Meeting Minutes

Digital Bridge Collaborative Body

Meeting Information

Date:	May 7, 2020	**Location:**	1-866-516-9291
Time:	12:00 – 1:00 PM ET	**Meeting Type:**	Virtual
Called By:		**Facilitator:**	John Lumpkin
Timekeeper:	Charlie Ishikawa	**Note Taker:**	Jelisa Lowe
Attendees:	See attached		

	Agenda Items	Presenter	Time Allotted
1	Call to Order and Roll Call	John Lumpkin	12:00 PM
2	Agenda Review, Approval, and Conflict of Interest Declarations	John Lumpkin	12:08 PM
3	Consent: Charter Correction	John Lumpkin	12:12 PM
4	Update: Partnership Management Transition	Brandon Talley, CDC Foundation	12:15 PM
5	Actions: • Nominations and elections process • Charge and formation of public health API workgroups • Charge and formation of use case project statement workgroups	 Vivian Singletary, PHII John Lumpkin	12:20 PM
6	Discussion • Special meeting follow-up: eCR scale-up and COVID-19	John Lumpkin	12:40 PM
7	Announcements		12:55 PM
8	Adjournment	John Lumpkin	1:00 PM

Decisions

1	The Collaborative Body formally approved the nominations and elections process for the executive committee. Motion by Walter Suarez; seconded by Vivian Singletary; verbal vote taken, all “ayes”, no “nays” or abstentions.
2	The Collaborative Body approved the formation and scope of the public health API workgroup and that Walter Suarez will chair. Motion by Walter Suarez; seconded by Vivian Singletary; verbal vote taken, all “ayes”, no “nays” or abstentions.
3	The Collaborative Body approved the formation and scope of the use case project statement workgroups and that John Lumpkin will select a chair after workgroup members have been defined. Motion by Priyanka Surio; seconded by Chris Alban; verbal vote taken, all “ayes”, no “nays” or abstentions.

New Action Items		Responsible	Due Date
A.	Nominate vice chair and/or executive committee members	Collaborative Body	5/24/2020
B.	Place votes	Collaborative Body primary members	5/29/2020

Other Notes & Information

1. **Call to Order** – Quorum was met.
2. **Agenda Review and Approval and COI Declarations** *(John Lumpkin)* –
    A. This is our second collaborative body meeting, and we have two new attendees joining us: Hans Buitendijk with Cerner and George Hobor who was at the in-person meeting in January. I want to take a moment, because this really marks the transition as we move from the collaborative body to the secretariat. Thanks to Vivian and Charlie for getting us so far. We could not make the progress we have without your engagement. The Public Health Informatics Institute (PHII) is moving to be a participating member of the collaborative body as we make this transition.
    B. There are no abstentions or changes to the agenda. We also have a policy on announcing any conflicts of interest. If anyone has a conflict at this point, please notify the group.
3. **Consent: Charter Correction** *(John Lumpkin)* –
    A. As you remember, we have certain items on the consent agenda, and if any member wants to pull them off, they can do that. The item on the consent agenda was a correction from the transcription that resulted in the charter that was approved. The consent is to correct that error. We do not need to take a vote, but you have an opportunity to pull this off the consent agenda. No items removed from consent agenda for discussion. No member opposed the charter correction. The copy/paste error will be corrected, signed, and reposted.
4. **Update: Partnership Management Transition** *(Brandon Talley)* **–**
    A. We have been engaging in multiple meetings with IPHI, PHII and Kahuina to transition the role of the project management office (PMO). Laurie Call and Samantha Lasky are serving as lead staff supporting Digital Bridge. We also have on today's call IPHI CEO, Elissa Bassler. The transition has been ongoing for about 45 days, and we are anticipating that it will be fully completed by the end of May. IPHI will be managing internal and external communications, fulfilling the program management/secretariat role for Digital Bridge, including stewardship of the workgroups and providing neutral convening and facilitation support. IPHI has also been conducting stakeholder interviews to help them gain a variety of perspectives on Digital Bridge and help them manage and improve operations on the PMO/secretariat side. I would like to thank everybody for their participation, and especially PHII and Kahuina/Charlie for their great work and support during this transition.
5. **Actions** *(John Lumpkin)* –
    A. **Nominations and elections process** *(Vivian Singletary)* –
    I want to thank the committee for all their hard work and attention to detail to make sure we got this right. To focus back on the charge, our purpose was to put forth an election process. We will not oversee the process, but we wanted it to be very transparent with an adequate number of nominees, qualified candidates, and balanced representation and continuity of the executive committee.

