Syndromic Surveillance Governance Council
Meeting Minutes
October 29, 2015
1:00 p.m. – 3:00 p.m.
DSHS, 1100 West 49th Street, M101
Austin, TX 78754

Attendees (* Voting Member):
*Carol M. Davis, BS, MSPH, Program Mgr., Health Service Region 7, DSHS
*David W. Gruber, Assistant Commissioner, Division for Regional and Local Health Services (RLHS), DSHS
*Peggy Hines, Health Information Technology Mgr., 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
*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, BS, CM, Executive Director, Cherokee County Public Health
*Don Vickers, Med, CEO/Managing Partner, HPT Healthcare
Leo Achembong, BDS, MPH, Health Systems Integration Program Fellow, CPEA, DSHS
Carrie Bradford, PhD, Team Lead for Syndromic Surveillance, RLHS, DSHS
Savannah Carlson, Administrative Assistant for Syndromic Surveillance, RLHS, DSHS
Steve Eichner, HIT Policy Director, CPEA, DSHS
Dulan Hailoo, MD, MPH, Houston Health Department
Alex Huff, Texas Hospital Association
Jay Jackson, Project Manager, RLHS, DSHS
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
Vinny Taneja, Tarrant County Public Health
Biru Yang, Houston Health Department

Voting Members Not Present:
*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

Proceedings:

1. Welcome
   - Mr. Gruber welcomed everyone to the Syndromic Surveillance Governance Council (SSGC) meeting and the importance of this meeting as the project is moving forward.
   - Roll call was completed and a quorum was present to conduct business.
   - The pace of the project is rapidly increasing as we have completed much of the paperwork and mechanics behind the system and are starting the implementation of the system.
   - Many of the regional advisory committees have met with the exception of Regions 1 and 6/5, but they are planning meetings soon.
   - The Governance Council relies on the regional meetings to provide feedback and to ensure that the field has a voice and that the Council is responsive to that voice.

2. Introductions

3. Approval of July 30, 2015, meeting minutes
   - The previous meeting minutes were approved as written.

4. Old Business

   a) Agreements
      - Still waiting to receive Memorandum of Agreement (MOA) and Data Use Agreement (DUA) templates from our legal department.
      - In general, there will be two versions, one for local health departments and one for hospitals. There will be some differences in the hospital template depending on if they are part of a hospital system.
      - The general HHSC DUA for local health departments has been approved and is being signed by local health departments. These local health departments will still need to sign an MOA for connection to the system and data sharing.
      - Regardless of the different programs local health departments deal with across HHSC, there is a singular DUA that needs to be signed by January 1.
      - The hospital MOA will be vetted through Texas Hospital Association (THA) and Texas Organization of Rural and Community Hospitals (TORCH) prior to being sent to hospitals for signature.

   b) Status of IT Contracts for Infrastructure
      - Handouts were provided as a reminder of the system configuration and timeline.
      - Three contracts will be necessary for the system infrastructure.
      - Johns Hopkins University – developed the front end application (ESSENCE). The software is free, but there is a cost to install, configure, and maintain the software. Johns Hopkins is not able to bid and the software is proprietary so going through the sole-source process to obtain a contract for consultative services. Documentation ready to submit to legal.
      - Uber Operations – contract would be to configure and set-up the Health Services Gateway and Rhapsody as well as an Enterprise Architect for 3 months to work with the DSHS Chief Technology Office for knowledge transfer. Currently in legal review.
      - Neither of these is on the critical path for the timeline because we have enough information on ESSENCE for the architectural design for SPARC review (SPARC is an

internal architecture review committee to make sure architecture set up to get what we want).

