Meeting Minutes

Digital Bridge Collaborative Body Special Meeting

Meeting Information

Date:	April 16, 2020	**Location:**	
Time:	2:00 – 3:00 PM ET	**Meeting Type:**	Virtual
Called By:		**Facilitator:**	John Lumpkin
Timekeeper:	Charlie Ishikawa	**Note Taker:**	Samantha Lasky
Attendees:	See attached		

	Agenda Items	Presenter	Time Allotted
1	Call to Order and Roll Call	John Lumpkin	2 min
2	Agenda review, approval, and conflict of interest declarations	John Lumpkin	3 min
3	Update: eCR and COVID-19		10 min
a	CDC Opportunities to Engage with COVID-19		10 min
b	Related efforts and initiatives	Walter Suarez	5 min
6	Discussion: Digital Bridge Role	John Lumpkin	15 min
7	Announcements	Charlie Ishikawa	5 min
8	Adjournment	John Lumpkin	Remaining

Decisions

1	Creation of a small, *ad hoc* group to discuss the four buckets and follow up with Laura, Adi, and MITRE.

New Action Items		Responsible	Due Date
A.	None.		

Other Notes & Information

1. **Call to Order**
2. **Agenda Review and Approval** – John Lumpkin reviewed the agenda; no additions, abstentions, or conflicts of interest.
    A. **Discussion:**
        - **John Lumpkin:** Our goal is to identify if there are ways that we can engage with all the responses that are currently going on within COVID-10 to leverage to the extent that we can accelerate adoption of eCR.
        - **Charlie Ishikawa:** Here we should have a pause for conflict of interest.
        - **John Lumpkin:** We are taking no action today, so I was going to roll through that.
3. **Update: eCR and COVID-19 – CDC Opportunities to Engage with COVID-19**
    A. **CDC** *(Michael Iademarco):* Michael Iademarco is standing in for Dr. Adi Gundlapalli, who is immersed in the CDC COVID-19 emergency response. Michael explained that even before the official response, since early January, CDC has had lots of ongoing data related activities. Our center, CSELS, has played a major role in concert with many partners, including APHL, ASTHO, CSTE, NACCHO, and healthcare industry partners. For example, the AIMS hub has been critical in myriad ways. Syndromic surveillance is being used, like never before. Not only providing real time emergency room data, but also being overlaid with other data. It's been helpful at every stage of the response we're trying to expand emergency department coverage from its current 72% of all emergency room visits nationally and principally this targets onboarding by California and Texas. The Biosense platform, which is integral to syndromic surveillance is being used for other purposes. For example, it's bringing in commercial lab raw data feeds from the from the big players. We're still working through getting real time industry partners and healthcare, broader participation of records that are in the electronic health record. Adi is working on this diligently and I would encourage people to work with him if you have any interest and participation there. I know he's already working with several you and there are many other data efforts that take existing data systems and programs, adapt them where needed and pull them together in a common operating platform. For example, you saw the NHSN, The National Hospital Safety Network, presented our last in person meeting, which focuses on hospital infections and it's been adopted to address hospital capacity, including admissions to the ICU, the hospital and ventilator use.

    Given the scope and scale of this pandemic in the United States for the first time, we've had to work in a new way with HHS and the rest of our federal partners in terms of data sharing, whereby our centralized internal CDC platform is being synchronized and in many patches of data shared government wide through another platform, NRCC, The National Response Coordinating Committee, which is being hosted. The platform itself is being hosted out of HHS and it's taking in a lot of non-healthcare data that's important to logistics in the response both for healthcare and otherwise. A lot of that data in those feeds are beyond CDC's purview. Michael wants to emphasize that it's critical for partners to work through the emergency operations center. If you haven't been through something like this before the usual contacts and relationships that you might have with CDC programs are not really in the vortex.

    First, most of those people are deployed into the emergency operations center and all the decisions are made through an incident command like structure. He reiterated that Adi is in the response. He runs the data resource and analytics task force is separate from the "epi" one and he is central to the data issues and the data coordination issues. We, who are not in the response, me and Laura for example, at the moment, although we could get sucked in at any second, we can help navigate

you to the right people in the response.

