06-EC-03

Committee: Executive Committee

Title: Coordinated state, federal and local public health surveillance using BioSense RT for early detection of possible public health emergencies

Statement of the Problem:
Public health preparedness needs collaboration at all levels to be as successful as possible. The national approach to enhancing public health surveillance to more rapidly and sensitively detect and characterize possible public health emergencies must include interagency coordination, a plan for data protection, and an evaluation plan. In addition, federal funding for these activities must be justified since it is diverted from other state and local preparedness and core public health activities.

The BioSenseRT deployment must include input from state epidemiologists and other interested state and local public health entities, as noted in a position statement from CSTE in 2004 (04-EC-04). At this time there are 67 current BioSense RT users, with federal plans to have 350 hospitals on board by the end of 2006.

Despite a dialogue between CDC and CSTE since September 2005, the following issues are still unresolved:

- Data acquired from participating hospitals are still not available to states even though 32 hospitals in 10 cities are transmitting real-time data to CDC.
- A procedure manual has not been provided to states
- The stated purpose of the current BioSense RT is situational awareness, although subsets of the collected data could also be used for early event detection. CDC is collecting more data than is needed for situational awareness. CDC representatives have stated that CDC is receiving all HL7 transactions within a hospital, which could include psychiatric consultations, HIV status, detoxification, and other specially protected personal information. These data are not clearly relevant to situational awareness or surveillance for public health emergencies; there is also no clear plan for their use in BioSenseRT.

Statement of the desired actions to be taken:
1. CDC should work with CSTE and other state and local organizations to develop and incorporate a coordinated plan and evaluation of desired outcomes for BioSense.
2. State and local health departments should be parties to all data use agreements involving hospitals and CDC.
3. Data obtained by CDC through BioSense RT should be made available simultaneously to participating state and local health departments using the same interface that CDC uses.
4. State and local health departments should have on-line or other immediate access to raw data and be able to write queries directly or download subsets of data acquired by such systems.
5. State and local health departments should have access to standardized metadata.
6. Any flag or alert generated by the system that is noted by CDC should be immediately communicated to state and local public health officials and state and local public health officials should be tasked with evaluating each alert. The workload necessary to follow up on alerts or aberrations should be evaluated in the event additional resources may be required.
7. CDC should work with participating state, local and hospital officials to develop mutually agreed upon protocols for response to alerts and for deciding the public health importance of each alert.
8. CDC should work collaboratively with CSTE to develop a plan for evaluation of the usefulness and limitations of BioSenseRT data for public health surveillance.

Public Health Impact:

1. Evaluation and accountability for enhanced public health surveillance funding
2. More efficient use of public funding for surveillance for bioterrorism and other public health emergencies
3. More effective surveillance with decreased morbidity and mortality from early detection of possible public health emergencies
4. Prioritization of surveillance funding to projects and initiatives with positive public health outcomes, or with a reasonable expectation of such.

Coordination

Agencies for response:

1. Julie Gerberding, MD, MPH
   Director
   Centers for Disease Control and Prevention
   1600 Clifton Road NE M/S D14
   Atlanta, GA 30333
   404-639-7000
   jyg2@cdc.gov

2. Michael Leavitt
   Secretary
   U.S. Department of Health and Human Services
   200 Independence Avenue SW
   Washington, D.C 20201
   202-690-7000

3. Michael Chertoff
   Secretary
   U.S. Department of Homeland Security (Do we need to add Homeland security?)
   Washington, D. C. 20528
   202-282-8000

Agencies for Information:

1. George Hardy (for now)
   Executive Director
   Association of State and Territorial Health Officers
   1275 K Street NW
   Suite 800
   Washington, D.C. 20005
   202-371-9090
   ghardy@asatho.org

2. Patrick Libbey
   Executive Director
   National Association of City and County Health Officers
   1100 17th Street 2nd floor
   Washington, D.C. 20036
   202-783-5550
   plibbey@naccho.org

3. Scott Becker
   Executive Director

Association of Public Health Laboratories
2025 M Street NW #550
Washington, D.C. 20036-3320
202-822-5227
sbecker@aphl.org

4. Millie Eidson, DVM, MPH
President
National Association of State Public Health Veterinarians
New York State Department of Health
Room 621 Corning Tower
Albany, NY 12237
518-474-6590
mxe04@health.state.ny.us

Submitting Author:

Allen Craig, MD
State Epidemiologist
Tennessee Department of Health
425 5th Avenue North
Nashville, TN 37247
allen.craig@state.tn.us

Co-author:

Gail R. Hansen, DVM, MPH
KDHE
1000 SW Jackson, Suite 300
Topeka, KS 66612
785-296-1127
ghansen@kdhe.state.ks.us