ACUTE CARE ENHANCED SURVEILLANCE (ACES) ADVISORY COUNCIL

MEETING MINUTES

Date: 2018-01-11	**Location:** Teleconference	**Start Time:** 10:00am
Chair: Dr. Paul Belanger	**Recorder:** Lara Gardner	**End Time:** 11:00am

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Present: L. Segan, A. Bell, M. Finkelstein, M. Whelan, D. McGuinness, J. Caudle, H. Ovens, P. Belanger

Regrets: K. Moore, C. McDermaid

Guests: J. Price, D. Battams, A. Varrette, L. Gardner

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1. General Updates

1.1. A. Van Dijk begins the discussion with an update about user numbers, which at the time of this meeting totalled 144. This was a net increase (including deactivations as per the user account policy) of 10 users since the last ACES Advisory Council (AAC) meeting in May 2017. The actual number of new users added was 29. Audits are conducted quarterly, and approximately 15 accounts were recently deactivated for delinquency, or because a user has left the organization which permitted them access.

1.2. Five webinar training sessions were held since the last AAC meeting, each lasting approximately 90 mins and delivered ad hoc as new hospitals come online. A. Van Dijk noted that new training videos will replace these ad hoc webinars, the series will consist of 3 videos along with references to the ACES manual. The videos will be immediately available to users and can be easily updated when significant changes are made that would change the user experience.

1.3. The first ACES newsletter was released in October, and A. Van Dijk notes that they are to be released tri-annually moving forward with the next edition to be disseminated in late February. Positive feedback was received from the first newsletter amongst our user base.

2. ACES Changes and Improvements

2.1. A. Van Dijk updates the council on aesthetic changes to the user interface that have been made, and notes that the homepage now features a self-registration tool for prospective new users.

2.2. False alerts were being generated frequently and our team has addressed this issue by reducing the number of syndromes that our algorithms run on in ACES. All of the syndromes we no longer alert on were non-specific categories or those that were not relevant to public-health surveillance. There are now only 29 syndromes (out of a total of 80) which ACES alerts on and this reduction has the added benefit of allowing the system to function more efficiently.

2.3. A new "Resources" tab was added to the dashboard on ACES allowing users to see unique graphs pertaining to public health issues. At the request of the Ministry of Health and Long-Term Care (MOHLTC), the ACES team created tables for influenza severity data which our team receives on a monthly basis during the respiratory season. CIHI+ data is also being used to represent opioid data graphically for all Ontario.

2.4. The user manual was updated to reflect changes made to the system. Additionally, more screenshots were added, and the document was transferred to html format so that it is easier to update when further changes are required.

2.5. Users can now download Line Listings; this was a feature that was frequently requested by users and was built in response to the opioid epidemic.

3. Technical Changes and Improvements

3.1. D. Battams reports that the biggest technical undertaking at present is transferring all hospitals to a single router. Those that had become part of the system in it's earlier years will need to move to the newer router, which is set to be decommissioned March 31, 2018. This will also allow for internal network modifications later in the year.

3.2. The user access framework was also amended to allow the technical team to more easily grant specific permissions to unique users. Alongside this change, security was improved for user access.

4. Monitor and Mapper Updates

4.1. A. Van Dijk reports that this is the fifth influenza season that the ILI (Influenza-like Illness) Mapper has been running, with this season beginning September 25th. A new feature added this year is Local Health Integration Network cut-offs, which are still being adjusted and will continue to be as more historical data becomes available. Traffic to the site is continuously being tracked, with an average of 250 visits per week through October and November and then doubling to 500 in December. December 2016 there were 180 visits per week. The last available week before the meeting was January 1st-7th, and the ILI Mapper had a record 840 visits during this period. A Van Dijk also noted that changes in laboratory testing this season has resulted in a lack of data being published about ILI severity. The data from the Ministry described in

section 2.3 above is also being published on the site. Excluded from publication on this public facing site is the death data, cell counts under five, and breakdowns by health unit.

M. Finkelstein notes that the MOHLTC has proposed to remove influenza from the reportable disease list, which will mean health units will no longer receive information on individual cases. Therefore, when the media calls public health to be updated about the current status of influenza in the community, health unit officials will no longer be able to provide these answers. The implication for ILI mapper is that if the proposed change occurs, the mapper site will need to be ready for potential increased traffic.

M. Whelan inquired as to whether there was a denominator for total number of hospitals included in the ILI severity data from NACRS and DAD on ILI Mapper. A Van Dijk responded that although there is record of the 170 sites that sent in data, those who do not cannot be said to have zero cases, but possibly have not reported to NACRS and DAD.

4.2. A. Van Dijk reports that the Surge Monitor and Opioid Monitor tools do not have usage metrics available, however, colleagues have reported that the Opiate Monitor is being used regularly across the province, and the Surge Monitor has been of particular use to LHINs, hospital infection control practitioners and physicians, the MOHLTC, and emergency planning.

5. Recruitment Update

5.1. L. Gardner reports that 18 hospitals have gone live since the last AAC meeting, and 20 remain before ACES has full provincial coverage. Of those 20, eight were in the process of integration at the time of this meeting.

P. Belanger addresses the council to note that K. Moore has been working on ACES recruitment since its inception in 2004/2005, and the stage the program is now at means that since that time it has grown to a place where it currently has nearly complete provincial coverage. He adds that of the remaining facilities, some are proving difficult to partner with and the ACES team at KFL&A would appreciate the advice of the AAC in recruiting these last facilities. H. Ovens responds that the list of facilities the ACES team is having trouble with can be sent to him, which he will pass along to regional LHIN leads so they can act as champions within their jurisdictions. He also notes that as a percentage of total coverage, it is likely that ACES receives around 99% of the total available provincial data.

6. Future Considerations

6.1. A. Van Dijk brings up the merger between Elgin and Oxford health units, which has the following implications, (1) new Data Sharing Agreements (DSAs), (2) map layers including postal code allocation will need to be changed, and (3) all the tools that use ACES data will need to undergo the same changes. Legal counsel may be required to determine what to be done about DSA's. M. Finkelstein advises the ACES team to review whether the DSA includes any clauses

which could apply to this issue. M. Whelan notes that Huron and Perth have also proposed a merger, and the same would apply to them.

6.2. A. Van Dijk also notes that the team frequently receives requests for access to ACES from LHIN staff, who can be granted access under our DSA to all functionality except for line listings. The team at ACES is looking at adding LHIN geographies so it is not necessary to grant these new users access to each hospital separately.
M. Finkelstein notes that LHIN sub-region activities may impact what is requested in the future. Most LHINS will have already published the maps of where these new boundaries would exist.
D. McGuinness recommends reaching out the MOHLTC GIS specialist for further information.