B. **CDC** *(Laura Conn):* Yesterday, I had an opportunity to testify at the Health IT Advisory Committee of ONC related to this. Basically, this has grown out of the fact that we were successful in implementing COVID-19 in our eCR implementations that we had and the increased interest that I talked with you about at our last meeting. There are three elements to eCR Now that have come about because people trying to figure out what they can do. The first is a cohort based rapid implementation of eCR in provider sites where they have EHR that have eCR capability in place. The second is a developing eCR Now fire application that will be, um, available and easily implemented in EHR products that don't have existing eCR capabilities now. The third, with a huge shout out to Shar for connecting us up with the care quality related to eCR, and working through their capabilities that eClinical Works and wanting to use care quality as the fresh framework. There we connected with a catholic care quality and with the COVID motivation, they are developing a fast track implementation guide that will support electronic case reporting that extends what we have existing already with the health exchange use case for eCR. We build that trust network to include the care quality implementers as well.

   EPIC released, a week or so ago, their streamlined implementation that is now at three days for an organization to implement. We rolled this out with the California regional user EPIC group. Last Wednesday, we had our initial California cohort start that included a Sutter Health, Contra Costa Health Systems, OCHIN (a health network that we've talked about at our in-person meeting in January). Sutter Health went live last night after a three-day implementation. That brings an additional 24 hospitals in California and many ambulatory and other healthcare centers. Along with that, Contra Costa and OCHIN we believe will go live tomorrow, midday. Our second cohort has an additional four implementers in it, including UCLA. We will be having our initial meeting with them tomorrow afternoon. So, this cohort-based approach is also getting pushed out to other jurisdictions. EPIC has reached out to Texas and there's a potential for 20 hospitals in the Texas EPIC collaborative. Also, we're hearing interest from North Carolina and from Wisconsin and we're looking to work with EPIC and the groups that organize those user groups across the country to get the word out.

   We are using existing infrastructure with the trigger code distribution. As we've seen already with the implementations that we've had, we're seeing these confirmed cases get into the public health agencies surveillance efforts, and no entry on the healthcare side and reducing that burden from providers. The fire application, again, rapidly being developed to implement an EHR with no ECR capability. Now, we are working on it in a way so it will not require a software release to clients. Again, once that's implemented in health record products and available for their clients, it will connect to the existing eCR infrastructure with AIMS and RCKMS and where we already have connections to the public health agencies. We will be available to start testing this app with EHR vendors on May 1st and we are looking to do a big splash at the HL7 Connectathon, which is May 13th and 14th with vendors to help us work through this and get it out there quickly over.

C. **APHL** *(Patina Zarcone Gange):* Patina presented a slide. She explained that it is a draft. They're continuing to evolve it and there are things they still must tweak. She also noted that some of the data flows represented there are not currently live. We are in the process of development and working toward them, but all of them are in some state of moving forward. APHL has been supporting the live feed of COVID-19 data from public health labs to CDC using the flu reporting mechanism, the PHILIP feed. We repurposed that feed, adding the appropriate terminology, and we were able to get 58 labs on board sending that PHILIP feed in a month.

   This past month, from March 1st to April 1st, we had 172,000 messages flowing through PHILIP, and the month before that was 173,000. Now that spiked up from months of just 10,000, 17,000, and 24,000. So, it really peaked and is continuing to go upwards. We're working on building a data repository on AIMS for lab reporting. Another part of the flow will be from private clinical labs, not necessarily the flow that's the same flow that's coming through Biosense for the big six, but we're looking at targeting the other smaller private commercial labs. This is going to also be moving the data from public health agencies, their ELR

feeds, repurposing that and getting that information to the CDC.

We have also been working with our partners at MITRE on an application for self-reporting symptoms of COVID-19 for suspect patients, that has gone live a couple Fridays ago. Right now, we have about three jurisdictions that we're onboarding. We're hoping to continue to onboard those and we're going to be working with our partners at CSTE, ASTHO, and NACCHO to support that. Last week, we announced that we are going to be providing e-tour solution for our member laboratories for COVID only for free. During the response, we are going to be using our e-tour solution lab web portal for this and we've got quite a bit of interest in that offering and we are just readying ourselves to move forward with onboarding.

