Algoma
PUBLIC HEALTH
Santé publique Algoma

June 3, 2020

BOARD OF HEALTH SPECIAL MEETING

Algoma Community Room - Webex video & teleconference

www.algomapublichealth.com

Meeting Book - June 3, 2020 Board of Health Special Meeting

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Board of Health Special Meeting

AGENDA

June 3, 2020 at 5:00 pm

Webex Audio and Videoconference | Algoma Community Room

**** Meeting held during the provincially declared emergency***

BOARD MEMBERS

Lee Mason - BOH Chair
Ed Pearce - F&AC Chair
Deborah Graystone - Gov. Chair
Dr. Patricia Avery
Louise Caicco Tett
Sally Hagman
Micheline Hatfield
Dr. Heather O'Brien
Brent Rankin
Matthew Scott

APH EXECUTIVE

Dr. Marlene Spruyt - Medical Officer of Health/CEO
Tania Caputo - Board Secretary

1.0 Meeting Called to Order *L. Mason*

a. Declaration of Conflict of Interest

2.0 Adoption of Agenda *L. Mason*

RESOLUTION

THAT the Board of Health Special Meeting agenda dated June 3, 2020 be approved as presented.

3.0 Reporting Concerns *L. Mason*

4.0 Announcements / Next Committee Meetings: *L. Mason*

Finance & Audit Committee Meeting
June 10, 2020 @ 5:00 pm
Webex Video / Teleconference |SSM Algoma Community Room

Governance Committee Meeting
June 17, 2020 @ 5:00 pm
Webex Video / Teleconference |SSM Algoma Community Room

Board of Health Meeting
June 24, 2020 @ 5:00 pm
Webex Video / Teleconference |SSM Algoma Community Room

5.0 Adjournment *L. Mason*

RESOLUTION

THAT the Board of Health meeting adjourns.

Algoma PUBLIC HEALTH Santé publique Algoma

Briefing Note

To: Algoma Public Health Governance Committee

From: Dr. Marlene Spruyt, MOH/CEO

Date: May 6, 2020

Re: COVID-19 Data Reporting to Municipalities

☐ For Information ☐ For Discussion ☒ For a Decision

ISSUE:

Some municipalities have expressed concern about the data that is being shared with them with respect to the current COVID-19 pandemic.

RECOMMENDED ACTION:

That the governance committee recommends that APH continue its current protocol of sharing COVID-19 data in keeping with the Ministry of Health guidelines and epidemiological best practice.

BACKGROUND:

Algoma Public Health has been fortunate in that they have relative to other health units, very few positive cases. Local community members have compared our publically posted data to that of other health units with higher case counts and have expressed concern that there is a lack of transparency.

How we handle personal health information and surveillance data:
As a Health Information Custodian, APH is obligated to comply with the Personal Health Information and Protection Act (PHIPA). In addition, the Health Protection and Prevention Act (HPPA) states:

Confidentiality:
39 *(1) No person shall disclose to any other person the name of or any other information that will or is likely to identify a person in respect of whom an application, order, certificate or report is made in respect of a communicable disease, a disease of public health significance, a virulent disease or a reportable event following the administration of an immunizing agent. R.S.O. 1990, c. H.7, s. 39 (1); 2017, c. 25, Sched. 3, s. 1 (3).*

However, much of our work involves surveillance data that is de-identified and in these situations, we follow the guidelines of the various agencies that provide us with data. To use data from the Canadian Institute for Health Information (CIHI) we sign an agreement that sets out the methods we can use to share data. See the link here regarding Executing Controls, page 24-25
https://www.cihi.ca/sites/default/files/portal_addendum_1407_pdf_en_0.pdf

The opioid data that is shared from the province regularly comes with the following reminder every time the data is shared….

Sharing the Data with External Stakeholders:
If you are sharing the information contained in the weekly reports with external stakeholders and community partners, we ask that you follow the guidelines below:

Cell suppression:
To maintain patient privacy and ensure no risk of residual disclosure, the ministry asks that counts or rates based on 1 to 4 cases be suppressed (e.g. reported as "1 to 4" or "less than 5"). We also ask that health units only share **monthly aggregate totals** rather than weekly data to further ensure privacy.

Stats Canada Dissemination guidelines make the following comments about information that is already de-identified

Prevention of direct or residual disclosure must also be addressed when determining product content. When assessing the potential for disclosure, a number of factors must be considered. The detail of individual variables, cross-classification of variables and the geographic level of the data will all contribute to the risk. For example, there may be no risk in producing households by number of persons in the dwelling and detailed groupings of age showing various characteristics of the household members for large geographic areas. However, the risk of disclosure would increase for the lower levels of geography…

…further use and disclosure of this information must be avoided by not reporting information relating to a small number of individuals (e.g., fewer than five) or by combining categories after the fact to increase the cell size to an acceptably large number.

Prevention of direct or residual disclosure must also be addressed when determining product content. When assessing the potential for disclosure, a

number of factors must be considered. The detail of individual variables, cross-classification of variables and the geographic level of the data will all contribute to the risk. https://www12.statcan.gc.ca/census-recensement/2011/ref/DQ-QD/2011_DQ-QD_Guide_E.pdf page 7

The Privacy Commission makes the following comments about sharing survey results:

Survey results are generally reported as aggregate information, thus protecting the privacy of individual participants. However, in some cases, a survey may result in small cells of information (i.e., where a small number of people is being represented) that could inadvertently identify or be used to identify an individual. For example, in an anonymous survey of institution employees, survey participants might be asked to specify their gender and employee category (e.g., executive, manager, supervisor, or staff). However, if there is only one individual of a particular gender who falls within a particular employee category (e.g., female/ executive), then that individual's responses will be easy to identify. If it is known in advance that a survey could result in information that relates to a small number of individuals (i.e., small cells), the collection of personal information can be avoided by eliminating or combining those categories that include few individuals. In the above example, the size of the cells could be increased by eliminating gender categories or by combining executives and managers into a more general category. However, if the potential occurrence of small cells is not anticipated in advance and personal information is inadvertently collected, further use and disclosure of this information must be avoided by not reporting information relating to a small number of individuals.