- After SPARC, we can submit to Texas Data Center Services (DCS, third contract), to get the infrastructure (servers and database hosting) in place.
- Uber Operations and DCS are existing contracts that just have an amendment for this project and do not have to go through the competitive bid process.
- Based on the timeline, we expect to spend December through April doing design and build and be ready for the San Antonio pilot by the end of April/beginning of May. In June we plan to do the migration of Region 6/5 data providers in the former TALHO system and the integration of a data stream from Tarrant County Public Health, with a project completion by June 30. Remaining data providers outside Region 6/5 and any other data providers not currently participating in syndromic surveillance will be connected after June as part of operations.
- A question was asked about the difference between migration and integration. Migration is moving data providers off the former TALHO system to the new statewide system while integration is that Tarrant County Public Health maintains their system and sends us a non-aggregated data feed of data that is going into their system.
- A question was asked about if this was different than previously discussed with Houston Health Department and Tarrant County Public Health. A comment was made that people may have left that meeting with different understandings; but the DSHS plan has not changed.
- Houston Health Department requested to discuss the misconceptions of the status of syndromic surveillance at the Houston Health Department. Portions of the attached transcript were presented (due to time constraints the entire document was not presented).
- Houston Health Department proposed to change “migration” to “integration” for Health Service Region 6/5. Houston Health Department requested a meeting with Tarrant County Public Health, Houston Health Department, Health Service Region 2/3, Health Service Region 6/5, and DSHS Central Office.
- While DSHS supports the proposal for a regional lead for partners and this is why the regional advisory committees were established, the information presented by Houston Health Department is contrary to what their leadership has previously indicated and what had been universally accepted as the way the statewide system would proceed. Houston Health Department, under contract with DSHS, was to maintain the former TALHO system as-is and DSHS did not agree to any changes made to the system.
- DSHS continues to support a regional lead and is looking to work with the regions and local health departments to bring hospitals onboard.
- DSHS will have a meeting with Houston Health Department leadership to go over what was discussed in the past and the new information that has been presented.
- A question was asked about the reason behind the former TALHO system dissolving. TALHO had financial issues and went bankrupt. Houston Health Department offered to maintain the former TALHO system and it was integrated in the Houston Health Department in 2013 with DSHS providing financial support (salary for two FTEs) to maintain the system. According to Houston Health Department, prior to 2008, they had assistance from the University of Pittsburg to build a syndromic surveillance system and hospitals connected directly to the Houston system. That support ended in 2008 and Houston Health Department transferred the connections to the TALHO system. Houston Health Department has the personnel and equipment to have hospitals connect directly with the Houston Health Department again. The only relationship that Houston Health Department has with the TALHO servers in Austin is to aggregate the connections and

send data back over to Houston (connections go from Houston hospitals to DROC back to Houston).
- A question was asked if the difference between integration and migration was solvency and if another local health department has a system and maintains it on their own, can the data be migrated and shared with the state system while the local health department maintains their own system. This configuration would be acceptable as long as the data points are the same.
- A question was asked to be discussed at a later time regarding governance issues and data sharing and how the data gets to the global system.
- A question was asked if Texas will share the data with the national system to represent the state. The data will be submitted to the national system.

c) Website
- The state syndromic surveillance meaningful use website has been up for a while and contains information stating there is no statewide system for hospitals to submit data under the meaningful use program and how to obtain an exemption letter.
- The Governance Council website was recently completed and contains meeting agendas and minutes, as well as council members and contact information.
- Currently working on a general background syndromic surveillance in Texas website that will link to information on the meaningful use and Governance Council websites.

5. New Business

a) Appointment of New Members
- Just before the last meeting in July, DSHS was notified that Natalie Lamberton, health care representative, would no longer be able to serve on the Council as she took a position out of state.
- DSHS has been trying to fill the vacant position and sent out a call to CEOs at hospitals throughout state (over 600 hospitals) to notify them that the position was open for applications/nominations.
- We received seven applications that were screened by a panel.
- The top two candidates were very qualified and could provide different views that could be beneficial for the Council as well as represent several areas of the state, including an area that we currently do not have representation at this time.
- Based on the charter, there is a minimum representation from hospitals of two people. Currently, there is one representative and a vacant position.
- One candidate has infectious disease and health informatics background and the other was engaged in setting up syndromic surveillance in South Texas.
- DSHS asked the Council to vote to expand the current membership by one to add expertise that is a good balance with the current health care representation and others currently serving and gives expertise not currently on the Council.
- This is not in contravention to the Council charter and is not necessarily a permanent increase in number.
- It can be a daunting concept to represent all the hospitals in Texas; therefore, it is prudent to add an additional member.
- Motion was made to add an additional hospital member and backfill the current vacant position. Motion was seconded and none opposed, motion carried.

b) Future Meetings Days and Times
   - Currently, the Council meets quarterly on Thursday afternoons. If there are no major conflicts, will continue this schedule for 2016. No comments were made.

c) Topics from SSRACs for SSGC feedback
   - Regional Committees are to meet and provide feedback to the Governance Council. Since the last SSGC meeting in July, four of the eight regions have met. Most of the regions are still forming and most discussions at the meetings are central office providing updates as we move forward with the implementation and the committees discussing their charters and membership.
   - Region 7 met twice since the last SSGC meeting and are working on charter development.
   - Region 8 had their first meeting and are working on their charter.
   - Region 9/10 had their second meeting and are working to complete their charter.
   - Region 11 had their second meeting and are completing their charter.
   - Other regions that have not met yet plan to meet very soon.
   - The regions have been asked for topics to bring to the Governance Council and there are none at this time.