We've been doing some work on the FDA side, as well. We created a vocabulary file for livid that basically has the COVID data in that file, and it's a reference file for our public health laboratories. The ones that are in production here, as I mentioned, were the PHILIP feed and the SARA Alert Tool (MITRE) application.

D. **ASTHO** *(Priyanka Surio):* First and foremost, we've been pulled into ASTHO's incident command structure. We've also set up an EOC as well to lead our COVID-19 response efforts, and, I'm specifically leading our data management and surveillance response task force. Within that, we've been conducting routine policy surveillance. What this looks like is what are the guidance that are being created and put into action around social distancing, around elective medical procedures and other things related to that. Then, we're mapping those on our States and Territories and Action COVID-19 Response Map. This map includes a couple of layers, including some of the things mentioned as well as state and territory health agencies, COVID-19 websites, and hotline numbers for both public and providers or other stakeholders.

   In addition to that, we were able to successfully participate in a COVID-19 syndromic surveillance collaborative project with CDC. This was really a SHO-led effort, and it ensured that we were able to get some of that ED-line level data shared quickly with CDC. Since then, we've heard that this has now been shared with that national response coordinating body that the White House created. We've heard now that every state that does have syndromic surveillance systems is sharing in that way.

   We have a call tomorrow with some of our key shows that led on that effort as well as a couple of others that were initially hesitant or had concerns, and others that are not currently connected or have syndromic surveillance systems. In addition to that, we've been engaging with external partners about new tools and technologies. A couple of ways that we've been doing that, like what Patina mentioned, we've been supporting the launch of the Sara Alert tool to monitor exposed individuals through to those that potentially are symptomatic to assist with contact tracing and then through to recovery. We're really seeing and assessing how that is coming to pass in terms of its launch in the Mariana Islands. Another jurisdiction that is interested and is close to, if not already, launching is Arkansas. So, we've been asked to potentially evaluate the efficacy of that tool in these jurisdictions and to do so and within a learning community context. We're having some internal discussions on that.

   In addition to that, we participated in several hackathons, where we've been a subject matter expert and consulting on different tools and technologies that have been developed. Right now, coordinating between CDC and ONC on the different tools/technologies that we're aware of for different facets of the pandemic life cycle to include peak response and post peak/recovery, and things around contact tracing, community mitigation. We are assessing what each tool technology addresses and seeing how we might be able to collaborate on our respective lists. Then finally, providing direct technical assistance and research for state and territorial health officials and their leadership staff for whatever they might need. Some of those top items that we've been providing assistance on a deal with telehealth, telemedicine, social distancing measures and their efficacy, medical guidance, elective procedures, recovery, and then usage rates and medicine.

E. **CSTE** *(Janet Hamilton):* The epidemiologists and those that we represent are deeply entrenched in this. I participated in the ONC high tech advisory meeting yesterday. My comments were focused on two main

areas. One is the issues around electronic laboratory reporting and the other one is highlighting electronic case reporting. We've absolutely been supporting other issues that we feel like are critical, like the syndromic surveillance piece, which is deeply important to this response and that community of practice as well as issues around reporting of death. CSTE did pass through the CSTE executive board an interim position statement for reporting COVID-19 cases.

The other thing that we're spending a lot of time on right now is trying to improve the data quality on electronic laboratory reports. That's been a longstanding issue, which is now greatly exacerbated by COVID-19. We are trying to work on improving how the order process can improve the data along the results. So, for this group, I really want to highlight that we are seeing that some of the most heavily impacted jurisdictions that race and ethnicity is consistently missing 80 to 85% of the time. Addresses and phone numbers are missing around 50 to 60% of the time. I think there's a real opportunity for this group to potentially help with that process. That's in the electronic health record, but it's not making it to those orders.

