Virginia Syndromic Surveillance Advisory Group (VSSAG)

Meeting 1 - March 31, 2017

In Attendance:

- Erin Austin, Virginia Department of Health
- Em Stephens, Virginia Department of Health
- Arden Norfleet, Virginia Department of Health
- Katie Kurkjian, Virginia Department of Health
- Diane Woolard, Virginia Department of Health
- Sam Rege, Blue Ridge Poison Control Center
- Laurie Forlano, Virginia Department of Health
- Cindy Shelton, Virginia Department of Health
- Glenn McBride, Eastern Virginia Healthcare Association
- Anna Barringer, Virginia Department of Health
- Sue Moeslein, Bon Secours Mary Immaculate Hospital
- Sue Felber, , Sentara Princess Anne Hospital
- Ana Colon, Virginia Department of Health
- Morris Reece, Virginia Hospital and Healthcare Association
- Andrea Alvarez, Sentara Martha Jefferson Hospital
- Stuart Hutter, University of Virginia Health System
- Michele Thomas, Department of Behavioral Health and Developmental Services
- Marshall Vogt, Virginia Department of Health
- Angie West, Virginia Department of Health
- Craig Camidge, Near Southwest Preparedness Alliance
- Janet Engle, Northern Virginia Hospital Alliance
- Colleen Ryan-Smith, Virginia Department of Health
- Denise Sockwell, Virginia Department of Health
- Amy Lay, Virginia State Police Fusion Center
- Trish Bair, Virginia Department of Health
- Paul Lewis, Armed Forces Health Surveillance Branch
- Jessica Deerin, Armed Forces Health Surveillance Branch
- Jamaal Russell, Armed Forces Health Surveillance Branch
- Vivek Khatri, Armed Forces Health Surveillance Branch

Discussion Notes

1. **Do you see a use for these data or reports within your business practice (i.e. healthcare, preparedness, public safety, research)?**
    - Sue Felber (Sentara Princess Anne Hospital) – Interested in hearing what expected from acute care hospitals?
        - Erin Austin (VDH) – Good question: what is the benefit to you? VDH wants some help in answering this, we have ideas about how these data might be helpful, may be other ways we can't think of at this time. Other infection preventionists on the phone, do you have any ideas?
        - Em Stephens (VDH) – ESSENCE used by the Virginia Department of Health since 2004 has been limited to VDH partners; CDC's National Syndromic Surveillance Program (NSSP) ESSENCE allows us to provide non-VDH partners access to data. New ability for hospital partners to access the data from their facility.
    - Michele Thomas (DBHDS) – Pharmacy services manager with Department of Behavioral Health working with Revive! Program to make naloxone more widely available – agency provides training and education on administration of Naloxone; would like to see integration of specific training geographic areas with syndromic (or death) data on overdoses, could potentially illustrate the effectiveness of the program.
    - Stuart Hutter (UVA Health System) – Value in monitoring flu season; use thresholds to determine need to wear masks, having access to the data would allow for more timely decisions; Recommend inclusion of Poison Control Center epidemiologist for opioid issue, emergency preparedness.
    - Sam Rege (Blue Ridge Poison Center) – PCC (Poison Control Center) tracking their different types of calls over time; have some trouble with how people call in, but being able to compare to another data source would help clarify issues. ED and UCC data trends could provide that comparison.
    - Morris Reece (VHHA) – Is this advisory group related to a previous BioSense workgroup with Amanda Wahnich?
        - Erin Austin (VDH) – Yes, this is a similar group with some tweaks. Similar goals – how to use these data, who to share them with. Interested in partnering with emergency preparedness more.
        - Morris Reece (VHHA) – VHASS (Virginia Hospital Alerting and Status System) network interfaces with WebEOC; could utilize real-time data in situational reports. Particularly useful in the past regarding ILI communication with hospitals. Syndromic data could be useful in the right situation for situational reporting.
        - Em Stephens (VDH) – Advisory group a little different from predecessor in that BioSense 2.0 (old syndromic surveillance system) had much less flexibility in querying visits. ESSENCE (new system) allows for searching for terms related to specific events like a rally or storm.
        - Morris Reece (VHHA) – Restricted list of users?

