

**MINUTES FOR THE MEETING OF THE BOARD OF THE
BOSTON PUBLIC HEALTH COMMISSION
Wednesday, October 11, 2017**

A meeting of the Board of the Boston Public Health Commission ("Commission") was held on Wednesday, October 11, 2017, in the Hayes Conference Room, 2nd floor, 1010 Massachusetts Avenue, Boston, MA 02118.

Board Members Present:

Francis J. Doyle, Esq., Chair; Monica Valdes Lupi, JD, MPH, Executive Director; Joseph Betancourt, MD, MPH; Harold Cox, Myechia Minter-Jordan, MD, MBA, and Manny Lopes.

Also Present Were:

E. Oscar Alleyne (via conference call), Kevin Cranston, Karol Samelko, Sarah Kennedy, Heather Gasper, Debby Allen, Puneet Sharma, Catherine Cairns, David Gallagher, Maia BrodyField, Samantha Bousiquot, Katie Donovan, Gerry Thomas, Edgar Doran, Amar Mehta, Marjorie Nesin, Stacey Kokaram, PJ McCann, Snehal Shah, Souad Elaraari, Elizabeth Remigio, Rita Nieves, Triniese Polk, Chief Jimmy Hooley, Debra Paul, Alicia Hemenway, Margaret Reid, Chanel Daly, Tim Harrington, Oyin Kolawole, Chuck Gagnon and Kathy Hussey.

Proceedings:

Chairman's Comments

Francis J. Doyle, Esq.

- Mr. Doyle welcomed everyone and called the meeting to order at approximately 4:07pm.
- We have an exciting meeting planned for today. We're pleased to welcome members of the new Health Equity Advisor Committee who are here. Monica, do you want to introduce folks? Monica stated we have time carved out in the agenda to present them formally to the Board. Terrific, well welcome anyway.
- We've been talking a lot about the Strategic Plan with our Executive Director and her team. We've also had several presentations. I also know that today we're going to cover kind of a forward thinking about the capital budget and other items into FY19 and to begin preparation for justification for FY18. We'll have a presentation on that as well. Then the national initiative Digital Bridge will be presented too. Then we'll go through showing the promise here in Massachusetts. We're delighted to have you here.
- I would entertain a motion to accept the minutes from the September Board meeting. Myechia Minter-Jordan has accepted the motion and Harold Cox has seconded the motion. Are there any objections? As there are no objections, the minutes from the September 13, 2017 Board meeting are hereby accepted.

Report from the Executive Office

Monica Valdes Lupi, JD, MPH

Executive Director, Boston Public Health Commission

- Thank you. I just want to run through quickly some updates for the Board.
- Since we last met, I did share with the Board some news about staffing transitions on the team. I see two of our senior leaders in the audience this afternoon and just want to make sure we have an opportunity to acknowledge them.

In the note that I sent to the Board, I relayed that we are really disappointed, but also thrilled, about new opportunities for our colleagues here at the Commission.

Debby Allen, Bureau Director, for Child, Adolescent and Family Health Bureau and has been here for nearly 9 years has shared with us that she's accepted a new opportunity. I'm not actually sure if that was not a covert operation at the time. I sent the communication to the Board, but I'm not sure if you can talk about it yet Debby. Debby said she can only say she's moving West, very far West. Monica said that's maybe to an organization comparable to where she works now to pursue a really exciting opportunity which we hope to share with you in greater detail as soon as her CORI clears!

I want to thank Debby for her tremendous leadership here at the Commission over the last 9 years and the work that she's lead across the divisions to support maternal child health activities, the work that we do with our school-based health centers and our peer initiatives and much of the work that we've presented to the Board over the last several months on our Neighborhood Trauma Teams. The work that we do on violence prevention and trauma teams falls under Debby's bureau. So thank you, Debby.

The other leader that I wanted to recognize is I know, one of the Board's favorite presenters at meetings, Snehal Shah, who has been our fearless leader of our Research & Evaluation Office for again about 9 years, has really done a lot of work. I know when I left the Commission the Research and Evaluation unit looked and operated much differently than it does now in terms of our report and our capacity to do really complicated analytics across multiple surveillance systems, both internal and external. We wouldn't have been able to do that without her commitment and her unwavering passion to data. Snehal is leaving to pursue a really exciting opportunity at Children's Hospital. Maybe Dr. Shah, Snehal if you could say a little bit about that?

Yes. I'm going to be working at a new center they started for Applied Pediatric Analytics and will also be doing some work with the ACLT and I'll still see patients.

Frank congratulated both of them and thanked them for all the work they've done over the years. The audience gave Debby and Snehal a well-deserved round of applause.

Monica continued that we've been meeting with Debby and Snehal over the last couple of weeks. Rita will be helping us to recruit for these vacancies. We will be able to announce an interim on a staffing plan to support their day-to-day as we work to backfill these two positions. Thank you, Rita, for your help with that.

