest of the Epic community
Jeff Engel	Co-chair the evaluation committee; lead short-term advocacy campaign to Congress on the PH data strategy	1. Complete evaluations from Houston and Utah 2. Quantitative evaluations of next six implementation sites 3. Data strategy campaign leadership 4. Promote eCR scaling among state and local partners in PH surveillance
Joe Wall	To work with our development team to complete our eCR solution and to get beyond any hurdles	1. Start engagement with strategic customers that may want to pilot with us 2. Work with our physician team so that they may be able to help advocate 3. Work with internal representatives to engage workgroups such as EHRA
John Lumpkin		1. Personally engage with governance body 2. Work with others in outreach to key stakeholders about eCR and Digital Bridge
Katherine Bruss	Work on developing public-private partnerships; work on strategic policy/comms plans	1. Schedule meetings with key players 2. Collaborate with internal POCs to develop strategies 3. Support relevant transition activities

Name	Commitment	Actions
Laura Conn	Organize and begin eCR operations transition	1. Establish eCR operations group PMO + CDC + APHL + CSTE 2. Support success of remaining DB demo sites 3. Begin broad communication about scale-up eCR activities 4. Outline eCR onboarding documents and get input from stakeholders
Mary Ann Cooney	Engage SHOs and Advoccy for standards/policy analysis and change	1. Meet with CSTE and Adam (legal) 2. Meeting/call with Pop. Health Informatics Policy Committee to do update 3. Post notice on IDPN web 4. Discuss with accountable health community on data collection plans for questions re. SDOH
Meredith Lichtenstein-Cone	To further the success of RCKMS	1. Continue partnership with APHL to update RCKMS tools on AIMS 2. Train and onboard 50+ jurisdictions to author reporting specs for 6 pilot conditions 3. Begin evaluation of RCKMS onboarding/authoring to determine RCTC roll-out plan 4. Continue post-production support and onboarding support for whichever jurisdictions are ready
Michael Iademarco	See Bill's response	1. Speak with John, Dave and Scott 2. Organize policy/communications track for CDC's part 3. Nominate CHIME to Digital Bridge 4. Think about other relevant partners in health care sector for Digital Bridge
Monique van Berkum	Actively participate in the governance body and further learn about and understand the Digital Bridge effort to be able to fully contribute to the effort.	1. Explore/discuss with AMA the issue of the need for advocacy (e.g., the Public Health Data Campaign) 2. Continue active involvement in governance body 3. As a new member, continue to better understand Digital Bridge (objectives, what's been done, path forward, etc.) 4. Continue to engage with a particular focus on burden of reporting to health care providers
Oscar Alleyne	Explore what feasibility/opportunities exist for building framework for local eCR implementation	1. Survey membership/informatics champions 2. Engage leadership 3. Follow up on workforce and training needs

Name	Commitment	Actions
Patrick O'Carroll	Continue to work with Vivian Singletary and PHII to engage with key partners as we define the appropriate (and evolving) scope and vision for what Digital Bridge is all about	
Richard Hornaday	Work with DB and internally at Allscripts to move us as a group and as an industry towards deployable eCR	1. Drive internal trial, including certification activities 2. Help DB understand more of the AFU mode of operations
Richard Paskach	Continue to support the tasks and vision of DB eCR; providing the provider perspective to discussions	1. Present at Minnesota eHealth Summit if abstract is accepted 2. Work with local department of health in support of DB 3. Attend governance body meetings and contribute as needed 4. Work with HealthPartners leadership in passing eCR with MDH and Epic
Scott Becker	Do everything I can to support our team to take on the transitions whilst advocating for continued support	1. Not pile on more work 2. Engage my membership in advocacy conference (?) 3. Better understand the multitude of informatics acronyms and terminology
Shan He	Actively push eCR scale-up at Intermountain	1. Tackle the one barrier left for scaling eCR up to all conditions 2. Promote/advocate eCR among clinical programs and gain medical championship
Tushar Malhotra	Engage and identify customers who have previously shown interest in eCR and introduce them to the concept of Digital Bridge	1. Identify customers who have shown an interest in eCR and introuce them to the concept of Digital Bridge 2.Try to have them matched up for future scaling up of the eCR use case 3. Help with legal/trust frameworks (on board for Commonwell and steering committee for CareQuality)
Vivian Singletary	Organization's commitment to support PMO activities around implementation and prepartation around transition (being agile and responsive)	1. I think the issue that needs to be addressed is around Digital Bridge scaling and more specifics on how C.O.P. for eCR will interact with this Digital Bridge governance (perseverance and readiness)

Name	Commitment	Actions
Walter Suarez	Continue being actively engaged in the governance body; chair the legal and policy workgroup and achieve its initial set of deliverables; explore within Kaiser Permanente the possibility of implementing eCR through an eHealth Exchange participation	1. Continue active involvement in governance body 2. Continue leading policy and leagl workgroup and deliver initial set of outputs (e.g., HIPAA RFI comments); develop a Digital Bridge advocacy strategy for 2019 3. Explore possibility of implementing eCR through eHealth Exchange 4. Facilitating a strategic group within the Digital Bridge governance body to focus on the larger picture of Digital Bridge--the future bridges of Digital Bridge (other providers to public health exchanges; health plan to public health exchanges; social services to public health exchanges; other public health exchanges)

Appendix 6: Bike Rack

Bike Rack	

Items discussed to completion during meeting	• Discuss and plan for advocacy more broadly*
	  ○ Craft a unified reduced provider burden message and deliver through multiple channels
	• Strategize on marketing eCR to various stakeholder audiences*
	  ○ Needed for more structure and effect

Items or ideas raised during the meeting, but not discussed to resolution	• How will a patient advocacy perspective be incorporated into Digital Bridge work?
	• Coordinate eCR outreach to healthcare systems among vendors and public health agencies
	• Consider eCR EHR or Health IT Certification
	• Identify strategic connections and synergies with similar efforts from an architectural or enterprise point of view; e.g., IZ Gateway, chronic disease
	  ○ To inform development beyond the current eCR approach, and prevent adding new siloed systems and architectures
	• What are the current workgroups, and what new workgroups will form as Digital Bridge up-scales?*
	• How do decisions like those associated with California's addition of Parkinson's reporting get made?* Example issues include:
	  ○ How to decide whether a condition is added to the national trigger set?
	  ○ How to determine whether the functionality is problematic; e.g., is it okay to use eCR as a method to auto-enroll patients in a registry?
	• What is the steady state for eCR sustainability, and how will those be met in the future?*
	• Use demonstration sites as "test beds" for additional use cases; e.g., Parkinson's disease*
	  ○ Expanding on the current approach, building upon the future approach
	  ○ Cautionary note: Do not force a solution on an ill-suited problem; avoid inappropriate application of solution
	• Digital Bridge as a big tent for protecting population health
	  ○ Digital Bridge is a positive name and brand
	  ○ Someone needs to lead effort; otherwise fragmentation will continue
	  ○ Advocacy that "sells" the Digital Bridge; establish a sub-workgroup?*
	  ○ What is our broader purpose?
	  ○ Find the data elements that are core across all implementation instances
	  ○ Important for the conversation with trusted exchanges
	  ▪ Keep in mind the difference between data, information and knowledge

*A related action item is also noted in the Action Items list