We're working on trying to leverage getting asks on order entry questions to be associated with the order process for electronic laboratory reports. We think that that is a critical immediate step. We, as a community, have come up with just some basic questions. We have five basic questions which I can share with this group to help support that, like employed in healthcare, symptomatic, hospitalized ICU, and pregnancy. These are all, yes, no, or unknown questions. The other piece where we're spending a lot of time right now is on the point of care testing technology. Point of care tests are not hooked up to electronic laboratory reporting. Those results are sometimes part of the electronic health record, but these are not conducted in laboratories. They are done in physician offices. With the roll out of those machines widely, we feel that we need an electronic feed from those machines to support the health response. The electronic case reporting piece is what we think is the transformation that we need for the fall. The issues that I'm already talking about around ask on order entry questions would be alleviated. The issues with the point of care diagnostics would be alleviated, the missing demographic information. Then, we are so close to needing other things, like the comorbidities (the eCR piece), treatments, and vaccine. All that would be in the electronic case report. We're very interested in not missing this opportunity to leverage the ECRP. So, I would just say that I am in daily congressional conversations about how we also support these activities on the congressional side.

F. **ONC** *(Daniel Chaput):* We've had a team at ONC watching and providing situational awareness internally since late January in collaboration with the Office of the Chief Technology Officer and Jim Daniel. We've been looking at the lab demographic issues that were just mentioned and have a couple of short-term work arounds that can help alleviate the issues of getting better data faster. One through using PULSE and other just providing data from Experian or Lexus Nexus, so that there's just easier data to look up. That's just a short-term situation until the root cause is addressed. We've been looking at several products, people have come forward to ONC with several products. A lot of them fit in to ONC swim lane, many of them don't.

   We've been working with several partners, including CDC and ASTHO, and we're going to be reviewing those to look for those things that are most applicable and are worth additional consideration. We're not going to be making any formal recommendation, but we are looking at all that information. We have a COVID-19 webpage, which is very narrow just for Health IT information, so that Health IT developers don't have to go sifting through lots of various sites looking for information. We repurposed the February 18th EHR vendor call and talked about some workflows with Texas tech. We've collected a large volume of information about potential products in the interoperability proving ground. We've updated the ISA, the Interoperability Standards Advisory, with a special section. We have not gone through everything that came out of the high tech yesterday. We'll be sifting through that tomorrow to prioritize and look at what's next. We have several implementations of PULSE going out. PULSE is the patient unified lookup system for emergencies piloted in California, used to look up patient information in an emergency, and it should prove useful in alternate care settings or alternate care facilities as those are stood up.

Lastly, we are looking out months ahead to say what's going to happen when there is a vaccine. When there's different sorts of vaccine clinics being stood up with nontraditional providers possibly giving those vaccines. Will the data flow through back to the immunization information systems? Who needs the data to be analyzed out of the immunization information systems? Also, looking at serology issues with point of care testing and potential issues with self-testing. If testing can be done at home, that information can find its way back into the electronic health records. Lot of that work is just risk mitigation, identifying the risks, identifying a potential mitigation.

G. **NACCHO** *(Lily Kahn):* Lily is speaking in place of Oscar. Both Oscar and I have been very deeply plugged into not only NACCHO's response, but also CDC's emergency operation center, or SAH, on as they roll up into the FEMA HHS NRCC, as has been the case with Scott, Priyanka, Janet and other partners from the NACCHO. We've been doing a lot to promote that roll out of that NHSN module that Michael had talked about. NACCHO had already been doing work with DHQP on making sure local health departments have access to those data and recognizing that the access for local health departments compared with the state health departments was much more limited even before COVID. This is an opportunity to expand some of that work. I'm getting local health departments access to information about bed availability or ventilator availability. Particularly, as local health departments have been getting those questions about what the healthcare capacity looks like, by way of bed availability and ventilator availability.

   The second thing is trying to understand to what extent, especially given FEMA's lead via the NRCC in this response and requesting information directly, that parallels/duplicates and causes a lot of confusion with the traditional public health surveillance information that we are used to operating in. I'm trying to make enough sense of that so we can help to alleviate some of that confusion. We know that CDC has also been doing a lot to distinguish what has traditionally been within CDC and HHS and then when you layer on FEMA on top of that. Certainly with all of these updates about ECR, we know that there is a lot of work to do in communicating to local health departments that are a little in the earlier stages of really trying to understand the power and the benefit that this electronic case reporting effort will mean in terms of the data they have access to. Local health departments are trying to figure out how to navigate their access to information on, not only the testing, but also the cases, the positives, those that recovered, and those who test negative. That tremendously varies also depending on how they are plugged into the state and higher-level emergency management systems. Like what Priyanka said, we also are promoting the Sara Alert tool. There are more concerns about the availability of race and ethnicity data and recognizing the limitations. We are navigating how to help local health department communicate to the public where some of those limitations occur right now.