- Since we last met, I also wanted to flag an advisory that we sent through our Medical Intelligence Center. I hope many of the Board members received this. It was at the beginning of the month of September. It was a health advisory regarding what we're seeing in terms of opioid overdose trends. What we saw from the data that we track through our Boston EMS narcotic related illness system is that typically August and September are busy months in terms of what we see in EMS transports of fatal and non-fatal overdoses. In this last reporting cycle, what we did notice was that in the first fourteen days of September there were 243 narcotic related illness transports, which was nearly twice as much as the entire month of September in the previous year.

We're continuing to monitor this trend. We have fielded multiple calls from external partners to get a better handle on what we're doing as a city, as a health department on this. I wanted to relate to the Board that in the last two weeks, we've stood up an internal working group that's being led with Devon Larkin, our Bureau Director for Recovery Services, Jen Tracy, Mayor's Office of Recovery Services and myself. We've been working in the short-term, talking with Health Care for the Homeless in terms of what they're seeing in their locations and also with colleagues from Boston Medical Center. We're trying to figure out some discussion topics that we'll tee up for a larger convening. I will keep the Board up-to-date on that. I appreciate everyone's support and guidance as we try to figure out how to ramp up our strategies and our interventions around dealing with the opioid crisis that we're seeing. Let me pause and see if there are questions about that.

Some things I would share with you are that we have ramped up our coordinated street outreach engagement activities with multiple community-based organizations and multiple programs across the Commission in our neighborhood so that has been successful. We're looking at taking staff, leveraging staff from other programs to help with that expanded outreach. We've been talking about

the importance of overdose prevention training and putting more of a focus on rescue breathing and the importance of ventilation in addition to the administration of Narcan. So that's another piece.

Another issue or challenge that we're all grappling with both locally, state-wide and nationally is how we use our surveillance systems to better predict and prevent overdoses. So we're really looking at our analytic capacity internally and in partnership with our state colleagues. Those are sort of the three things that have come in the last couple of conversations.

Myechia asked: Is there was a plan to convene the local providers, in addition to the outreach community agencies that we partner with, is there a plan to convene local providers to help create a frame-work that everyone should follow as we're thinking about this?

Monica replied that she thought we talked about this, that we'd take a leadership role in that. Actually, our Board Chair and I have been talking about that, for probably the last several weeks intensively now, to think through how we can better coordinate the services because it really is a remarkable time when so many of our partners have been involved in the response. We've had an investment of resources, so how do we make sure we're all involved in lock-step and know about each other's efforts. Even in the last couple of conversations, Devin and I learned things that we weren't aware of just in a smaller group discussion with our DPH colleagues. I think that is something definitely that the Board can help guide us in that direction. I don't know, Frank, if you want to say a little bit more about your preliminary thinking.

Sure. There are a lot of levels that want to enter into this collective that we're all in as you mentioned Dr. We've talked as a Board about the convener role at the Commission. It seems that we really are in a period of time where getting harnessed all of these resources, and we have a wealth of resources. It seems there's never enough on this issue. We certainly haven't taken it down to the purative stage at all. There are a lot of resources and a lot of activity. And as Monica noted and I know you understand as well, there's not a lot of coordination of all that's going on, even though there is a lot going on with all the right intent. So, we've been talking at the state level, as well as at the city level, about who should be that kind of convener and what that convener would mean and look like as opposed to just getting us all together to kind of think through. We can engage independently and talk a little more about that.

Dr. Minter-Jordan said she would like to see that because we have been talking about the convening role of the Commission for a long time; for as long as I've been on the Commission. We do that in different ways and I think that this is a really important space for us to do that and to create a plan of action around that and to act sooner rather than later. As you've already stated, just the sharing of information about what people are seeing on the front lines, as well as resource sharing, as well as we all struggle with trying to hire people in this space, if there's an opportunity to make sure we're getting the right people into the right jobs as we try to work on this issue. I think there are so many pieces of that that we could really formalize as a means of keeping people on a regular basis. I'll be happy to help in working around that.

Frank had one other question. I noted in one of the pieces that were in reaction to the report we had given out about the most recent data, that there was still investigation and study being done as to the potential reasons why we were seeing the increase. We talked earlier about whether it was seasonal. They also mentioned in that other piece I saw, that they are not sure yet, and I didn't know if Chief Hooley might have any data coming out of EMS around are we seeing higher levels of Fentanyl in the opioids. What are the Chief and the people with their boots on the ground, the EMTs, seeing, or feeling, or even guessing at this point, as to any external impacts are, other than the seasonal way that this has fallen over the last few years.

