Outline for Biosurveillance Workgroup Recommendations to the AHIC

I. Context

a. Specific charge
b. Broad charge
c. Overarching goal - Build on BioSense program and existing capacity in local and state health departments to implement a biosurveillance program to transmit minimal data from emergency departments and labs across the country simultaneously to local state and federal public health departments as feasible.

II. Definition of functional needs of biosurveillance – as described in the scenario document

a. Initial event detection
b. Situational awareness
c. Outbreak management
d. Response management

III. Differentiate between traditional disease surveillance and using extant healthcare data

IV. Describe existing activities and capacities of public health related to biosurveillance

a. Results of ASTHO survey
b. Results of NACCHO survey
c. Other ongoing activities

V. Data Elements

a. Minimum data set to meet the specific charge – might not be feasible to get all MDS elements from every source – leads to pronged approach
b. Discussion of value of subjective and objective types of data – subjective may be impacted by worried well, or chief complaint notes such as, "my wife made me come to the hospital"

VI. Scope – geographic coverage

a. Pronged approach must be considered, where the most gain may be realized from a combination of both prongs.
    i. Prong 1 – Describes a deep and narrow approach. The focus for Prong 1 is narrowly focused potentially to healthcare systems from major metropolitan areas, where deep refers to data that is at the level of detail described in the minimum data set. Healthcare systems would still self-select under this approach, and the data provided would support initial event detection, outbreak management, situational awareness, and response,
    ii. Prong 2 – Describes a shallow and broad approach. Prong 2 is directed at highly opportunistic data from sources that would potentially provide broader geographic coverage such as: hospital systems and health plans that have the infrastructure to provide diagnoses now; claims clearing houses that can support timely data; preliminary diagnoses from laboratory test orders; diagnoses that may be interpreted from medication orders; and chief complaint data. This data tends to provide coverage for initial event detection, some aspects of situational awareness, and limited aspects of response.
b. Determine what data is available electronically from clinical care (data from AHA to support this?)
c. Focus on willing health care providers (call for participation from AHIC?), in the short term and rely on policy levers to incent a larger group of health care providers to meet the broad charge of the workgroup.

VII. Data Flow

a. Data flowing simultaneously to local, state, and federal public health
b. Continue traditional investigation roles at local and state public levels

VIII. Privacy Safeguards

a. Data will not be for public release, consideration must exist to only provide the data that is necessary to meet the functions. Link should be provided that can be used by the data source to identify the individual in the event of an authorized public health investigation. Otherwise, only links, not identifiers would be provided.
b. HHS should offer practical implementation guidance for HIPAA to clarify provider and local and state public health agency concerns about transmitting data for public health purposes.

IX. Evaluation of Data

a. Determine objectives and metrics to evaluate usefulness of data in the near-term