As stated above, note that the provincial Act provides that an educational institution may use personal information in its alumni records and a hospital may use personal information in its records for the purpose of its own fundraising activities, if the personal information is reasonably necessary for the fundraising activities, subject to additional requirements. See sections 41(1)(d), 41(2) and 41(3) of the provincial Act. 26 Best Practices for Protecting Individual Privacy in Conducting Survey Research (e.g., fewer than five) or by combining categories after the fact to increase the cell size to an acceptably large number.

https://www.ipc.on.ca/wp-content/uploads/2015/04/best-practices-for-protecting-individual-privacy-in-conducting-survey-research.pdf page 12

And finally, because in a Pandemic situation the data comes from a variety of sources not listed above the Ministry has provided specific guidelines posted here https://www.ontario.ca/document/data-standards-identification-and-monitoring-systemic-racism/public-release-and-reporting

http://www.ehealthinformation.ca/wp-content/uploads/2014/08/2011-Best-Practice-Guidelines-for-Managing-the-Disclosure-of-De-Identificatied-Health-Info.pdf

How we approached the challenge of communicating data for COVID-19 pandemic:

This unique situation of the COVID-19 pandemic required us to balance the need to inform the public of their potential risk and use the information to convince the community to engage in protective action against that of protecting an individual's privacy. A plan was developed before the first case was identified. Many of the first few cases were travel-related and publicizing any details of travel plans would, especially if connected with a geographic location, lead to the potential identification of the individual. We followed the lead of other jurisdictions in the province and reported based on Algoma as a whole. Even if no travel details were required, we did not wish communities without positive cases to think that they were not at risk. In the early phases we, along with other health units shared more details about the individual situation using this as a technique for informing the public how infections were acquired and that all ages of individuals were potentially at risk and that APH had contacted all people and places at risk to inform them of their potential exposure. This early reporting was very labour intensive and as numbers increase across the province the reporting format shifted to minimal details of subsequent cases and the beginning of a framework that would illustrate the demographics of the outbreak across the province and within each health unit. The intent was and still is to show numbers in geographic areas, combined with age and gender distribution. Fortunately for Algoma, the numbers have not increased substantially and in many of our sub-regions, the case counts are less than 5.

Concerns expressed by some municipalities:

Some municipalities feel that they should be informed of the exact number and some of them feel that they should be broken down into individual municipalities rather than the sub-regions we have identified. Our question to them has been what you would do differently if the number was 3 or 4 cases. Once numbers exceed 5 cases the actual number will be reported on the website. If we were to use even smaller geographical areas there would be an even greater risk of identification of a specific individual. We also do not want individual municipalities and their residents to become complacent if their count is zero. We also recognize that there is considerable travel between municipalities both within the sub-regions identified and between them and identifying sub-regions while not

perfect, serves the purpose of demonstrating that there is some risk across the district of Algoma.

Statements have been made that other health units have broken the data down differently. Sudbury our nearest neighbour, and the one with which we likely have the most interaction is reporting in exactly the same way as we are, as are all the other HU in NE Ontario. NWHU has been identified as posting by municipality but upon closer examination of the site, these are health hub areas that are named after the largest municipality in that sub-region. The LHIN identified health hubs consist of an area that includes a hospital, primary care clinics and several smaller communities including FN communities. They are very similar to our identified sub-regions.

Concern has been expressed about the delay in sharing information. In almost all cases the information has been shared publically on the same calendar day as the report is received at APH. In some cases when the report is received very late in the evening notifying the individual of their and tracking the potential contacts has occurred the following morning at a more socially acceptable time and public reporting has occurred well within 24 hours. In one case, the report went to the primary care provider that did the swab and we were not notified until the next calendar day. Concerns have been expressed by municipalities that the individual could be spreading around town while we delay in reporting to them. Firstly, individuals tested are advised to self-isolate while waiting for results and secondly, they are the first point of contact after we get the result so we determine that they have remained in self-isolation. For the municipality to be involved in containing them, we would have to provide personal information that we cannot do. We then identify everyone they have been in contact with or where they may have travelled and we contact those individuals or places. Some municipalities think it might be their responsibility to order a place closed/cleaned if it has been “contaminated” but that is the role of public health. We contact everyone who might have been exposed and they go into self-isolation pending development of symptoms or follow up testing. The municipality is not responsible for tracking any potential exposures.

Concern has been expressed about the delay in sharing information with the Community Emergency Control Groups (CECG). At the onset of the provincial response, many municipalities had not activated their IMS system. Traditionally APH shares a press release internally with its staff and its Board of Health members and with its respective municipalities if the media release potentially affects them. It was recognized that the function of communication with the BoH and the municipalities usually is the responsibility of the MOH office and not the Communications department. Due to a different procedure being required during

the pandemic, it was recognized that the municipalities may not have received information before it was released to the press. This was an oversight and has since been corrected. Once a CEGG identifies that they have activated they will be included on the early notification list and will receive the same information that the media receives but it will precede the release to media.