Monica replied that it's definitely Fentanyl. Fentanyl is driving that we're seeing. Rita Nieves commented that the last data looked at for mortality data for 2016 was like 50 something percent. Snehal said that it was higher than that; it was closer to 70% in deaths from 2015 where the ME documented Fentanyl as contributing to that and that's increasing the proportion of deaths. Monica continued that definitely Fentanyl is a driver and also Fentanyl in other substances, such as cocaine, marijuana and heroin.

Frank asked: do we see these drugs come in with different potency and at different periods? I'm just wondering if the Fentanyl we've seen now in these cases is any more potent, is it any worse, or is

it just the same trickle of Fentanyl into all of these other carriers, if you will. Monica said she didn't know what the answer to that was in terms of Fentanyl potency. Rita said she thinks it varies. They do controlled buys and sometimes there's more Fentanyl in the sample they buy than in others. This weekend was a very tragic one. We had a number of deaths and they were spread around, too. We suspect that drugs with higher potency get on the street. And that's why we see the spikes sometimes.

Rita continued saying the other really big challenge we have is the deaths of people that are unknown to us. They've never had any encounter with EMS or its system of care. Then they show up in our numbers as a fatality. Typically, about a third of the deaths that we see are in homes, in the intimacy of peoples' homes, people that are totally unknown to us. Thinking about how to get information and prevention and harm reduction messages to people in that situation continues to be a big challenge. The other people tend to be people we've had at least one encounter with EMS or are known to us in one way or another, whether they're a guest in a shelter or a client in a treatment program within the city.

Myechia asked: do we have any sense, when that happens, and I'm assuming that most of these happen within Boston and are the people who are dying in homes from Boston? Rita replied that it's all Boston. Myechia asked: meaning that they didn't come in from somewhere else and die in home in Boston? They are Boston residents as far as we know? Rita responded that they tend to be residents. They have do have an address, but sometimes someone can be visiting and die in somebody else's home. Myechia said part of the reason she asked that question is we talk about the network of community health centers. Is there a way to leverage the community health centers by having some community sessions for providing more education? I think, again, that the convening role and laying out a framework of what things should happen, and using which stakeholders could do that type of work. I think each health center is taking this on in their own way but if there were a game plan that the Commission created to say once a year we'll hold a community session and invite people in to educate them. That's a means by which we can get this information out more broadly. So I would encourage you to tap into that resource.

Manny said he agrees and would echo and look at some of the examples, such as measles, mumps, breakouts like swine flu vaccine. We've been successful when we leverage the network and the resources that we have in the city. And, of course, we all know it's about time. We've been in this crisis for a long time and now we're seeing an increase. It really is time now to call everyone to the table and maybe even rethink some of the work we're already doing. We're all being approached by different private and government agencies that everyone's coming up with their own ideas or their own ways of tackling this issue. I agree it's probably still not enough money, but there's quite a bit of money flowing in to each one of our organizations. There's a better way for us to organize and say here's the path we're going to take, at least, to deal with this issue in this city and hold it up as a model at some point. I would agree that it's time for the Commission to step in.

Monica commented she thinks the suggestion about how to leverage that CHC, community health center network is a good one, particularly since we see the data by EMS transport by address. So when we're thinking about opportunities for those patients where there are non-fatal overdoses, I definitely see an opportunity there in terms of harm reduction and prevention efforts. That's certainly something that we can follow up on.

Myechia stated there is funding, but there is also new funding coming online through the RISE Fund. That may be a really strong proposal to submit to them around engagement of community resources and as a means of outreach and prevention. I happen to sit on that board as well, so we can certainly talk about this offline.

Frank said lastly, to add on to what Manny and Myechia have said I would encourage staff to understand that these cycles, as you know, of government attention, philanthropic attention, last for very short periods of time. So, this high-level, not wealth of, but high-level of resources that we currently are seeing from GE and other philanthropic entities, like Grayken Center, as well as other federal and state funds that have come in, will begin to be redirected to other causes. I think both the beauty and the challenge for us and for the city when we get to the kinds of things you were talking about Commissioner Lopes, is to be able to package them for sustainability. The populations that

we're talking about, largely but not all are Medicaid recipients. That means that in the new world beginning in January, and more effectively in March, Accountable Care organizations will be responsible for the costs of those lives in that population. If we use the money wisely now and come up with some both clinically and financially structures that we could talk to our ACOs about as far as sustainability later. We would have done a great service during this period having some dough to be able to expend on ideas and collective action to be able to get them to sustain over time. It would be to their own self-interest, not only just for the patients they care for most about, but for their own financial interests.

- Monica had a couple of more updates. I want to acknowledge that this has been a tough couple of weeks. In addition to the advisory that we sent last month, because of all these natural disasters that have been happening in the Caribbean and then also in Mexico. Many of our staff and colleagues have been personally impacted. I know Rita was personally impacted; her family is ok. There's a lot of work to do. I know Dr. Betancourt was personally impacted by this.

