American Health Information Community

Workgroup: Biosurveillance Subgroup

Draft Meeting Notes
Date: Friday, April 21, 2006
Time: 12:30 pm ET – 2:00 pm ET

Discussion

Review of previous subgroup meeting outcome

- Revisited MDS to achieve consensus on the most needed and most useful clinical data fields for public health
- Reviewed what data was feasible to obtain across a large geographic area of the country
- Proposed a 2 –pronged approach
  - Prong 1 – MDS, only applicable to certain locations across country
  - Prong 2 – Potentially a more limited dataset shared across a larger area of the country, capture opportunistic data such as health plans, chief complaints, claims clearinghouses

- Questions – none were asked

Survey Report

ASTHO (Angela Fix) and NACCHO (Paula Soper) provided a verbal summary of survey results. Written summary will follow on 4/25/06.

Questions

1. Does infrastructure capacity exist to support this effort?

   Response

   - Larger jurisdictions which make up 10% of total jurisdictions have better capacity

2. Is there a set of metrics to measure success for meeting the specific charge?

   Response

   - Charge is high level and relatively subjective, therefore it is difficult to measure

Update on Existing Data –

Update on existing data was given by Laura Conn

- CDC has been pleased with response from hospitals willing to provide data in real time into BioSense. Hospitals have found it feasible to provide the specified level of data.
- Current BioSense data includes:
    - Prong-1 Narrow / Deep data – Phase 1: ADT, ED and Utilization data, Phase 2: Laboratory, Radiology and Pharmacy data
    - Prong-2 Broad and shallow - Lab orders, DOD and VA are providing ambulatory care and ED data. This opportunistic data has a broader geographic coverage. BioSense has been receiving these feeds for several years and is working on getting them in more real-time.
- Assessing Claims Clearinghouse data, it has been expressed that it is more timely now than before, we are doing research on what they're doing and determining the timeliness of when the data is available

National lab data picture – Jason Dubois

- There is a willingness to move forward
- Labs are capable of moving forward
- The need for funding is a recurring theme
- They are already providing Nationally Notifiable Disease reports to ~3000 PH departments and have found them to have differing infrastructure capabilities which leads to concerns about how the data would be provided, particularly in addition to existing data feeds

Questions

1. Will the laboratory feeds be sent using HL7 messaging?

Response

- Good assumption but it depends on HITSP

Filtering Approach

MDS – really refers to types of data, the subsets to be considered for each type of data need to be determined. This filtering discussion is relevant for both prongs, and there are implications on what filters should be considered.

- Eileen Koski – Expressed that it is sometimes more difficult to filter the data than to send it all
- PHDSC is collecting data on reportable conditions already being sent.

        - John Loonsk expressed that this differs from what we're discussing for biosurveillance. BSV goes beyond this, and relies on other types of data to be sent.
- Clarification – This is not about initial detection, nor is this about syndromic surveillance. ICD codes have been mapped to syndrome categories by CDC and others. This has been done by making syndrome categories from the likely presentations associated with each potential bioterrorism agent and aligning the ICD-9 codes that may be representative of that presentation to the corresponding syndrome category. (e.g. syndrome category of respiratory illness corresponds to a clump of representative ICD codes). This has been used as a starting point to assess what should be filtered out and what should be included. It is not conclusive or definitive unless it is a test result that is being sent but it may be starting point for the appropriate group to consider in driving to a definitive list of codes that are needed.

Questions

1. What approach should be used to determine the filtering approach within each data type?

    Proposal

    - Identify and convene group of experts in this area
2. Who is the appropriate group?

    Proposal

    - Kelly Cronin will work with co-chairs to determine the subset of experts to determine direction

Scope

Two pronged approach has been proposed. Prong 1 - Narrow and deep approach targeting MDS; Prong 2 - Broad and shallow, opportunistic data.