d) Topics from SSGC for SSRAC feedback
   - Regions have asked for the Governance Council to provide topics for them to discuss at their regional meetings.
   - After meetings with Houston Health Department and Tarrant County Public Health, bring back to the Council the concept of what is being proposed for discussion and then take to regions for feedback.
   - A question was asked if there are any issues with the data use agreements and negotiations with hospitals that need to be worked out. DSHS had a call with the regional representatives about the best methodology to get agreements out and signed. The regions felt the best way to approach hospitals is for regions to work with the local health departments in their jurisdiction and the local health departments (or regional office when no local health department) work with hospitals in their jurisdiction.
   - Hospitals will not have to sign the HHSC DUA, they will sign a much shorter document agreeing to share the data because they are a HIPAA-covered entity.
   - This is a way to preserve and embrace the local relationships with hospitals.
   - THA and TORCH have agreed to vet the agreement prior to it going out to any hospitals.
   - The Governance Council will be able to see the templates prior to them going out to hospitals.

e) Meaningful Use and Intent to Submit/Queue Process
   - As the system gets developed, and as part of meaningful use and the onboarding process, there will be step by step instructions of indicating intent, getting the agreement signed, and getting through testing to active data submission.
   - We intend to have all of this on the website.

6. Open Discussion
   - Question was asked regarding how does syndromic surveillance fit in with health information exchange activities and that relationship. This is a consideration and it has been discussed how this could be done. HHSC encourages the use of HIEs whenever possible, but we have to consider if there will be a cost for the HIEs to send the data to us and how significant is

this cost, In addition, there would have to be an agreement with the hospital and the HIE. We also have to consider how frequent the hospitals report data to the HIE (for example just daily reporting). In the past, HIEs received grant money to allow connectivity with state agencies, but HIEs can also be privately funded in which there might be a cost or issue with getting the data. The model was that hospitals go to the HIE through electronic health records, and meaningful use dollars would be used to pay for that health record which included syndromic surveillance. The design was that hospitals feed to HIEs which feeds to the region, then to the state and federal levels. Funding sources are set up to help with that. Idea is to allow hospitals to leverage existing connections with HIEs and the HIE would forward to the statewide system. The interoperability standards have already been established and it is up to the state to identify how those standards are to be integrated into the electronic health record systems. For syndromic surveillance, the components are there but the standards have not been defined in Texas. Once the definitions are there, any hospital receiving meaningful use dollars are meeting the standards, it is just a matter of whether the data goes to the HIE or one of the state systems.

- Regional groups have been asking for more guidance for a year and have not received it yet. In the interest of buy in and building something people will use, regional input important.
- From a regional perspective, one way to jumpstart regional advisory groups is to get them some basic topics to discuss. Region 7 decided that two items to discuss until they get more direction from the Council are 1) if there was an ideal system with no restrictions, what would it look like (what is the wish list), and 2) document concerns and fears with developing a system. In the past there have been tensions between health departments and hospitals and hospitals and the state. It is important to document these issues so we do not repeat the same mistakes as in the past. It is important to provide a purpose for the regional groups to meet.
- The original intent was to stand up the regional committees to ensure there are relationships between the local health departments and the hospitals in their jurisdiction, and to form these relationships as needed. We have also educated on what the system is and how we intend to establish the system and its intended uses.
- Identify best practices in the different regions, what is going on with syndromic surveillance, and how are people using the system.
- Regions should be provided a standard set of topics that should be discussed at each meeting (for example, issues with bringing hospitals onboard).
- Regions should also be provided a standard presentation that represents what syndromic surveillance is, best practices, and showing work done by Tarrant County Public Health, Boston, and New York. This would show the field epidemiologists what can be done with the data and allow for everyone to have a similar knowledge base.
- Send any ideas to Carrie Bradford.
- Another standing agenda item for regions could be what the concerns from the region are and if there is any other feedback they would like to provide.
- It was also suggested to do a full analysis of the HIEs as a potential way to do syndromic surveillance and other disease surveillance. Tarrant County Public Health and Austin/Travis County Health and Human Services Department can provide information.

7. Proposed 2016 Meeting Dates and Times
    - Meeting notices, agendas, and updates will be sent from Carrie Bradford or Savannah Carlson.

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

8. Closing
    - Motion to adjourn the meeting was passed and the meeting was adjourned.

ATTACHMENT:
Proposal Submitted by Houston Health Department

A Proposal for a Statewide Federated Syndromic Network

Presented by Biru Yang, PhD, Informatics Manager for HHD and Wesley McNeely, MS, MPH Syndromic Surveillance Program Coordinator for HHD to the Syndromic Surveillance Governing Council on October 29, 2015.