So I did just want to share with you some updates from our perspective here at the Commission about how we're working with the Administration on preparing for receiving evacuees from Puerto Rico in particular. I want to acknowledge that a lot of devastation has happened throughout many islands in the Caribbean. We have stood up a working group at City Hall that's being driven by the Office of Emergency Management and our colleague Rene Fielding. It is a cross-departmental group with the usual people you would anticipate are participating: everyone from the Boston Police Department to Boston Public Schools, Sheila Dillon, DND, Boston Housing Authority, the Commission, many of our Health and Human Services cabinet, the Disabilities group, Office of Fair Housing, food access. Chief Hooley and I represent the Commission. We've met twice and wanted to give you just a sense of what we're doing internally. Even before we met, we'd already stood up an internal working group here that our Director of Public Health Preparedness, Stacey Kokaram has been leading for us.

Some of the things where we're being tasked with coordinating and helping to prepare updates and facilitate action items are around some of these activities. Clearly health insurance support, so when colleagues, friends, family from Puerto Rico are coming to the city, we're able to assist them in terms of a whole host of eligibility requirements that they'll have to go through. Whether it's for MassHealth, with SNAP and other benefits, our Mayor's Health Line is ready and can be quickly mobilized to help with those. They are involved with community-wide meetings with partners that are already thinking through how to prepare for people who are arriving. We're still awaiting some clarification from the state about those eligibility requirements, but know that we'll play a role in terms of coordinating.

Internally at the Commission, we're assessing our language capacity. I'm really proud the diverse languages that many of our staff speak. Other departments have also been asked to shore up and identify and assess internal capacity in terms of Spanish speaking staff. I think just last week, Police Commissioner Evans sent 15 police officers who are bi-lingual to Puerto Rico for a two week rotation. The language capacity is something that we'll be providing and coordinating internally.

Disaster and Behavioral Health Services were working with self-evacuees, with our residents, with our own colleagues and workers to provide Disaster and Behavioral Health Services, this actually comes out of Stacey's team in Public Health Preparedness, in making sure that we're paying attention to the behavioral health needs of our own clients and also our staff, as again, many of our staff have been impacted. Helping with outreach and education, Stacey has reached out to federal HHS to get a handle on risk communication and the talking points that we should be using. I personally reached out and shared with Commissioner Bharel that I had reached out to colleagues at CDC. Several of us have worked with the person at the CDC, Sam Tavares, who was the point of contact at CDC for Zika response activities in Puerto Rico and, is again, have identified as the supporting role at CDC with FEMA, who's the lead agency at the federal level.

Health Care Services. We have been working and thank you to our health center colleagues, for doing your internal assessments to develop a sense of search capacity and where you will be able to support with primary care needs of the families that will be arriving. We've reached out to John Irwin at the Conference of Boston Teaching Hospitals again. We know that they're also doing a lot

of internal work to assess their ability to provide search capacity. They're figuring out in terms of donations of medical supplies they can be making in the ongoing rebuilding and recovery efforts.

We also have learned from our Region 1 colleagues that federal HHS has activated a program, I hope you have all learned this by now, called the Emergency Prescription Assistance Program or EPAP for Puerto Rico which will allow people who don't have health insurance to replace their medical products after a disaster. This covers things like their prescription drugs, medical supplies, vaccines and other durable medical equipment. We can share that with you offline if you haven't seen that advisory.

We're also working on food assistance with colleagues. Gerry Thomas and her team had already been working on it, thank you, with our colleagues at the Boston Health Care Conference in creating a map inventory of all the different food resources that are available by type and across our neighborhoods. We've shared this as a model with our colleagues at City Hall so that can use that as a starting point to collect information from other city departments.

Finally, we're also working with Boston Public Schools and Superintendent Chang on this Tiger Team that he's assembled. So again, multiple departments involved in that helping prepare students for registering for schools and making sure the transition and any support they need to help with that transition as quickly as possible.

I wanted to share that with the Board so you knew how we were involved and engaged in the city-wide process. I know that Joe has been leading a lot of this work in the community and wanted to give Joe a chance to share any updates.

Dr. Betancourt. First, I want to thank you for your leadership with all the things that have been going on. I think it's been a challenging time, with Houston, then Florida, the Islands, then Puerto Rico, then Las Vegas and now the fires in Northern California. The attention span of the media is to jump to jump to jump. I don't think we should forget any of those tragedies and certainly be responsive and responsive quickly, in any and all ways that we can. I think we still have the majority of the Islands without electricity and water. About 40% of cell towers are up, so people are still struggling. I don't know about you, Rita, but I haven't heard about a lot of folks coming. I think people are sticking it out. They want to get their communities back. I think we may not get this surge we're preparing for just because people want, despite really tough circumstances, feel they want to be a part of the rebuilding.

