Syndromic Surveillance Governance Council

January 28, 2016
1:00 p.m. – 3:00 p.m.
DSHS, 1100 West 49th Street, M-101
Austin, TX 78754
Conference Call Line: (877) 820-7831
Participant Passcode: 150459#

Attendees (* Council Members):
*Raouf Arafat, MD, MPH, Asst. Director, City of Houston, Dept. of Health and Human Services
*Linda K. Gaul, MPH, PhD, State Epidemiologist, Office of Epidemiology, DSHS
*David W. Gruber, Assistant Commissioner, Division for Regional and Local Health Services (RLHS), DSHS
*Philip Huang, MD, MPH, Medical Director, Austin/Travis County Health and Human Services
*Diana Martinez, MPH, PhD, Program Mgr., Harris Co. Public Health and Environmental Services
*Belinda Medrano, MPH, Infection Preventionist, Valley Baptist Medical Center-Brownsville
*Thaddeus Miller, MPH, Dr.PH, Associate Professor, UNTHSC, School of Public Health
*Santos Navarrette, Jr., MA, MBA, Assistant Health Administrator, Abilene-Taylor Co. Public Health District
*Christopher Taylor, MPA Candidate, Executive Director, Cherokee County Public Health
*Carl Vartian, MD, MS, Chief Medical Information Officer, HCA-Gulf Coast Division
*Don Vickers, Med, CEO/Managing Partner, HPT Healthcare

Leo Achembong, BDS, MPH, Health Systems Integration Program Fellow, CPEA, DSHS
Herminia Alva, Region 11, DSHS
Roger Barker, Deputy Regional Director, Region 4/5N, DSHS
Carrie Bradford, PhD, Team Lead for Syndromic Surveillance, RLHS, DSHS
Savannah Carlson, Administrative Assistant for Syndromic Surveillance, RLHS, DSHS
Miguel Cervantes, Region 9/10, DSHS
Shannon Creekmur, HIPAA Privacy Officer
Steve Eichner, HIT Policy Director, CPEA, DSHS
Madan Gopal, DSHS Chief Technology Office
Julie Graves, MD, MPH, PhD, Regional Medical Director, Region 6/5S, DSHS
Tre Green, Project Manager, RLHS, DSHS
David Gross, Application Development Unit
Carla Gutierrez Tyler, Region 11, DSHS
Dulan Hailoo, MD, MPH, Houston Health Department
Steve Hannemann, Region 8, DSHS
Dave Heinbaugh, Tarrant County Public Health
Alex Huff, Texas Hospital Association
Sylvia Hobbs, Deputy Regional Director, Region 11, DSHS
David Leary, Region 4/5, DSHS
Dr. Huai Lin, Region 6/5S, DSHS
Jyllisa Mabion, Epidemiologist for Syndromic Surveillance, RLHS, DSHS
Andy Mauney, Emerging & Acute Infectious Disease Branch
Kevin McClearran, Epidemiologist, Health Service Region 1, DSHS
Wes McNeely, Houston Health Department
Beverly A. Pritchett, Director, Office of Public Health and Deputy Assistant Commissioner, RLHS, DSHS
Eunice Santos, Houston Health Department
Mary Starboard, Team Lead, Office of Public Health
Bill Stephens, Tarrant County Public Health
Rick Tull, Region 1, DSHS
Vinny Taneja, Tarrant County Public Health
Brad Winterton, Region 8, DSHS
Biru Yang, Houston Health Department

Council Members Not Present:
*Carol M. Davis, BS, MSPH, Program Mgr., Health Service Region 7, DSHS
*Peggy Hines, Health Information Technology Manager, DSHS

1. Welcome and Introductions
   - We had an opening for a hospital member and we needed to fill it. When we went over applications we found talent of the highest level and new approaches that could be brought to the table. This is the reason for bringing two new members on board.
   - New Council members:
     Belinda Medrano –
     - Infection Preventionist at Valley Baptist Medical Center – Brownsville.
     - MPH and BS in Clinical Laboratory Sciences, Certified Medical Technologist.
     - Previously – Epidemiologist for Hidalgo County and recruited and established data feeds for syndromic surveillance, provided education on using the system, and monitored the data and provided feedback to facilities and the community.

     Dr. Carl Vartian –
     - Infections disease doctor by training, was in practice for 24 years in Houston. Joined the hospital side of things and got masters in health informatics.
     - Chief Medical Information Officer at HCA – Gulf Coast Division.
     - MD and MS in Biomedical Informatics.
     - Previously – Private practice of infectious disease, then was chief medical officer at two HCA hospitals.
   - New team members:
     Tre Green –
     - IT Project Manager in replacement of Jay Jackson.
     - Project Management Professional (PMP).
     - 20 years of experience project/program management and IT service/operations management.
     - Lots of project experience helping deliver projects in the public side.