   To go back to point of care testing, we have been getting questions not only about that as an issue, but what helps departments are trying to do by way of coordination and partnership start alleviating and anticipating ways to alleviate some of that. To look further out, we recognize that international travel is at a very minimal level, but even that information coming in will eventually increase tremendously when those international travel restrictions are lifted. So, how do you manage and how do health departments manage that additional volume of information coming in and how that ties back to the contact tracing that is necessary. Beyond that, it is also taking us a fair amount of energy and effort to navigate all of the different technologies that are bringing solutions to contact tracing and data collection and how that layers onto the existing systems that we have been working on for so long to supplement that public health surveillance.

   i. **Art Davidson:** I just want to touch on three very local things that I might share. The first is echoing what we talked about with incomplete data for lab. There are two efforts going on locally. One is to force LabCorp and Quest to send all their lab results to the HIE, which has a very strong NPI with referential matching with Lexus Nexus, and could help fill in some of the data that are incomplete now with lab reporting. We're hopeful that the governor will get this to happen.

      The HIE receives all the ADTs from the hospital. So, we've been trying to harness the current ADT

feed to figure out who's in the ICU bed, how much of the resource has been used in this hospital versus another and be able to track that through the automated ADT feeds. Which may be parallel to what NHSN is doing or maybe a little bit different using more raw data. Lastly, I was so impressed with Laura's presentation last month about having found 26,000 cases using eCR in just a few places and just a short time. I tried to begin talking that up with the local health officials here to see if we could spur the state on to become an eCR site.

We have plenty of EPIC sites. I think Laura's report again points to opportunities here for engaging state health departments that are already in line or state health departments was not in line to do eCR. Maybe get them with the sort of encouragement of local health officials, all of whom are very interested, getting the types of data that we could get from eCR more available to them.

H. **Related efforts and initiatives** *(Walter Suarez):* Overall, it's clear that we're all after quality and comprehensive data that can feed into and from lab results that are tied to individuals with compromised comprehensive information about them. This includes data about patients that are being seen and followed in ambulatory settings, patients that go into a hospital and the ER. They go through clinical progress of the patient inside the hospital from ER to hospitalization, to an ICU, to a respirator, to a final outcome, and then even the post-care follow up to see how things are continuing to evolve. One of the challenges that we have experienced, which is the multiplicity and the variety, and in some instances, the disparity of the data points, reporting requests and the data sets being collected. All the hospitals got a letter from the Vice President from the White House requesting a series of data to go to NHSN by 5:00 PM. In California, we were reporting somewhat similar to the department of health. We got some more communications from HHS this past weekend about facilitating their reporting of the data and allowing perhaps, for example, states to report on behalf of the hospital or hospital associations that are in that region.

   Then, there has been other efforts going on that we wanted to bring up here. One that everyone is probably aware of is the COVID-19 healthcare coalition, that is supported by MITRE and has over 600 different organizations involved. They are speaking on the actions they are taking and share information for best practices for identifying and managing patients. They are also discussing improving the capturing of the data and reporting of the data.

   We now have another COVID-19 implementation guide developed by Logica, which is also used as a fire standard to communicate a comprehensive set of clinical data. We also have a standard being developed to report hospital resources and utilization data. So, I think that the interest that I had, and I brought up to the group to bring together this meeting in many ways was to identify opportunities to coalesce even more. Now, I know that there is a lot of efforts that you all describe the different activities and the different efforts that are going on from your organizations. In some way, my sense is there is still a need to pursue improvements in the efficacy, consistency, and effectiveness of the data collection. I just came off a conference call with AHA, where this was a specific discussion point to improve ways to reduce the multiplicity of data point reporting and of data type reporting to bring some consistency. I thought it would be great if Digital Bridge could facilitate some of that.

   i. **John Lumpkin:** When you suggest Digital Bridge taking some action, did you have some thoughts in mind what that might look like?
   ii. **Walter Suarez:** We don't need anymore standards or implementation guides. I think we need a resource that can direct people to where and how data needs to be reported. It's like an RCKMS version of what data needs to be reported to whom when it comes to condition. This could include when you need to report this data, what are the alternatives, and what are the pathways you can follow to report it in an effective way, considering the expectations that these entities have. Maybe it's more about coming out with some guidance with respect to the reporting pathways and feeds.