Rita agreed and commented that she heard people are being charged \$1600 for a one-way ticket to come to the U.S. Who can pay for that?

Dr. Betancourt continued saying he thinks that, as in all these cases, vulnerable populations, the elderly, the ill, the poor, and children are most at risk. We've seen how signs of impending public health crisis with new cases of **??sporosis??** and other mosquito borne illnesses that are kind of rearing their heads. There's a long story here to be told, but I appreciate everybody's engagement and leadership around this in the city and state and certainly the Commission. For all of these, I don't think Puerto Rico is the only spot, but for all of these situations, I think we need to be attentive and responsive.

Frank commented. Just to finalize, Joe's been playing a very important leadership role quietly in the background, as he often does. I just want to assure all of you that the Mayor, on an important night for him on September 26th, began his speech by highlighting the difficulties that were being experienced throughout the Caribbean, led off with Puerto Rico. He said not only are we going to dedicate our city's resources where possible and needed and requested to assist the people of Puerto Rico. More so, he said we were going to sustain that throughout the crisis in Puerto Rico; we will be with you. As was noted, as these things float in off the front page, the city is committed to do that. Those of you who are already engaged in this longer term program of relief, perhaps longer than any of us would like, you have support all the way to the top of the Administration.

- Monica continued. One final note. On the Las Vegas mass shooting, I did reach out to my colleague Dr. Joe Iser, who's the health officer there. Thank you, Debby, for sharing some of the resources developed from your team post Marathon bombing. We were able to share that with Dr. Iser and are working as a community of health officials to support him in his ongoing efforts in Las Vegas.

To that end, I had reached out to Dean Galea at BU's School of Public Health given his work on gun violence as a public health issue. He is definitely interested in coming to a future board meeting to have a conversation with the Board about what we see as this ongoing challenge around guns and mass shootings and the potential role of the health department in this space. I think Dean Cox will be helping us with this presentation that we'll have by Dean Galea.

Harold commented that Dean Galea certainly spent a lot of time thinking about issues around gun violence and has been involved in a lot of different ways in thinking about the issues. Largely in thinking about what happens around how universities are responding and how we think about this issue in public health schools, but also what the individual communities are doing. When I spoke with him just recently, he's very willing to come and engage with us about some of his thinking and maybe help us think about where we are with our own thinking as well. We'll schedule that around whatever is an appropriate time for the Board and the Dean's schedule.

- Monica said she will forego the IGR updates in the interest of time and will provide the updates in the minutes. So we will just transition over to Grace Connolly, our Director of Administration and Finance to talk us through FY19 budget and strategic planning with the Board.
- While Grace was walking up for her presentation, Manny thanked the Board and the Commission for the letter of support for the health center funding cliff; more to come there. We have gone over the cliff essentially, but there is work in progress to try to get the funding restored and sustained over the next couple of years. So hopefully at the next Board meeting we'll be reporting some good news on where we stand with the health center funding.

Discussion: FY19 Budget Strategic Planning
Grace Connolly, Director of Administration and Finance

- Thank you. We anticipate the FY19 process will be substantially similar to FY18.
- A new Chief Financial Officer for the City of Boston is still to be determined. Justin Sterritt is the new OBM Budget Director and Shekeima Dockery is our new OBM Analyst.
- **FY18: Tw Step Process:** As a reminder, the FY18 budget is a two-step process: 1) Maintenance request and 2) New budget proposals: operational reforms; budget savings; new initiatives/investments; and revenue proposals.
- **FY18: Approved Expansion Proposals.** We have been approved on the following expansion proposals: EMS Community Assistance Teams (4 FTEs); PAATHS expansion to nights and weekends (4.1 FTEs); BRS and Trauma FTE support related to reduced federal funding (1.59 FTEs); and Woods Mullen FTE support to ensure 24/7 operation (3.5 FTEs).
- **Capital Budget Projects.** These Capital Budget projects will address urgent needs while planning strategically for the city's future: BPHC Budget Software (new project; \$200,00 in FY18; total \$500,000); South End Fitness Center Pool (in design; \$379,117 FY18; \$1,129,000 total); EMS Station Study (study underway; \$40,000 FY18; \$100,000 total); Woods Mullen Shelter (new project; \$346,998 FY18; \$1,346,998 total); EMS Training Academy Study (study underway; \$50,000 FY18; \$50,000 total).
- **SEFC Pool.** At this point, there was a lengthy discussion amongst the Board members, Monica and Grace regarding the continued funding of the South End Fitness Center pool.
- **FY18 Timeline.** Grace reviewed the FY18 budget timeline which began in November 2016 when Capital instructions were released up through June 2017 with the City Council vote and the all staff meeting to review the budget.
- **FY19 New Initiatives/investments.** Included in FY19 new initiatives are: BPHC strategic priorities; Operational audit – final stages; and Capital – property site visits with OBM capital team (Long Island, Woods Mullen, 112 Southampton); and IT infrastructure investments: preliminary proposal to COB DoIT on September 29, 2017.

