FTS CDC OPTER

Moderator: Lazenia Harris
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1:00 pm CT

Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen only mode. During the question and answer session, please press star 1 on your touch tone phone. Today's conference is being recorded. If you have any objections you may disconnect at this time.

I'll now turn today's meeting over to Ms. Lazenia Harris. You may now begin, Ma'am.

Lazenia Harris: Good afternoon. I would like to first begin by apologizing for the technical difficulties that we've experience. Nevertheless, my name is Lazenia Harris and I am the partnership and outreach coordinator for the division of emergency preparedness and response and I would like to welcome everyone to this afternoon's Real Time Real Talk teleconference.

We'll begin this afternoon's conference with opening remarks from Dr. Robert Martin who is our division director. The agenda will follow with Dr. Jerry Tokars giving an update on the influenza tool then Colleen Martin will provide an overview of the BioSense webinar activities.

Now I'd like to turn it over to Dr. Martin.

Robert Martin: Thanks, Lazenia and good afternoon to everyone. Again, sorry for the delays in getting on but thanks to all of you for participating in the call this afternoon.

I thought I'd start out today because I am new to the division and just give you a little bit of background information and update you on who I am. I was for the last almost year now, I think it is, have been the acting director for the National Center for Public Health Informatics while we were doing a search for the permanent director.

We do have a permanent director now. His name is Dr. Leslie Lenert and Dr. Lenert has been on board for about a month. He comes to us from the University of California in San Diego where he was a professor, also practiced medicine in the VA system there in San Diego and has a real wealth of experience in biomedical informatics.

He has been a board member on the American Medical Informatics Association. So we welcome his joining us. Those of you who may be at the PHIN conference would see him and meet him there. But again, he's already providing great leadership for the national center.

So when Dr. Lenert came on board, I was asked to step into a vacancy that we have here in the Division of Emergency Preparedness and Response and so I'm currently the Acting Director and we again will be looking for a Director for the division over the course of the next few months.
I will be eventually moving on to the coordinating center office but for the time being I'm going to be working with a wonderful group of people here in

the Division of Emergency Preparedness and Response and with all of you and look forward to that.

One of the things I was also asked to comment on was the request for proposals that was out related to Health Information Exchanges (HIE). That proposal has been out for some time. We've received proposals and they're going through the process now. Announcements about awards we anticipate probably towards the end of September.

That RFP is basically about engaging health information exchanges and in turn health information exchanges engaging public health around biosurveillance issues and related of course to BioSense.

We collectively feel this is going to be a way to approach the collection of important information, again, to both CDC and to state and local health departments and we're working very closely with the Secretary of Health office, Secretary Levitt's office, where the office of the national coordinator resides.

The office of the national coordinator is currently chaired by Dr. Rob Kolodner. He developed the system the VA is currently using, the electronic health record Veterans Health Information Sysytem and technology Architecture (VistA) . His activities are really around the development of a nationwide health information network, so we're working very closely with them as well.

As their prototypes are released they will be announcing awards if they haven't already done that within the next few weeks I believe and those awards are to states to help establish the concept. So we're once again working closely with them to be sure that we're leveraging all of the resources

that we have as we move towards an electronic health information system in the country.

So these are very exciting times for us and once again, we're going to be looking forward to working with all of you as well as with other partners in the development of this work.

So I'll just ask my colleagues around the table here if there's anything I've left out or important to say just now. If not – I don't see any suggestions so I'm going to turn this over to Dr. Tokars.

Jerry Tokars: Thanks. This is Jerry Tokars. I'm an epidemiologist in the division. I'm going to talk briefly about a project that we call the Influenza Module. It's going to be a module in the BioSense application. It has been in prototype form for roughly the past year. It's scheduled for release in late September. These things do tend to be a little bit delayed so I'm looking for it in maybe the October-ish timeframe.

It is exciting because it's a collaboration with the influenza division here at CDC and it actually features six data streams, three standard influenza surveillance from the influenza division and three from BioSense. And so that is the first time that particular sort of activity has been done.

Maybe some of you have actually seen some screen shots or been at a presentation when we showed this. We have sort of shown it fairly often. We have revised it fairly heavily over the past few months and it features time series data and maps and it's very interactive. So it's what we think of as the new generation of what the BioSense application can be.

I guess maybe the only last thing to say is that as the time approaches that we would be able to release this, we will have some webinars and Colleen and her group will lead some training sessions on introducing it and trying how to use it.

And maybe one other little thing, this is obviously a release of the application, the BioSense application, there will be another fairly major change in the BioSense application right around the same time and that will be the, Veteran's Affairs (VA) and Department of Defense (DoD) data which is currently shown only in the old module on the left side of the application will start to populate the right side of the application, in other words, the modules that show hospital data currently.

And so you will be able to see both the BioSense hospital data and Veteran's Affairs and Department of Defense data all in the same module, both in the influenza module that I started off talking about and in other parts of the BioSense application around in the October timeframe.