- Currently the following capacities exist
    - Situational Awareness – 70% states, 60% locals
    - Outbreak Management – 20% states, higher for locals
    - We're looking at 25% of states that are able to receive data
    - Haven't teased out timing or method for getting the data

- Leah Devlin– Expressed that capacities may be more optimistic than reflected by the survey. Many states are doing work that extends beyond the 6 month period reported in the survey. ,
- Acknowledge receipt of Dr Freidman letter by working group.
- Kelly Cronin- Staging recognition of all work being done that we should build off of. As time goes on, opportunistic now, add MDS as time goes on and extend
- Feasibility of the pronged approach was again questioned and a fever index was again suggested. This included age group counts of fever from any jurisdiction,

which would support tracking of influenza. It could be entered manually thru a web interface or provided electronically by with the capacity. This could also include utilization data and would express the concerns expressed in the NYC letter and NC letter as well.

- Kelly Cronin - Community members did come to consensus that the specific charge was broader than just the fever meter. Workgroup would shift focus to the broad charge over the summer. Right now looking to address the specific charge.
- ACEP is surveying capability of ED information systems to electronically capture diagnostic fever and send it electronically. Many places record this on paper. Agree that it would be valuable but not sure how available it is?
- John Loonsk – Capture of fever data electronically is pretty low right now. Because it is usually recorded on paper, other sources such as preliminary diagnoses from EHR type systems should be considered. There is a greater penetration of ER systems than most have thought was available.
- Quest asked if a panel of information has been defined that clinical labs would be involved in trying to pull together? In the past, reporting out of national labs has largely focused on positive reportable disease results. Broader testing results, those that might map against syndrome list, are generally not reportable. CDC receives test orders, and others are getting results at different levels to different programs. CDC is looking at test results, not specific to notifiable diseases, that may be indicative of events or of monitoring events.
- Discussion should focus on making sure what is defined is doable with funding as a consideration.
- The Biosurveillance WG of HITSP has been considering a HAVE spec which uses web service approach to collect resources from various hospitals. The HITSP work is to include the data structure, as well as standards to address security and transport. This may assist labs with disparate capacities because it will provide some standardization for sending data by addressing non-uniform standards. Jason Dubois, ACLA, commented that he is not sure if the reduction in non-uniform standards will go far enough to resolve disparities in lab reporting capabilities.
- Rick Friedman – Is there an issue in collecting everything and sorting it out later? BSV approach should be piloted but evaluated and considered later on.
- Laura Conn clarified that BioSense was not receiving all the data – the data was anonymized at the data source before being sent by the source to BioSense.

Data Flow

The recommendation is to support simultaneous data flow from healthcare providers to local, state, federal agencies for either prong.

- Rick Friedman – need to coordinate needs up front, and express the value that the MDS will have value for PH
- Privacy concerns – these are addressed by including a randomized data linker in the data that is sent. The data would be anonymized and the link would be used by the data source and local public health in the event of an authorized public health investigation.
- Ed Barthell –experience was that during Katrina, some locals wanted to control their own data and not even share utilization data except in the event of emergency.
- John Loonsk –it is important to reiterate that locals have primary responsibility for response and will continue to have that but there are demonstrated needs at all levels for this type of data
- ASTHO has published an issue brief on privacy that will be shared and discussed at the WG call.
- Important to make sure health providers and public health are aware of what this program will support and how it is intended to help public health.

ACTION ITEMS – OPEN					
Source	Date Opened-ID	Priority (H, M, L)	Lead/Owner	Short Description and Actions to Complete	Due Date
4/21/06 BSV Subgroup Meeting	4/21/06-1	H	Laura Conn / Shu McGarvey	Broad and shallow approach – what is right subset of data for this approach? What kinds of data should we be thinking about? • Capacity data • Chief complaint data	
4/21/06 BSV Subgroup Meeting	4/21/06-2	H	Kelly Cronin	Filtering of data within each type of data within the MDS – Kelly to work with co-chairs to determine group of subject matter experts to convene and discuss the filtering approach.	