Presentation: Announcement of the Health Equity Advisory Committee
Margaret Reid, Director, Office of Health Equity

- **Three Strategic Priorities.** Our three strategic priorities are: Improve treatment and prevention of substance abuse; Strengthen the partnership between BPHC and the healthcare community to improve population health; and Advance health equity.
- **Community Engagement Plan.** We are working towards equitable community engagement. Key points are to inform, consult, collaborate, transfer decision-making and be community driven and led.
- **Health Equity Advisory Committee Members.** The committee is comprised of 10 residents representative of Boston's ethnically and culturally diverse population, with various economic, educational, age, gender, and neighborhood experiences. They are: Ms. Paulette Durrett, Mr. John Arthur Howard, Ms. Kendra Liburd, Mr. Damián Lima, Ms. Tiara Murphy, Ms. Kristen Risley, Ms. Edna G. Rivera-Carrasco, Ms. Angelica Sierra, Mr. Tim Wan, and Ms. Athene Wilson-Glover.
- **Role of Health Equity Advisory Committee.** Our role is to bring resident and community perspective to BPHC by advising on: the implementation and tracking of BPHC Strategic Plan; the implementation and tracking of BPHC Community Engagement Plan; how best to communicate data to support data-driven decision-making; and the development of new strategic and community engagement plans.

Presentation: Digital Bridge Initiative
Oscar Alleyne, National Association of County and City Health Officials

- **Digital Bridge Initiative.** We're pleased to welcome our colleague Dr. Oscar Alleyne from our national association, NACCHO. He's joining us remotely from DC to provide an overview of the Digital Bridge Initiative and a national perspective about its implantation to-date.

Thank you to Kevin Cranston from the Massachusetts Department of Public Health for being here today. He will follow Oscar to talk about the state's involvement in the project around electronic case reporting and opportunities for us.

- **What is the Digital Bridge?** It is a partnership of health care, health IT and public health organizations. The goal is to ensure our nation's health through a bidirectional information flow between health care and public health; be an incubator for growing projects that meet this vision; and be a forum for sharing ideas and solutions.

It is funded by the Robert Wood Johnson Foundation and the de Beaumont Foundation. Program management is provided by Deloitte Consulting and the Public Health Informatics Institute. The initial focus: electronic case reporting (eCR).

Participating organizations include: Allscripts, APHL, ASTHO, Cerner, Center for Disease Control (CDC), Council of State and Territorial Epidemiologists (CSTE), eClinicalWorks, Epic, HealthPartners ParkNicollet, Kaiser Permanente, Meditech, NACCHO, Office of the National Coordinator for Health Information Technology and Partners Healthcare.

- **Organizational Structure.** The Governance Body is split into three (3) segments. **Health Care** comprised of: HealthPartners, Kaiser Permanente, and Partners Healthcare. **Public Health** comprised of: APHL, ASTHO, CSTE, NACCHO, and CDC. **Vendor** comprised of: Epic, Meditech, Allscripts, Cerner, and eClinical Works.

The **Program Management Office** consists of: PHII, Deloitte, and Ishikawa Associates. ExOfficio Members are: CDC, ONC, Deloitte, and PHII.

Workgroups. Members of the governance body are divided into four small groups that each work on particular topics related to the Digital Bridge, including oversight of eCR implementations, evaluation of resources to expand the project nationwide, guidance on legal and regulatory issues, and counsel on the future of the Digital Bridge.

- **Complexity of the Public Health System.** A chart was shown depicting a public health agency at the center then spreading out to the various components that it interacts with and makes it work,

such as: hospitals, non-profit organizations, schools, EMS, doctors, CHCs, neighborhood organizations, laboratories, civic groups, faith institutions, nursing homes, mental health, drug treatment, law enforcement, fire, corrections, elected officials.

- **Electronic Case Reporting (eCR).** eCR is the automated generation and transmission of case reports from the electronic health record (EHR) to public health agencies for review and action.
- **How Electronic Case Reporting Works.** There are 5 steps to the process.
 1. **Provider enters information.** Health care provider documents patient visit information into electronic health record as part of regular workflow.
 2. **Health Technology Sends Information.** Criteria in electronic health record or health information exchange triggers an electronic case report (eCR) to automatically send.
 3. **Determine Reportability.** Case report is validated and if reportable, is forwarded to the appropriate agency. Health care provider is notified if disease case is submitted.
 4. **Analysis and Evaluation.** Public health professionals received the disease case for analysis and evaluation.
 5. **Additional Feedback to Provider.** In the future, the provider can choose to receive guidance on patient care and outbreak response from public health.
- Digital Bridge is implementing electronic case reporting across states and local jurisdictions. Currently there are seven states using the program.
- **eCR Site Participation.** Wave 1 is April – Fall 2017 in the following locations: Kansas: Lawrence Memorial Hospital (EHR Vendor: Cerner); Michigan: local public health clinics (EHR Vendor: NetSmart); Utah: Intermountain Healthcare (EHR Vendor: Cerner). Wave 2 is scheduled for Fall 2017 – Early 2018 in these locations: California: UC Davis; Houston: Houston Methodist; Massachusetts: Partners HealthCare; and New York City: Institute of Family Health (EHR Vendor: Epic for all locations).