    Executive Committee Size and Scope: We resolved that the executive committee should consist of seven members: the chair, the vice chair and five others. There are six key charges of the executive committee—to highlight a few: pursue financial resources to sustain Digital Bridge, guide communications strategy, and monitor progress of the workgroup, including decisions needing collaborative body input and review.

Nominations and Elections Process Recommendations: There is a total of seven positions. You will notice we have two sections: one section for the chair, public health representation and at-large representation which will be a two-year term to begin. The second group includes industry partner representation, sponsor representation, health care representation, and the vice chair with an initial term for those four positions as three years, so we have a staggered process rather than having an entire committee turning over. In 2022, the elections will come up for the two-year terms, and in 2023 the election will come up for the three-year terms, and then odd and even year elections.

Two seats that you see on the executive committee are the at-large seat and the sponsor seat. The at-large seat remains open for any new future member types (e.g., consumer representative or some other sector). I also want to point out the sponsor seat: members who are eligible for that seat can be members who have been sponsors in the past or are current sponsors. We are proposing ranked choice voting. For example, if there are three people running, you can select your first, second and third choice. This forced ranking will allow us to do an instantaneous run off should there be a tie.

Nominations will start today. Anyone is able to make a nomination, but if you do, make sure the person you are nominating agrees. There will be a two-week period that we will accept nominations, and Dr. Lumpkin and Kahuina will oversee this process. For ballot preparation, include the name, a photo, the position you are nominating for, the nominator and candidacy reason and then the rank choice. You can nominate the same person for multiple positions. The election itself will result in one ballot per member. Whoever is the primary member for the organization will be the person expected to cast the vote or if they need to delegate, they may do so. Voting will be anonymous, and we are suggesting that there are five days for the election. So, once we have the ballot, we will send it out via a method like Survey Monkey, and you will have five days to cast your votes.

Eligibility: All voting-member representatives—primary or alternate—are eligible to vote for the chair, vice chair or at-large position. But in this current election we are conducting, we are just voting for vice chair and other remaining executive committee positions since we have already voted on the chair. Nonvoting members are not eligible to run for officer or executive committee positions. Public health, industry, health care and sponsoring members are eligible to vote for their sector-specific executive committee representative seat.

Nominations: Any voting or nonvoting representative may make nominations for any post as long as there's agreement with the nominee. Nominations are made by an online form (*Vivian walks through example of nomination form and how forced ranking voting works*).

Ballot Mechanics: There will be links to the ballot that will be sent to the primary representative of all voting members by email. The ballots will be tailored to permit voting on the representative-specific sector executive committee seat, but you would also vote for the at-large members and vice chair. Ballots will also use force voting in a particular sequence, so you will vote for vice chair first, then the sector-specific seat and then the at-large member. We are suggesting this sequence because if someone is nominated across multiple areas, for example, vice chair and a sector-specific seat, they would get eliminated in the next round of voting if they have already been selected as vice chair. Votes will be tallied in rounds until a single candidate has a majority—greater than 50 percent of the votes—of first-preference votes.

Timeline *(Charlie Ishikawa)***:** The next two weeks will be open nominations, then we'll make an announcement of the candidates at the end of the nomination period, then ballots will be prepared, and we'll send out electronic notifications of the election, and then we'll notify candidates of the final results. First, we will notify the candidates of the results, and then they will be announced.

Discussion:

- **John Lumpkin:** Michael Iademarco asked if any member can nominate anyone for any of the posts?
- **Vivian Singletary:** Yes, anyone in the collaborative body can nominate anyone for a post.
- **John Lumpkin:** He also has a follow-up question: then can any eligible voter cast nominees for more than one sector?
- **Vivian Singletary:** You can only vote for your specific seat per sector, plus vice chair and the at-large representative.
- **John Lumpkin:** We need a motion to approve if you are willing to move forward with this process. **Moved by Walter Suarez; seconded by Vivian Singletary; verbal vote taken.**
- **Walter Suarez:** I wanted to thank the leadership of Vivian and creative mind of Charlie to build this graph to help us all understand this complex process. I am amazed and thank you.