4. **Discussion – Digital Bridge Role** –
   A. **John Lumpkin:** We've heard some updates of what our partners are engaged in as well as some thought

about how there is already a multitude of systems that are collecting data and the need for some clarity through this. Any ideas that we can come up with that will help with implementation would be important. I'll give one example, after the last meeting, when we had the update from Laura and Grace, I was able to reach out to the North Carolina Health Department. I think we heard today in the update that they were actively exploring now adopting Digital Bridge. What are the things that we think we can do collectively as Digital Bridge as well as those of us as individuals?

B. **Bob Harmon:** A quick update from Cerner. We've already met online twice with the eCR Now team and we've expanded our eCR solution development team to high priority status and we're going to accelerate our work on all the three different elements of eCR Now.
C. **John Lumpkin:** Great. I know that Jim Daniels was tied up. Other thoughts on where we can go from here as Digital Bridge?
D. **Scott Becker:** To Walter's last concern, we've been very concerned about the requests that have been hitting hospitals and health systems to essentially sending flat files and sending spreadsheets and all of that. I think Michael alluded to it in that that's the work that Adi is doing. I'm wondering if in the very near future, like maybe sometime next week, we can get really a broader understanding of what that is because APHL is working really hard with his team, as patina mentioned, to try and repurpose some of the tools that we already have. I wouldn't say that's a Digital Bridge thing. I think its what CDC's engagement is in this big massive response and trying to bring some sanity to the description that you accurately described of all this massive need for all this data. So, that's an ask that I would have if Michael can maybe see if that can be arranged because a lot of work is going on in that space and it just may not be as apparent, it'd be helpful.
E. **Art Davidson:** I'm wondering if there's a place here for Digital Bridges to some leadership around how CDC provides guidance on the use of the dollars that will come from the 8.3 billion trench or any other subsequent allocations to states and locals. I like the word that Walter used about coalescing. About figuring out how we can be more efficient and cost effective with these dollars given the gravity of the situation and given the fact that we don't need to build a lot of different systems. We need to build the ones that just solve each of the requirements and coalesce to build that better system rather than everybody gets a little bit of money and they invest in whatever way they want.
F. **Richard Hornaday:** Is there any opportunity for us to provide some level of consistency and guidance like listening to you all there? There's a couple of things that really jumped out as being common themes: promoting the NHSN feed and how we can adapt that and optimize that, the ELR demographic information. Are we in a situation where everyone's rowing hard, but they're rowing in different directions? And what they really need is somebody just to say, these are the top priority items that we need to be looking at. Is there any benefit that possibly we could do as an overall group to sort of highlight the one or two key things that would really be a call to action?
G. **Andrew Wiesenthal:** What we've got now is a whole bunch of people with paddles up, all sort of pulling, but there's no coxswain. There's no coxswain telling them how fast and what direction steering the boat. So, you're asking for somebody to coordinate all the paddling.
H. **Richard Hornaday:** I doubt we can do that entirely, but if you can understand, if you can get one little bit of activity, usually that's beneficial in and of itself.
I. **Andrew Wiesenthal:** We must keep saying that what the person is requesting is in the electronic health record, not all, but most of it. We have a way of getting it out. “You want it, here's how”, and we have a standard method if you want bed occupancy information or immunization information. If you are doing to be using point of care, want you to integrate that with the EHR because that is to benefit of the patient and to the benefit of public health. There are lots of statements we could make. The problem beyond that making of making statements is how do we get those statements to be heard by people who can influence the direction of the funds flow.
J. **Richard Hornaday:** I was hoping that maybe we had opportunities of people participating in these things where they could say the same sort of thing. And if you're on a call and five people start saying the same thing. Yes, I agree. That is the number one thing. Just even this level of pre coordination could help to possibly sway things. I'll even go a little bit farther than what you identified. It's not so much what information that you need to have. I know that they came to Allscripts, as an example, and a whole bunch