Sites will support five conditions initially: pertussis, gonorrhea, chlamydia, salmonellosis, and Zika. Participating sites will participate in eCR evaluations. Any public health agency participating in eCR outside of Digital Bridge is encouraged to continue to do so.

- **Digital Bridge Approach for eCR.** Digital Bridge is an interoperable, scalable, multi-jurisdictional approach to eCR. It is not a *new* technology product. The Digital bridge approach is based on existing eCR tools and standards, and seeks to support their development and adoption. eCR is incorporated into the EHR as a background operation requiring little or no effort on the part of the clinical end user. The implementation sites' technical solution will remain EHR vendor-agnostic so that any vendor can adopt the solution and pass on this functionality to their clients.
- **Benefits to the Digital Bridge Approach.** A unified approach to information exchange eases the burden and costs for all stakeholder groups. It streamlines the reporting and data collection processes for health care and public health. Earlier detection of cases, leads to: earlier intervention and diminished transmission of disease. Digital Bridge lays the foundation for greater bidirectional exchange. Clinicians will be easily informed about population health, environmental risks and outbreaks. Bidirectional data exchanges can eventually encompass non-communicable diseases.
- **Contact Information.** For updates, go to: www.digitalbridge.us. For questions and input, go to: info@digitalbridge.us.

Presentation: ESPnet: An Overview of Electronic Case Reporting Using EHRs
Kevin Cranston, Massachusetts Department of Public Health

- **ESPnet: EHR Support for Public Health.** ESPnet is an open-source software and architecture to query EHRs and extract, analyze, and transmit notifiable electronic health information from health care providers to public health. It queries EHR data to identify patients with conditions of public health interest (per public health reporting regulations). It generates secure electronic reports for the state health department and is designed to be compatible with any EHR system.
- **Limitation of Case Identification Using Manual Clinical Reporting.** Manual clinical reporting is a burden for providers, especially for high-volume diagnoses, e.g. chlamydia, HCV,

Lyme. It requires active communication between provider and public health, e.g. follow-up on risk history, pregnancy status, and treatment. It frequently results in missing information; limits analysis and interpretation for action. Labs are blind to purely clinical diagnoses, e.g. culture negative TB, early Lyme, PID. Manual reporting is a poor discriminator between active and resolved, or acute and chronic disease, e.g. acute vs. chronic hepatitis B & C and new versus old syphilis. Key information is often missing and desired information is not consistently reported, e.g. pregnancy status, race/ethnicity.