B. **Charge and Formation of Public Health API workgroups** *(John Lumpkin)*
As you remember, we identified two sets of workgroups: one being the API workgroup and the second being the four use case workgroups. First, we will talk about the API public health workgroup. They will be producing a white paper by November 1 and deliver it to the collaborative body with a dissemination plan and a drafted press release. The members who have volunteered are on the list. The charge was distributed through Basecamp, and you can also see the schedule for their activities.

Discussion:

- **Priyanka Surio:** I know for each of the other workgroups the charge is to development a project statement first. Since this one is different, will this group start just working on the white paper?
- **John Lumpkin:** That is correct.
  Moved by Walter Suarez; seconded by Vivian Singletary; verbal vote taken.
- **John Lumpkin:** According to our new bylaws, one of the collaborative body chair's responsibilities is to appoint the chair of the workgroup. For this one, I have asked Walter and he agreed to chair this workgroup.

C. **Charge and Formation of Use Case Project Statement Workgroups** *(John Lumpkin)*—
These groups are designed to scope out the four use cases. So, we think there's potential validity for the use cases, the workgroup will scope it out and bring it back to the collaborative body. If the collaborative body agrees there is something there to do, then that will be approved and an implementation workgroup for that use case will be established. Not all these areas are equally the same in that work has not been thoroughly developed for each. We have a significant number of volunteers for the newly reportable conditions and immunization workgroups but a limited number for SNIFS and cancer registries. As a reminder: you can nominate individuals from your organization to serve on the workgroup or you can identify SMEs beyond members of the collaborative body to participate.
Moved by Priyanka Surio; seconded by Chris Alban; verbal vote taken.

D. **John Lumpkin:** As we fill out membership, I will appoint a chair for each workgroup.

6. **Discussion: Special Meeting Follow-up: eCR Scale-up and COVID-19** *(Laura Conn and Michael Iademarco)* –

A. **Michael Iademarco:** Keep in mind I am standing in for Adi Gundlapalli, who is our chief informatics officer. Last time there was discussion about how to coordinate various informatics and technical assistance needs that were coming at us from COVID-19 response. But also, in the mindset that this is an opportunity, and there are some medium- and long-term chances to get things fixed in the long run. There is also a sense of prioritization, so I wrote a few things down and got internal CDC input to reflect on this conundrum. We are in the middle of this on different calls with CSTE and APHL, and it is all the same overlapping issue. Along with Adi and Chesley, we had a call with ONC to look at this organizational puzzle. The objective is to improve data collection efficiency, with attention to burden, and effectiveness so that we can have better analysis and answer critical local and federal response

questions. So, the question is, what can partners do to improve the system to enhance data collection for more rapid progress and efficiency?

There are all types of questions to consider to put together better data flow. I think there are some high-level questions at a federal level in terms of reopening cluster detection and a possible resurgence after successful control. But there are smaller questions critically important at a local level. How do we frame this out? There are three buckets about the data: data around the person (both reporting and syndromic), lab is data about the person, and health care resource data. All these things are tied together by policy. In conversations with CMS, Adi and I started to look into response and see what the root-source systems are to identify gaps of things we need to make progress on quickly or in medium terms. We also need to prioritize—there is only a small team in health care with the companies who produce these systems, and they can only do one thing at a time, so they need prioritization.

How do we promulgate the Digital Bridge view of this problem? CDC is cranking hard on this, and CDC, APHL, and NACCHO have strong views on this. I don't think we need a workgroup to figure this out, but we need to do more internal work to flesh out section D (legislation around COVID-19 test orders and results) and have a meeting with SME thinkers and transform it into something promulgated.

(Michael Iademarco asked the collaborative body to comment on the document he presented and send feedback to Grace Mandel or himself).