of people got together and said, what's the best way we can give them the information they want? Unfortunately, that's like a shotgun approach. If you can truly say, I'm going to get a large portion of what I want if I beef up NHSN and some of the items that you've talked about where people are already looking to optimize and extend, if we can get them directed on a specific methodology, instead of it being, here's the ocean I could boil, but I'm going to focus on the specific flow that I want to be able to optimize that flow. You approach it in a systematic view. Since it's so political and it's so urgent, I imagine that that sort of stop and take a chance to look at things is not happening. If we could have multiple people who are here, but also participate in these things, get together and describe what the top things we think people should be looking at might help.

K. **Michael Idemarco:** I agree with Richard's, sort of, framework. So, maybe practically what could happen is to come up with this prioritized list of where people should be pushing to do whatever and make the connections and have the data flow. It could be that a small group, maybe just one or two people facilitated by Laura, to talk to Adi in the response and come up with that list. Then, it could be vetted in some way with Digital Bridge. I think instead of creating some new guidance and trying to sell it under Digital Bridge, we might incorporate it into the health coalition framework that MITRE putting up in some kind of subsection around prioritizing areas for data flows to be ramped up during the COVID response. One, recognizing Richard's idea to get focus and prioritization based on the data that's needed, but from a systems engineering perspective to getting that prioritized list quickly. I would argue Adi has the best access into the response and Laura could help facilitate that with the few right people. It would have to involve, there's a couple of key people for example, that would have to be in on that and then three we could push that into the MITRE health coalition is sort of the place to tell people where to look.

L. **Walter Suarez:** Truly, the priority is around three major buckets and is basically all the information that we're looking at. Number one is case reporting and all the things around the case. Number two is lab reporting and all the things around lab. And number three is resource reporting and all the things around resources. So, think about the way I see it is really those three buckets, case reports on all the clinical information that is needed, all the opportunity lab reports, and all the mechanisms and processes that are there on resource reporting. As an example, hospitals receive a letter where there was a new portal that was created to report labs. Some of the functionality wasn't yet in place. So, there is several things being pushed out. One of the things I think that hospitals are looking for, is to come back to a consistent way of doing it, but we need to make sure that this is the one way to do it and we don't keep changing it. Just in the last two weeks things have changed a lot in terms of the reporting. Michael, your suggestion is we look at these three buckets. We say these are the three things we need to focus on. And, when you're dealing with case reporting, this is the mechanism when you're dealing with a lab reporting, this is how you do it. And when you're dealing with resource reporting, this is how you do it. I totally agree with that.

M. **Daniel Chaput**: I would suggest we get our requirements straight. We're jumping to a lot of solutioning and I think the requirements and what people are going to do with the data once they have it needs to be determined. Because this should, in my opinion, it should all really flow up from the bottom, from the local to the regional or the County to the state, to the region, to the federal. Because this disaster is sort of the first time, we've had a disaster in the whole United States at the same time and we've needed things at the national level. We do want hospitals reporting once, because we don't want multiple reports.

N. **Michael Idemarco:** I think the federal requirements are clear to the federal people in the response. I like Walter's three buckets idea, if the first bucket also includes syndromic because that's not exactly vases, but you could think of it in terms of your framework. I think your third bucket about resources includes bed capacity and ventilator capacity, et cetera. I think we've outlined a plan that could work and follow up.

O. **John Lumpkin:** My takeaway from this is a recommendation that we have a small group to discuss the three buckets. We will ask for volunteers. Also, adding in a fourth bucket on reporting of policy efficacy, which can be derived rom those to have a discussion with Laura and then follow up with Adi and the MITER initiative. We will work with the PMO to see if we can facilitate that small, ad hoc group. We would appreciate if you could contact Charlie on your willingness to participate.

5. **Announcements** *(Charlie Ishikawa)* —
   A. The Collaborative Body's second quarter meeting will be May 7, 2020 at 12pm to 1pm Eastern.
   B. We have other action items to expect between now and that time.

6. **Adjourned.**