- **ESPnet Goal.** The goal is to combine the best of traditional clinician-initiated reporting and electronic laboratory reporting systems: fast, accurate, clinically detailed, digital reports automated to reduce clinician reporting effort.
- **Decoupled architecture.** ESP is decoupled from the host electronic health record. **Universal:** allows system to be agnostic to the source EMR (local codes mapped to common variable fields). **Unobtrusive:** offloads the computing burden from clinical systems (and keeps ESP invisible to clinicians). **Secure:** ESP can remain within the host practice's firewall.
- **ESPnet: Automated disease detection/reporting for public health.** The practice EMRs diagnoses, lab results, meds, vital signs and demographics are processed through the ESP server. Notifiable disease case reports are then sent to the DPH. Selected diseases are: acute hepatitises, active TB, Chlamydia, Syphilis, Gonorrhea, HIV, PID, Lyme, and Pertussis.
- **Capabilities and Features.** Individual-level notifiable disease reporting currently: Chlamydia, Gonorrhea, Syphilis, Acute hepatitis A, Acute hepatitis B, and Acute hepatitis C. New: Longitudinal case reporting/monitoring of chronic infections in development: HIV, Hepatitis C, and TB infection. Potential: Aggregate-level reporting of conditions/policies: Influenza vaccination, ILI reporting, HIV and HCV screening, Lyme disease, and Program evaluation.
- **Variables:** Patient demographics; responsible clinician, site, contact info; basis for condition being detected; treatments prescribed; symptoms (ICD9/10 code); pregnancy status; vaccine history (when pertinent). **Potential Variables:** expedited partner therapy (Chlamydia); test of cure/re-infection (Chlamydia); risk history; housing status; and insurance status.
- **Case Logic.** Case logic is based on CDC surveillance case definitions modeled for coded data captured by EHRs: simple laboratory based definitions, e.g. Gonorrhea and Chlamydia; complex laboratory based definitions, e.g. Acute Hepatitis C; and clinical diagnoses +/- lab data, e.g. Tuberculosis.
- **HIV Case Detection Algorithm** includes any of the following: Positive Western Blot; Positive HIV Antigen/Antibody test and positive HIV ELISA; HIV RNA Viral Load >200 copies/mL; HIV Qualitative PCR; ≥ 2 ICD codes for HIV and history of prescription for ≥ 3 HIV meds ever; and Concurrent prescriptions for 2 sets of 3 or more *different* antiretrovirals at least 1 month apart.
- **Acute Hepatitis B Case Detection Algorithm** includes both of the following: ICD9/10 for jaundice OR liver function tests >5x normal and IgM to core antigen **OR** All five of the following: ICD9 for jaundice OR liver function tests >5x normal; Hep B surface antigen or 'e' antigen present; Total bilirubin.1.5; No prior positive HepB specific lab tests; and No present or prior ICD9/10 code for chronic hepatitis B.
- **Algorithm Validation.** Algorithms are refined and validated by reviewing medial charts for a selection of cases. Cases identified by ESPnet are compared to cases captured in MAVEN during the same time period. Any discrepancies are documented and assessed by MDPH. Modifications to algorithm are made if necessary.
- **Nothing is Perfect.** Not all data elements of interest are systematically captured in EHR (e.g. sexual or substance use history). Patients may get some of their care outside of ESPnet partner practices (e.g. HIV/STI/HCV screenings). Ongoing mapping maintenance as lab and diagnostic codes changes; EHS adaptations. Validation/QC of new data elements reported from the EHR.
- **ESPnet Participating Sites.** Currently there are three (3) partnering networks in Massachusetts. Cambridge Health Alliance: 20 sites; 400,000 patients. Mass League of Community Health Centers: 18 sites; 300,000 patients. Atrius Health: 27 sites; 800,000 patients. This equals approximately

1.5million patients (20% of Massachusetts' population). New partners under discussion: Partners Health Care, BMC, BMC Healthnet.

Updates: Intergovernmental Relations
Heather Gasper, Director

- As previously mentioned by Monica, here are the IGR updates provided by Heather Gasper, Director of Intergovernmental Relations.

- **Federal update:** The Commission again joined our colleagues locally and nationally in voicing our opposition to the repeal of the ACA. Thankfully it was successfully defeated.

Sadly, while attention seemed squarely focused on the repeal efforts, multiple federal health programs were not reauthorized in time for the September 30th deadline, including funding for the community health centers through the Health Center Fund and healthcare coverage for low-income children through the Children's Health Insurance Program and Disproportionate Share Hospital Payments.

Last month Chairman Frank Doyle and board member Manny Lopes asked that the Board be on the record advocating for the reauthorization of the health center funding. You will find a copy of the letter sent from the Board to federal appropriators and the Boston Congressional Delegation.

Like everyone else, we continue to pay close attention to Congress's every move. We remain engaged with our DC Intergovernmental Relations rep and our national associations.

- **State update:** There has been a lot of activity at the State House as committees continue to hold hearings on the many filed bills for this session. I testified last week in front of the Joint Committee on Financial Services in support of one of the Mayor's legislative priority bills, a bill to promote comprehensive reproductive health services and birth control options by expanding coverage for long acting reversible contraceptives (LARC).

BPHC has also weighed in with our support for other bills this month, including an increase in the minimum wage and support for two housing bills that would work to end homelessness, reduce resident displacement, and provide critical support to those in need.

In addition, Denise Garlick, Chair of the Joint Committee on Mental Health, Substance Use and Recovery invited Berto Sanchez, Program Manager, Addiction Services to the State House to do Narcan training for members and staff. It was very well received and we thank Berto for representing the Commission.

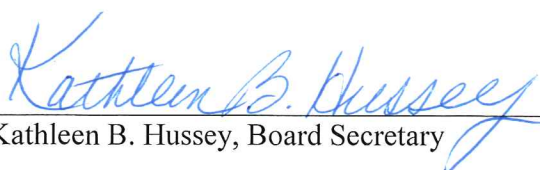
Adjourn

Mr. Doyle thanked Monica and our other presenters for their reports and thanked the audience for coming. He adjourned the Board meeting at approximately 6:10p.m.

Addendum:

PLEASE NOTE: This report is a synopsis of the board meeting. Presentations are posted for review a day or two after a meeting to our BOH webpage: <http://www.bphc.org/boardofhealth/Pages/board-of-health.aspx>. All board meetings are recorded. Requests for a copy of a recorded meeting should be made via: info@bphc.org. Thank you.

RESPECTFULLY SUBMITTED BY:


Kathleen B. Hussey, Board Secretary