And so I guess that's all for me. We'll probably get some questions later but next will be Colleen Martin.

Colleen Martin: Good afternoon everyone. This is Colleen Martin. I'm an epidemiologist here with the division. I just wanted to give you a brief update on the jurisdiction specific webinars we've been doing with our public health and hospital partners.

The rationale for these webinars was to be able to talk with our users in a more specific and jurisdictional specific way. So for example, instead of just having broad meetings where we can't get into the specifics of data from a

certain state or hospital or we can't show the applications, with real data we wanted to be able to do that so that's why we started having these webinars.

We've conducted 19 webinars from February through August in which we've engaged 21 state and local public health jurisdictions and nine hospital systems. The goals of the webinars were to introduce partners, understand roles and build relationships, to provide an overview of what we at CDC do with BioSense and to understand appropriate points of contact, to review the data from each jurisdiction sending data and answer any questions that might exist about the data, examine the BioSense applications together and gather any feedback and just to provide a forum to discuss relevant issues and experiences with each particular jurisdiction.

And so we've found that these have been really helpful for engaging our public health and hospital partners. We've obtained a lot of really useful feedback regarding the application, ways in which we can improve in the future.

We've learned a lot about how our users are using the application. We've identified a number of training needs and we've taken some steps to try to address those and start to develop some materials and methods for improving change regarding those needs.

Some other outcomes, we're in the early stages of some collaborative projects with some of our partners, primarily around hospital utilization and mortality data. We've really seen an increase in interaction between the biointelligence center and public health partners, I guess just introducing the right people to each other helps with that.

We've reported several events to public health and helped support follow up efforts and we have planned future webinar sessions to increase and continue this level of collaboration.

Jerry Tokars: This is Jerry Tokars again. I should just mention that a fuller discussion of this project will be on Wednesday during the 1:00 to 2:30 session at the PHIN conference and someone else is actually presenting that because Colleen will be going out of town, but there will be a fuller presentation then.

Lazenia Harris: Okay, we did have a fairly short agenda today but that's fine because it allows you to ask more questions, give your comments or concerns at this time, so I'd like to open the lines for questions.

Coordinator: Thank you. We will now begin a question and answer session. If you would like to ask a question, please press star 1 on your touch tone phone. You'll be prompted to record your name. To withdraw your request, press star 2. One moment, please, for our first question.

Our first question comes from Tracy Devenoix. Go ahead, Tracy.

Tracy Devenoi): Go, Tony

Tony: This is a question for the DOD part, the DOD guy. Could you be more specific about what kind of data you're getting from DOD hospitals? You were talking about hospital utilization and mortality data. We're interested in seeing what kind of feelers you're getting from DOD and if they're useful or not.

Jerry Tokars: This is Jerry Tokars. We've been getting data from the DOD for three years. We've been getting roughly the same data. We get it from outpatient clinics

and we get a final diagnosis, it's an ICD-9 coded final diagnosis, from roughly 370 or so outpatient clinics associated with the Department of Defense. Does that pretty much answer the…?

Tony: So you only get ambulatory care data, not hospital data?

Jerry Tokars: Right.

Tony: Thank you.

Jerry Tokars: We have been in contact and working with the Department of Defense to receive richer data feeds when those become available and that is at an indeterminate time in the future. We do realize that the utility would be greatly increased by having additional data but that will be work for the future.

(Tony): Could you also provide us with a website where we can go and dig more information through your system, please?

Jerry Tokars: Yes.

Colleen Martin: The website is www.cdc.gov/biosense.

Tony: Okay, thank you.

Colleen Martin: And we also do provide bi-monthly training sessions regarding BioSense, so certainly you're welcome to depend on those to view a demonstration of the system if you're interested.

Tracy Devenoix: Okay, thank you.

Coordinator: Our next question comes from Jill Tedon. You may ask your question.

Jill Tedon: Yes, In July I put a request in to try to do a trace back of patients at a hospital to request additional testing. I have not heard back on how to do that. Can you tell me there that's been?

Colleen Martin: Sure. I guess my first question would be who exactly did you try to request this from, because I know I didn't get it.

Jill Tedo: Matthew Miller answered me back and passed it on to Carolyn and Emily.

Colleen Martin: Okay. Okay, the whole issue with performing patient trace back is definitely an issue identified actually through these webinars as a huge training need. The capacity for doing that exists but unfortunately a lot of folks don't really know how to do it.

It's definitely something we're addressing. We developed some pilot tools that we're testing with some jurisdictions and some hospital folks to get their feedback and then we'd like to implement those more widely to improve training around this.

If you want to talk further about the specifics and maybe I can help you in the interim, please feel free to contact me directly, or you can send an e-mail to biosensehelp@cdc.gov and I'll make sure that it gets routed to me and maybe we can talk further after this call.

Jill Tedon: I'll just follow up. The last e-mail I got was from Carolyn or Erica.