     Jyllisa Mabion –
     - Epidemiologist for syndromic surveillance program.
     - BS in Sociology, completing her MPH.
     - Previously – Public Health in the Air Force as well as National Guard (still active National Guard), worked in STD clinic and TB.
   - Roll call of Council members and introductions of other attendees.

2. Approval of October 29, 2015, Meeting Minutes
   - Clarification on item 4b – there is not a cost to maintain the ESSENCE software, only a cost for upgrading the system.
   - Minutes approved.

3. Old Business
   a. Agreements
      - We are still waiting for templates from our legal department for the data use agreements.
      - We should have them next and we will present those at the next meeting.

   b. Implementation Project Update
      - Contracts with UBER gateway and Rhapsody.
        - There is an amendment to the existing contract that will allow us to use it.
        - Do not expect there to be a hold up.
        - Server and database hosting – waiting on ESSENCE user application and Sole Source approval, we do not believe we will have to modify the timeline presented today.

- Houston proposal - during the October 29, Syndromic Surveillance Governance Council meeting, Houston Health Department made a proposal for a hybridized/federated model, partnered with Department of State Health Services (DSHS). The proposal (shown on the last two pages of the October meeting minutes) consisted of 5 points *(DSHS response in italics)*:
  1. All three agencies (TCPH, HHD, and DSHS) need their own instance of ESSENCE.
     - *DSHS agrees that TCPH, HHD, and DSHS would each have their own instance of ESSENCE.*
     - *One version of ESSENSE on state server, any addition to base requirement would be at the cost of user.*
  2. All three agencies share the entire state's data across a Texas wide network resulting in a highly available clustered system with failover capability. If one goes down the others serve as backup.
     - *Users will be able to see data within their Health Service Region and aggregated data for the state. The statewide system has a backup built into the system. In addition, it is not consistent with the DSHS IT policy to have a backup network outside of the agency firewalls.*
     - *With cloud contract, that comes with backup, and there is no need for extra backup.*
  3. TCPH and HHD to administer their own regions.
     - *We not have any problem with this, however this should occur in coordination with the SSRAC and the Regional Medical Director (chair of the SSRAC) for each region.*
  4. DSHS should administer the remainder of the state.
     - *DSHS will administer the statewide system and obtain data feeds from TCPH and HHD as part of the statewide system.*
  5. DSHS should also actively recruit and develop new regional system hubs that can own and administer their own ESSENCE instance to reduce the workload on the state.
     - *We don't see any reason to spend extra funding for that, the statewide system will be in place and there will not be a need to spend funds for additional regional hubs. The staff intact can handle the work load.*
- Discussion:
  - Steve Eichner (DSHS) – Looking at data standards, we need to make sure that data needs are consistent so there are no data gaps and data needs are met. We also need to look at relationships between repositories.
  - Diana Martinez (Harris Co. Public Health) – On 3rd bullet, can there be some clarity regarding administering own regions?
    - When partners deal with each other and maintain relations (i.e. Houston and local hospitals) we believe it would be contrary to our goal to go against existing relations and encourage them to continue with the success that has been built. They would continue their existing relationships with hospitals and feed into the larger system. Regions will have access to all regional data. Region 2/3 will have two avenues to access data, by going into Tarrant County regional data as well as the larger state-wide system to see state data. Regional data is detailed and state data is aggregated.
  - What data contains "detailed data"?
    - We have a 26 page document with all the data points (i.e. discharge data, gender, age, etc…) that will be downloadable into a spreadsheet. If you want to do a query that goes into historical data you can do so.
  - Dr. Huang (Austin/Travis County Health and Human Services) – Where does the data come from right now?
    - The former TALHO system, and we do not have the option to continue to get our data from that system once the larger system is in place.