I've been asked by my leadership to speak on the issue of syndromic surveillance at the Houston Health Department (HHD) as it relates to the current plans with the governing council. The thrust of this short presentation will be two-fold: a) to address some misconceptions about the nature and status of the syndromic program at HHD and b) to prevail upon the council to give serious consideration for a modification to the existing plan that we believe, far from upending the cart, will speed the success of the program and allow the state to meet and exceed its goals.

What we propose is a partnership between the state and other existing syndromic systems in what is being called a federated or "hybridized" model. The council has already partially acknowledged the expediency of such a model by changing their original plan from the outright absorbing of Tarrant County's system to partnering with them, in fact allowing them to continue on as they are. This new approach is a move from "migrating" to "integrating". If the council were to simply extend that idea to the other existing networks in the state, the overall strategy would continue as before with DSHS acquiring their own ESSENCE based system and joining an already robust syndromic network. The federated model represents an enhancement, not a weakening of the statewide plan.

HHD has not communicated effectively to the council how integral the Houston syndromic network is to the overall electronic disease surveillance program at HHD. Syndromic data is a but one of many vital components in an overarching public health informatics program at HHD that includes electronic laboratory records, electronic health records and several other data streams. HHD is consolidating our previously disparate streams into single VPN tunnels from each hospital system and syndromic surveillance streams are part of this consolidation.

If the state were to migrate instead of integrate syndromic connections and relationships that already exist we believe it will degrade rather than support the local health department's ability to work with and engage local hospital systems directly and closely. At its best public health is a local endeavor. This would stifle and restrict our overall plan of electronic surveillance which has been many years in the making and serve to diminish relationships with our regional hospitals that have taken years to develop. This will also threatens our contractual agreements with some of our major funding sources, runs contrary to good public health practice as well as the mission of our department.

It has been stated that HHD's system is wholly reliant upon DSHS for support and withdrawal of that support would render our program inoperable. In actual fact the Houston RODS system was purchased and installed in 2003 partially with federal funds, and the University of Pittsburg who developed the system and initially bore much of the cost. After this that HHS was left on its own to run the system with no outside support for several years. Then in 2007-2008 when our director Stephen Williams was the chair of the TALHO board he instructed us to give funds to TALHO as a way of shoring up their budget and in return TALHO would act as our data connection aggregator. This was completed in 2008 (along with an upgrade to RODS and the addition of the remaining large Houston area hospitals). When TALHO became insolvent in 2012, because they were our aggregator HHD stepped in and assumed ownership of the most critical elements which included their own RODS instance (which HHD does not use and serves other jurisdictions and an outdated ESSENCE instance which

replicates their RODS). HHD also retained two temp FTEs. These FTEs alone are the point of support provided to HHD by DSHS since late 2012. However all other operations are managed by HHD. Let me reiterate, the ex-TALHO servers are relevant to Houston Health only insofar as they route connections back to HHD which started in Houston to begin with. Houston Health does not use the RODS or ESSENCE server that is installed in Austin: the only relevant part to our syndromic system is the MIRTH server in the DROC (Disaster Recovery Operations Center) which redirects Houston area feeds back to HHD. All the same HHD manages the other syndromic servers at the DROC which are used by other LHDs in Texas with support from DSHS.

I ask the council to remember the example of Biosense 1 of 12 years ago which failed because the CDC did not engage the local health departments but communicated directly with hospitals. Only after millions of dollars were spent and relationships damaged was this acknowledged as a failed process. To this day there are regional hospitals in 6/5S which will not join the RODS network because they are cooperating with Biosense in a agreements made over a decade ago without any notification to our program.

Biosense version 1 failed for these reasons:

- lack of inclusion of the local and state health leaders until after the system was developed
- lack of understanding of the culture of public health surveillance by the developers
- result was 80% junk data

For similar reasons we maintain that a centralized system run by DSHS will be unnecessarily costly with a strong likelihood of failure unless alterations in the existing plan are made. To date syndromic planning has proceeded as an IT project, working on hardware specifications and infrastructure, not as a bottom up community endeavor starting with a user needs assessment. We argue that even a technically excellent system from a functional standpoint will likely fail without community input and a needs assessment. These issues must be addressed first before a single technical schematic is drawn.

Instead we propose a hybridized/federated model, partnered with DSHS instead of the current centralized proposal.

- all three agencies (TCPH, HHD and DSHS) need their own instance of ESSENCE
- 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.
- TCPH and HHD to administer their own regions.
- DSHS should administer the remainder of the state.
- 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.

At this time I would like to request that a side meeting be held between the leadership of TCPH, Region 2/3, Region 6/5S, HHD, Mr. Gruber and Ms. Pritchett on a date and place to be determined later.

This concludes our remarks.