        - Erin Austin (VDH) – BioSense 2.0 did not have flexibility in access roles, so user lists were limited. ESSENCE has the ability to limit access roles to line level, specific facilities, or aggregate areas.
        - Morris Reece (VHHA) – Wants to identify preparedness groups that would benefit from this access and work on developing protocol.
    - Paul Lewis (DoD) – Big opportunity in collaboration between bases and surrounding areas. DoD data will be in NSSP ESSENCE within next month or two.
    - Erin Austin (VDH) – Is there anyone who doesn't see a potential use of these data?
        - No response
    - Hope White (VDH) – Incident about a month ago where one of the area hospital IPs requested immediate access to the data related to a patient overload in the ED. The day the request came in, the epi team was offsite investigating an outbreak. The request was sent to the state level and was responded to in 48 hours. However ICP indicated that response time was not satisfactory. Therefore, it would be very beneficial to have the ICPs have access to the data themselves.
2. **What data do you currently use for business decision-making and how could syndromic surveillance data complement them?**
    - Stuart Hutter (UVA Health System) – UVA uses internal PCR testing results for ILI surveillance, flu reports from state health department have a lag in data reporting; syndromic surveillance would be a quicker manner of describing ILI.
    - Sam Rege (Blue Ridge Poison Center) – One data source used – calls into the PCC; syndromic surveillance would be a great comparison; Interested in seeing data from counties under Blue Ridge PCC's jurisdiction; Way to link syndromic surveillance and PCC datasets would be beneficial; Does chief complaint recording include ICD-coding?
        - Em Stephens (VDH) – Chief complaint is free-text, discharge diagnosis is available for most, but not all visits, and is ICD-9 or 10 coded.
        - Erin Austin (VDH) – The chief complaint and diagnosis are different fields, but can be combined for analysis
3. **Any other questions about syndromic surveillance data format?**
    - Stuart Hutter (UVA Health System) – Are there still limitations on viewing reports for other geographic regions?
        - Erin Austin (VDH) – NSSP ESSENCE has ways to configure different geographic access roles; some limitations in terms of how patients are assigned to geographic area
        - Em Stephens (VDH) – Two ways to identify location of visit: patient's 5-digit residential zip-code or location of facility. In majority of cases, patients visit a facility close to where they live, but not always. Could provide data at line-level detail to your own jurisdiction or facility and aggregate access to a larger geographic area. Also helpful to note that NSSP ESSENCE includes aggregate access to data from DHHS Region 3 (Virginia, West Virginia, Pennsylvania, DC, Maryland, and Delaware)

- Andrea Alvarez (Sentara Martha Jefferson Hospital) – Would be helpful to have better situational awareness in surrounding area since UVA and Martha Jefferson are so close.

4. **What is the best way for the different stakeholder groups (i.e. healthcare, preparedness, law enforcement, research) to be informed related to syndromic surveillance topics? Direct access to data for you or other colleague? VDH-produced reports?**
    - Anna Barringer (VDH) – Really like reports generated, also really like direct access for ability to respond to events as they're occurring; can then turn around and share data with local community or specific facilities; has been using syndromic surveillance since its initiation in Virginia, wishes had more time to sit and explore data as they provide a wealth of information.
    - Katie Kurkjian (VDH) – Mentioned training to go along with direct access to the data?
        - Erin Austin (VDH) – Yes, training would accompany access to data.
    - Janet Engle (Northern Virginia Hospital Alliance) – Reports are preferable; 22 healthcare organizations in different geographic locations – too difficult to keep track of all of their data.
    - Colleen Ryan-Smith (VDH) – Interesting to know more about collaborative communities between healthcare organizations and their local health departments who are monitoring syndromic surveillance; Would like to see some online communication to share results of surveillance
    - Stuart Hutter (UVA Health System) – Prefer direct access to data; special pathogens group, chronic disease, readmits, and other innovative arenas could really benefit from data
    - Sam Rege (Blue Ridge Poison Center) – Both formats hold value; poison control currently has a similar setup with both online tool for analysis and reports.
    - Em Stephens (VDH) – Will be pinging group for topics they'd like to see reports on. Currently have ILI and overdose reports, but have also done heat=related illness, strep throat, exposure to environmental hazard, etc.
5. **What topics would you like to discuss at future meetings?**
    - If you have any ideas, please let us know!
6. **Next Steps:**
    - Em Stephens (VDH) will be sending out short survey for assessment
    - Looking to hold next meeting in June.
        - Attendance in person would be ideal.
        - Longer meeting (approx. 4 hours) to allow for more in depth discussions.
    - Please address questions to Em Stephens at emily.stephens@vdh.virginia.gov or 804-864-7254.