        - When TALHO dissolved DSHS contracted with Houston to continue to run TALHO until a state system was created. Until Houston comes up with their new system (that is not a replacement for the TALHO system) the data that you see will be coming from that same pathway which is the state pathway. When Houston creates their own ESSENSE server they will decide who that data feeds in to. The ability to continue discussions will continue except for the state system will be the main system. We will not prevent people from getting information from another organization; however, we will not fund extra systems because they will not be necessary.
        - The servers that were the former TALHO servers that were operated by Houston are not the Houston database, the information is on the DROC system in Austin. Houston piggybacks on the MIRTH server and then is bounced back into their RODS server. Most of state is using the MIRTH server. There is no Houston system for the state. The state server is old and needs to be replaced. Houston is managing the system until it is updated. Houston has data from region 6/5S but not Austin/Travis County, all are within region. Went through a phase where they were getting signed up to receive info from BioSense but that has not occurred as of today. They have submitted test data but it has not been incorporated.
    - Dr. Huang (Austin/Travis County Health and Human Services) – reinstating that Austin is not losing the ability to get any data.
        - Beverly Pritchett (DSHS) – it will be an enhanced view as you will be able to view data from the entire region as well as an aggregated state view which nobody has at the moment. The current system in Houston will upgrade to have access to ESSENCE much like the Tarrant County system. TALHO users will sign an agreement to send us data. When we are done with the TALHO system we will start to accept new users and more people will be feeding into system.
    - Belinda Medrano (Valley Baptist Medical Center-Brownsville) – We could view health records with medical numbers while working at health departments, will this be happening on the new system?
        - Yes, names are not one of the data elements.
    - How much information can one health department see as opposed to another health department?
        - The only big change is the medical record number so it is traceable and identifiable. The county needs PHI for county information but that need disappears from the larger system with aggregated data. Will be able to see the cluster in another county but will not be able to see the patient information.
    - One issue in Houston memo – are we continuing to maintain the same relationships as we had with TALHO Houston?
        - By request we are going to ask LHDs to work with hospitals to maintain relationships.
    - Data points will depend on what DUA's say – should have some language that the data will be shared at the state level.
    - Another concern about potentially identifiable information – may be too identifiable in smaller counties.
    - Hope the data is collected to the standard showed by CDC is the standard for the state. Depending on DUA we can restrict access. The intent is to collect the data.
    - We will table this conversation and leave it as an item for next meeting if needed.
- VPN and SFTP Discussion
    - Madan Gopal (DSHS Chief Technology Office) – standard for any entity to interact with DSHS is SFTP

- Request is that we all focus on business requirements and what we need to set up connections so that there are no issues. One of the risks of VPN is that it is a hole in a system's network and is a security risk. With this day in age with hacking and stealing of information we need to make sure connections are safe.
- VPN technology is not favored among IT groups. CDC has used web services which is the state and national standard.
- FHIR – H07 standard, but not included in the meaningful use standards.
- Dave Heinbaugh (Tarrant County Public Health) - provide perspective from ten years' experience in syndromic surveillance with both SFTP and VPN, and provide rationale for why they've standardized on VPN transport as well as future use-cases.
- In discussion with folks at DSHS, VPN came up as a point of discussion as why do we do things with VPN instead of SFTP connections.
- In the process of turning RODS off. In transition to newest forms of ESSENSE, in moving to meaningful use, have gone from 5 to 70 hospitals. Working with a fairly large list of new hospitals. Used TALHO as initial data vendor, moved away from TALHO about 2 years before they went out of business and moved the data into Tarrant County into a VPN.
- Experience over the past ten years is that once they set up the VPN with hospital there are seldom issues, no lost data, and can handle outages and downtime. From a maintenance standpoint it is very viable. Problems occur occasionally with hospitals changing connection.
- If VPN connections are set up right and natted at each end, this allows ends to be tinkered with and still run smoothly.
- The reason for this conversation is because Houston and others want to submit their data via VPN for real time data however real time is a varying thing and there are multiple ways to satisfy the real time need, with VPN not being the only option.

c. Websites
- SSGC website contains all meeting minutes and the website is live.
- SS website hope to have completed and up soon to contain background information on syndromic surveillance and updates as we move forward. It will also include information on signing MOUs and frequently asked questions.
- MU website being updated to reflect Modifications to Meaningful Use rule published by CMS in the Federal Register on October 16th, 2015, and effective on December 15, 2015.

4. New Business

a. Fact Sheet
- Handing out for comments and ask that provide feedback by **February 5th** due to upcoming statewide webinar.
- Developed for distribution at Syndromic Surveillance Regional Advisory Committee meetings and to other stakeholders.
- Provide written explanation of TxS2, goals and objectives, and status.
- Basis for SS website.

b. Statewide Webinar
- Webinar for all local health departments and health service region offices to learn more about TxS2 and our plans for moving forward. This is tentatively scheduled for February 8 and an invite will be sent out as soon as confirmed.

