ACUTE CARE ENHANCED SURVEILLANCE (ACES) ADVISORY COUNCIL

MEETING MINUTES

Date: 2016-01-18	**Location:** Teleconference	**Start Time:** 10:00AM
Chair: Dr. Kieran Moore	**Recorder:** Lara Gardner	**End Time:** 11:00AM

Present: Dr. Michael Finkelstein, Melissa Helfery, Ameet Ahluwalia (C. Shingler's designate), Cameron McDermaid, Dr. Brian Schwartz, Michael Whelan, Don McGuinness, Dr. Howard Ovens, Dr. Ian Johnson, Dr. Paul Belanger, Dr. Kieran Moore

Regrets: Nina Arron, Dr. Jaelyn Caudle, Dr. Brian Schwartz

Guests: Adam van Dijk, Allan Varrette, Lara Gardner

1.0. Welcome and Introductions

Roll call was taken by K. Moore and guests from KFL&A Public Health who would be providing updates during the meeting were introduced.

2.0. Approval of Agenda

The agenda was approved, and H. Ovens requested that updates for the addition of hospital level users be added to the list of discussion items. K. Moore requests that H. Ovens provide update for CEDIS e-triage status.

3.0. Approval of Minutes – 2015-04-17

The ACES Advisory Council approved the minutes of 2015-04-17. Action items were reviewed; all were actioned with the exception of RSV Mapper. K. Moore stated that this is not a strategic priority at this time.

4.0. Approval of Terms of Reference

The ACES Advisory Council approved the Terms of Reference.

5.0. Updates (presentation by KFL&A Public Health)

5.1 CEDIS E-Triage Status

H. Ovens says that an electronic triage solution will be mandatory for 73 emergency departments currently using paper records in the province, and 60 smaller hospitals will be given the option to participate. Hospital staff will be required to use one of the presenting

components from the CEDIS list to catalogue patients' complaint. The project is moving forward in 2016 for early adopters with full compliance set to occur by spring of 2018.
K. Moore notes that he and A. van Dijk completed an evaluation of the infectious disease, drug, alcohol, and overdose syndromes and found that CEDIS codes were not as specific and helpful as free-text complaints.

ACTION: D. McGuinness to send K. Moore a list of each hospitals' ED volume in order to determine how much representation ACES currently has.

5.2. Hospital Recruitment Updates

L. Gardner notes that ACES is currently partnered with 125 acute care hospitals across the province. Of all the eligible acute care facilities in the province, ACES is currently partnered with 74%. Of the remaining 26%, 63% fall within the South West and are connected through a central hub called cSWO. Efforts throughout the remaining portion of this fiscal quarter will be directed towards establishing a partnership with cSWO.

K. Moore notes that an initial teleconference has occurred with cSWO and they are in support of moving forward with this partnership.

5.3. ACES for the P/PPAG

A. van Dijk updates that all but four of the target hospitals within the P/PPAG footprint were on board by the time of the Games. The remaining four had technical issues which could not be resolved in time. The reporting sheet used daily by PHO was provided. No alerts were generated related to the Games, although the system did detect an instance of carbon monoxide at a school in Durham.

K. Moore adds that a panel of international experts were consulted in March 2015 to ensure best practices prior to the Games. The result was more robust surveillance and analytic capacities, as well as anomaly detection, than was used during the London Olympic Games in 2012.

P. Belanger reported that the Toronto Central LHIN was provided with a unique dashboard of de-identified data for the top five syndromes at any given point in time. This tool is still being used by this LHIN.

5.4. Threat Risk Analysis

A. Varrette reported that health system partners had wanted to see this happen, largely to determine what the risk of re-identification of patient data is. Results indicate that this risk is extremely low, and that an intrusion specialist was unable to gain access to the system in any way.

The first draft of recommendations made by consultancy, Threat Risk Management will continue to be reviewed in the coming weeks to determine strategic priorities and act upon simple deficiencies.

ACTION: A small working group has been established at KFL&A Public Health to finalize the TRA and implement the recommendations. The final report will be shared with partners, stakeholders, and the Advisory Council.

5.5. Directions for 2016

K. Moore states that the following are strategic priorities for the ACES team in 2016:

- The successful recruitment of hospitals within cSWO catchment area as well as recruitment of any other outstanding hospitals where applicable.
- The implementation of recommendations from the Threat Risk Assessment
- Improved documentation (both end user and technical)
- Build, test, and deploy the most requested features from end users:
    - improve both classifiers (inpatient admissions and ED visits)
    - custom alerting with automatic notification
    - generate epi-curves over different time intervals (e.g., hourly, weekly, or monthly)
    - display multiple syndromes on a single epi-curve plot

K. Moore asks H. Ovens whether there is value in having stoplight signals that indicate hospital surge volume for the general public. H. Ovens responds that there are issues to consider that make this inadvisable for the public, but that it may be useful for hospitals and LHINS to assess system performance, as well as for large public gatherings and natural disasters. M. Finkelstein adds that from a patient flow perspective, it may be useful to have this retrospective data.

ACTION: K. Moore requests further discussion with stakeholders to assess future directions of a hospital surge dashboard.

5.6. Help Desk

A. Varrette introduces the Help Desk platform, a vendor product that provides a self-serve knowledge base for quick solutions. The knowledge base will contain how-to articles and frequently asked questions. ACES project staff can easily track support requests and ensure a reasonable time-to-response. Users will be notified via email upon the creation and solution of a ticket for their issue. This also gives project staff access to better metrics about the kinds of issues partners are having.

5.7. ILI Mapper Update

A. van Dijk reports that this is the third respiratory season since its inception. The team participates in weekly influenza risk discussions with PHO and MOHLTC. This season saw rise in some respiratory syndromes during the Christmas break, however Influenza has not yet spiked.

Real-time graphs have been replaced with cached data from the end of the previous day to reduce lags. A new Asthma Mapper was introduced in September of 2015, and uses the LHIN as the unit of geography, and an age range of 2-50 to exclude COPD from the data.

5.8. Q&A

A. van Dijk updates that 24 new hospital level users have been trained and added to the system since December. Adding hospital users is dependent on ACES partners sharing information that this is now available; point of contact for ACES team is usually executive level. K. Moore notes that the ACES team has been invited to present to the Ontario Hospital Association.

K. Moore speaks to the Patients First Proposal, specifically how surveillance supports the intended formalized relationship between LHINs and LPHAs. C. McDermaid notes that the consultative process with hospitals will be key for decision making at LHINs level with regards to staffing, time trends outside seasonality, etc.

ACTION: K. Moore suggests brainstorming to determine how ACES could be used at the LHIN level and how to support the mandates of public health.

Next Meeting: June 2016