B. **Laura Conn:** As we talked about last time, eCR Now has three components: one is the rapid acceleration of implementation for COVID-19, the second is the eCR Now FHIR app and testing implementation for EHR vendors that don't have eCR capability in their products natively now, and the third is the extension from eHealth Exchange to Care Quality to extend the trust network. You can see that eCR implementers in production now are now are the four that we had through the Digital Bridge initial implementations and as of Tuesday, we brought on three organizations. The list is building, and we are looking towards ways to show how the coverage of these implementers is picking up. This is our first attempt *(showing map)* at trying to identify locations of clinics and hospitals that have eCR capabilities in production now. We have a group that is currently implementing here as well as others we have in process for full eCR prior to COVID, which are still moving forward. The good news is we have a group that is either in queue for implementation or seeking approval to move forward. The second element—FHIR app—the initial code was released last Friday, and we will be working on it with vendors in the HL7 Connectahon next week.

Discussion:

- **Art Davidson:** I think that's great progress. As you onboard these institutions, do they give you a sense of what their denominator is so we can express this to say "X" percent of the population is covered by eCR institutions or eCR-mediated reporting?
- **Laura Conn:** We are searching for that common metric. Some places easily say, "we cover 1.5 million patients," and other places give us annual encounters. Those are sort of related but not the same metric. Sometimes we get number of physicians or providers, but we are looking for that common metric we can easily combine to show that picture.
- **John Lumpkin:** I do not know about others, but this is really exciting.
- **Art Davidson:** It is impressive.
- **Laura Conn:** Thank you. It has been exciting for the team to see the interest and the drive-in clinical care that understand the value in this and are willing to accelerate it. The winner of the timeframe now is just less than three days of implementation at UC San Diego.
- **Chris Alban:** What is the rate limit per adoption at this point for extending them out? Is it the need to implement, is it desire and awareness?
- **Laura Conn:** I think it is awareness and communication. We have not seen people saying they do not think they can do it. The only one we talked to that has not moved forward had their whole

informatics staff furloughed during COVID-19. Those that are hearing about it and have the ability to assemble a team are doing so rapidly and see the benefit of COVID, for sure, but see the promise in the long term of extending to all conditions in their jurisdictions.

- **John Lumpkin:** So, given that, Laura, would there be some value in doing an update or some short article to something like Health Affairs or some of the other journals?
- **Laura Conn:** I think that is a great idea, and I turn to health care and the vendors to tell us where would give us the most visibility for organizations that need to implement.
- **Art Davidson:** You say it took three days to do this in California: that is because they already had a state health department that was primed and already had done this. So how many state health departments have not yet taken a step?
- **Laura Conn:** We have nine that have not connected to AIMS to receive the reports from an implementer. We have all but one that has authored rules in RCKMS so case reports can be identified for them. We do have a shortfall in a few jurisdictions to build their capability to receive them. We definitely have work to do with health departments to process and automatically consume and use, but the ones that do not have that ability yet are taking advantage of the HTML format of the case reports that AIMS is delivering. It is definitely a lift on the public health side to have additional support in processing, but we have not had any public health agencies say they don't want the data even though they're not fully processing it into their systems.
- **Art Davidson:** I wonder if there is some sort of gauge that ASTHO or CSTE might create for their members to show their status and how they compare to others or next steps. There must be a receptor site that is fully functional for you to get the three days.
- **Laura Conn:** I would not say California is fully functional, but they are accepting the case reports and they are working to get it automatically in their systems in parallel to receiving the case report. While they're doing that system work in parallel, they see the value of getting the case reports in a way that they can just visually see them in conjunction with electronic lab reports that are coming in that often don't have basic data on it.
- **Priyanka Surio:** Thank you, Laura. I think what you just presented that there are these various health care providers that are interested or in the process were the questions we were getting from states on how wide scale this is and the number of providers that are connected. Some states are just not at capacity yet. Though they would like to be able to have that information, it is still a little bit of a burden.
- **John Lumpkin:** A couple of things to follow up on: explore how we might generate awareness of this and better understand, from state perspectives, challenges they face in receiving these.

7. **Announcements** *(Charlie Ishikawa)* —
   A. Next meeting will be September 3.
   B. The executive committee will be voted on this month.
   C. Nominations will be open for the vice chair and executive committee members, and you will be receiving a ballot to vote on them once nominations close in two weeks.
8. **Adjourned.**