- The statewide webinar is needed as the community is unfamiliar with syndromic surveillance and we find it beneficial to lay out information for all to learn.
- With the limited number of lines we will ask that local health departments and regions share the information they learned with the hospitals in their jurisdiction.
- Chris Taylor (Cherokee County Public Health) - a separate phone call is needed for the hospitals as opposed to relaying the information to them.

c. Topics from SSRACs for SSGC feedback
- 2 of the 8 regions met since the last Governance Council meeting
  - Region 1 – first meeting, in which DSHS provided purpose and direction of project.
  - Region 11 – charter is in final draft stage and its approval will be voted on at the next meeting.
- Questions –
  - Is there a way the regions could view the system in action (or what it may look like)? Many of the Committee members don't currently have access to syndromic surveillance so it's hard to visualize what this system can/may do without being able to see it visually. Being able to get a visual of the system in action will help towards having better focused discussions at our meetings.
    - Have asked John Hopkins University for screenshots.
  - Is there cross region information sharing?
    - Not related to syndromic surveillance information, related to meetings and information that comes up. We need to figure out how to have an "in the weeds" discussion.
  - Can hospitals see aggregate data within the region?
    - We have not decided on that yet. Should hospitals be able to see aggregate data?
    - Hospitals are sensitive and sometimes do not want their data shared.
    - Bill Stephens (Tarrant County Public Health) - Hospitals have appreciated the data that they can see, that way they can see if what they are dealing with is also going on in the rest of the region.
    - You can lock the data down to region if you choose to be that restrictive.
    - ESSENSE is very flexible in that manner.
    - The ability to share the aggregated data is important for preparedness and the user agreements become fine with the hospitals as they see the aggregated data they can see.
    - Is there an opposition to shared aggregated data within county and region?
    - When you are in a rural county does the information become aggregated at the county or regional level? The worry is being able to point out a smaller hospital.
  - Additional questions provided by Health Service Region 4/5 were discussed and are attached to the meeting minutes.

d. Topics from SSGC for SSRAC feedback
- Information and comments provided at the October meeting was shared with regions.
- Chris Taylor (Cherokee County Public Health) would like to make sure we have a framework for those conversations and breaking the meeting into technical aspect, legal aspect, and medical rationale, so that meetings are constructive and professional and get the info we need.

5. Open Discussion

- Legal aspects concern about the sharing of information, can we invite someone from legal?
  - Expect to have MOU next time, the legal document is not that complicated.
  - Once we get the documents from legal we will have a call to discuss them and get them moving forward.
- VPN or not is an important conversation to make sure data ends up in the right hands.
  - Need to make sure data is absolutely de-identifiable, the hospital is comfortable with what we are providing, and we need to provide a FAQ sheet and a contact for questions regarding security.

6. Remaining 2016 Meeting Dates and Times

   April 28, 2016, 1:00
   July 28, 2016, 1:00
   October 27, 2016, 1:00

7. Closing

ATTACHMENT 1:

Questions from Region 4/5N:

- Will notifiable condition reporting be merged with, or a part of the SS software package? If not, can this be considered? Hospitals in particular are unhappy with having to fax everything.
  - Syndromic surveillance data do not contain all the information (for example, name) that is needed for a notifiable condition report. Therefore, the method for reporting the notifiable conditions will not change.
- Will hospitals be required to log into the SS tool to provide the data that is needed for surveillance, or will the data be extracted directly from their EMR?
  - The data will be extracted automatically, nothing will change on the hospital data entry.
- What data will hospitals have access to see? Will they be able to easily see what we have extracted in a report format?
  - We have provided a listing of the data elements (PHIN document).
- When can hospitals expect to see an MOA/MOU?
  - We are waiting for these to come from our legal department and hope to have them next week.
- Is "hospital" a catch all phrase? In other words, will we try to partner with stand-alone ER's, urgent care providers and those who do not pursue meaningful use?
  - Yes. We also are interested in stand-alone ERs and urgent care centers.
- What level of detail will exist in the data that is extracted? DSHS EPI staff would prefer that we be able to have county or city level detail so that we can better target responses if necessary.
  - PHIN document includes all specific data points.
  - Done by zip code, can get down to that specificity.
- How will hospital partners be approached, and by whom? Does the regional committee have a role in this? If so, what it is it? Would it be led by DSHS region staff?
  - We have asked our regions to get with local health departments, and if they are acting as the local health department, they will reach directly to the hospital.
- Will there be a cost to the hospital? If so, is there a ballpark already? Will the hospital have to have I.T. staff dedicated to the project, short term or long term?
  - Cost to hospitals is IT time, between a few hours and a few days, to create the connections.
- What will be the approach for handling large hospital systems? Contracts may have to go to principal administrators, but the CEO's of the smaller component hospitals will want the opportunity to take the items to their central admins and discuss.
  - Our intent is to start at the local level and will be happy to facilitate with large corporations but local level will be dealt with first.
- Can the regional team have the call-in information for SSGC meetings to listen only?
  - This has been provided to the regional teams.
- What is the role of the region group? Are we leads in bringing in hospitals and others, or will we be given people to contact – how will this work?
  - We have contact information that we can provide but most of our local health departments work closely with hospitals and will rely on those relationships.
- We find it challenging to know who the main person to contact within a hospital is, do we have a list of IT within hospital?
  - We have created a survey to collect that information and will create a master list. The survey will be sent out after the statewide call on February 8th.