Colleen Martin: You can also just give me a call directly and I'll give you my number and my e-mail. My number is 404-639-7612 or you can e-mail me at cmartin5@cdc.gov.

Jill Tedon: Alright, thank you, Colleen.

Colleen Martin: Sure.

Coordinator: Thank you. Our next question comes from Thi Dang. You may ask your question with Texas Health Department.

Thi Dang: Hi, I was wondering if you could talk in a little more detail about the sources for the influenza data. You said there were three from BioSense and three from the regular flu surveillance.

Jerry Tokars: Right. From standard flu surveillance the three are the Sentinel Providers Surveillance Network, the laboratory data which is the National Respiratory Virus Surveillance System (NRVSS) Collaborating Laboratories and the last one is the State and Territorial Epidemiologist Assessment as to whether flu activity is high or not. That's a qualitative assessment.

From BioSense we're getting VA/DOD diagnosis of acute respiratory disease and then from the hospitals, acute care hospitals, also a similar diagnosis of acute respiratory disease. And then from BioSense hospital emergency room chief complaints, the three chief complaints are fever, cough, or flu, so we'll be looking at those.

And just on a sort of technical note, when we say acute respiratory illness these were some ICD-9 codes that we collaborated with the flu division and they felt were the best. And so they are 460 through 467 and 480 through 487.

Some people use all 460 to 487 which is a whole range of respiratory disease but there are some in there that code for chronic respiratory disease so those are taken out. So the short interpretation would just be the whole variety of ICD-9 codes that code for acute respiratory illness.

There are some other valuable sources of data that we could get from the flu division. One of them is the 122 cities mortality and that will be a priority to include for next year for the flu season in 2008, 2009. We had to just sort of limit this to what we thought we could accomplish for this season.

Thi Dang: Thank you.

Coordinator: Thank you. Our next question comes from Catherine Smith. You may ask your question with the New York State Department of Health.

Catherine Smith: Yes, this is a question about the flu again, the chief complaints. You're looking at fever, cough, flu – any single one or any particular combination? Is it fever or cough or flu or fever and cough?

Jerry Tokars: Right, it's any one of those, fever or cough or flu. We're persuaded by some of the work and really some of our own work that it's asking a lot to have more than one concept in a chief complaint. Usually it's just one thing so it tends to really narrow it down way too much if you try to say fever and something.

Catherine Smith: Right. Did you rule out sore throat?

Jerry Tokars: Let's see, we did not find that – at least in the data we have so far – looked really strong. What we did is we took all the various chief complaints and we looked at their frequency and how well they're correlated with the provider's

data. We chose three of them that looked good plus ones that were used by other groups and that is sort of our first cut.

Really we will probably be looking at this again and revisiting it maybe after this flu season is over to get the best indicators.

Catherine Smith: Can I ask why you would include ICD-9s like 460 to 467 because we're usually looking at this where we're looking for a laboratory confirmed flu diagnosis. But say the 460's, etc, could be a variety of infectious agents. But you're going with 460 to 467 or 480 to 487?

Jerry Tokars: Yeah, good. These are not, you know, laboratory confirmed cases. They're only diagnoses or chief complaints and so they're not as specific as you would get with laboratory confirmed. They are merely indicators of a wide variety of opinions as to which are the best indicators.

Some of the work I've personally done would indicate that keeping the list narrow is better just looking at diagnoses specifically. It doesn't mean it's laboratory confirmed. It just means that…

Catherine Smith: Yes.

Jerry Tokars: That's the one that correlates most closely. And I should emphasize that we are a very collaborative group of people. We collaborate with our users and we collaborate with the flu division and they have a very strong opinion that this was the best way to do it and so we are in collaboration mode.

Catherine Smith: Right. So would the other ICD-9s, would it be fair to call those influenza like illnesses?

Jerry Tokars: Well, yeah. I mean the thing is that unless you test everyone you don't really know who has flu.

Catherine Smith: Right. I'm just wondering if there was a separate definition for influenza like illnesses or if what you've just described really covers the field.

Jerry Tokars: For the ICD-9 codes we're calling it acute respiratory illness.

Catherine Smith: Okay.

Jerry Tokars: So it's fairly broad. We'd love to have our users analyzing some of the data and finding out better ways to do it but that's part of – that would be very good for both BioSense and flu division and the users.

Catherine Smith: Okay, thank you.

Coordinator: At this time there are no further questions.

Lazenia Harris: Okay, if there are no further questions, we would like to thank everybody for their participation and time this afternoon. Our primary purpose for doing this conference call is to figure out the needs of our partners and stakeholders. So if there are any specific topics that you would like to hear on further Real Time Real Talk calls please feel free to e-mail me with those topics.

My name is Lazenia Harris. That e-mail addresses is cwx3@cdc.gov. My telephone number is 404-639-7604. Thank you all and have an excellent day.

Coordinator: Thank you. That concludes our call for today.

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