PANDEMIC RESPONSE in Long-Term Care Homes

Long-Term Care Commission Briefing

February 12, 2021

OVERVIEW

- **Public Health Measures**
  - Guidance for LTCHs and Directive 3
  - Universal Masking Policy in the LTCHs
  - Cohorting Isolating within LTCHs
  - Visitors and Essential Caregivers Policies
- **Appendix: Overview of CMOH Directives**

Public Health Measures - Roles and Responsibilities

Ministry Emergency Operation Centre (MEOC)

- Oversees and coordinates input from OCMOH, PHO and OH to support alignment and consistency across guidance documents
- With OCMOH, MEOC helps develop and update the Case Definition with advice from PHO and developed a self-assessment tool
- Support drafting and issuing of memorandums, guidance and Directives

Ontario Health (OH) develops a range of operational guidance documents for health system partners

Office of the Chief Medical Officer of Health (OCMOH)

- Leads development of some documents primarily related to school/childcare outbreak guidance and public health measures/reopening
- Where the CMOH is of the opinion that there is or may be an immediate risk to health, he **may issue a directive** to any health care provider or health care entity respecting **precautions and procedures to protect the health of persons** under the *Health Protection and Promotion Act*
- Participates in technical working groups to determine content of guidance documents
- Receives feedback from stakeholders on guidance
- Approves guidance issued by ministries
- With MEOC, OCMOH helps develop and update the Case Definition with advice from PHO

Public Health Ontario (PHO)

- COVID-19 laboratory testing (PHO Lab) for the public health field and scientific support (test development, strategy)
- Provides epidemiological guidance through enhanced surveillance directives and technical advice about case and outbreak management
- Supports PHUs to manage outbreak contacts
- Provides scientific and technical advice to Ontario government to support policy-making, and to other sectors (e.g. education)
- Reviews drafts of guidance materials to ensure technical information is captured appropriately
- Develops evidence guides for public and providers

Ministry of Long-Term Care (MLTC)

- Issues sector specific, guidance and Minister's Directives under the *Long-Term Care Homes Act, 2007*.
- Facilitates the distribution of guidance, memos and directives from the OCMOH and PHO to the LTCHs sector

Public Health Advice & Guidance

- Public health measures are **voluntary** (*recommend* actions) and **non-voluntary** (*mandate* actions). Effective response involves the use of both types.
- Ministry of Health has issued a number of **memos**, **guidance documents** and **Directives** (issued by the Chief Medical Officer of Health) to the health system that have informed and directed the COVID-19 response. Guidance developed with input from experts, ministries and stakeholders, and has changed as the knowledge of the virus evolved.
- Ministry of Long-Term Care issued sector specific guidance through memos and Minister's Directives under the *Long-Term Care Homes Act, 2007*
- Guidance posted online for public and providers:
  - Public Health Guidance: Ministry of Health's website
  - Minister of Health Orders, CMOH Directives, and memos of each of the Health Command Table meetings: Ministry of Health's website
  - LTC Sector Specific Guidance and Minister of Long-Term Care Directives: LTChomes.net Portal
- Summary charts prepared for the LTC Commission and updated monthly of all Guidance Documents for the LTC Sector – **see Appendix 2**

Document Reference: Orientation on Pandemic Management in Ontario's Health Sector: Briefing with the Long-Term Care Commission Slide Deck, 2020-09-08

Process of Developing Guidance

Ongoing work at the policy level to take the guidance from conception or revision to approval and release.

- Situation Reports and other vehicles as appropriate
- Situation Reports sent to stakeholder associations/groups
- Post on MOH website

1. Conception or Revision

- Establish process for working with MOH area or another Ministry
- Agreement on stakeholder engagement
- Identify potential supports to guidance and dissemination vehicles
- Revisions based on substantial change in information that resulted in need for new guidance, or refinement based on feedback

2. Review of Draft

- Stakeholders
- PHO
- MLTSD
- MOH/MLTC Legal and OCMOH

3. FYI / Approval

- MOH/MLTC Program Area and/or other ministries
- MOH/MLTC ADM, MO, and DMO

4. Release

CMOH Powers to Issue Directives (s. 77.7 of the *HPPA*)

- Where the Chief Medical Officer of Health is of the opinion that **there is or may be an immediate risk to health**, he/she may issue a directive to **any health care provider or health care entity** respecting **precautions and procedures** to protect the health of persons.
- The directive **may not be used to compel regulated health professionals** to provide services without their consent.
- Directives are legally binding (vs. guidance, memos). Guidance documents may still exist to complement directives and provide more detail.
- CMOH has issued five Directives since March 2020, which have been amended and re-issued from time to time – **see list in Appendix 1**
- Directives are available online here.

Directives: Evidence and Approval Process

- Initial versions, built upon pre-existing guidance for outbreak management (i.e. for seasonal influenza) and were adapted over time for the COVID-19 context (e.g. how the virus was behaving).
- MOH works closely with PHO who provides evidence reviews and jurisdictional scans. This evidence informs whether Ministry policies need to change to adopt changing COVID-19 concerns or emerging knowledge.
- Policy team is responsible for gathering the science and drafting the directives. PHO, legal, MOL and MLTC also assist in the evidence-gathering process at this stage.
- Once the directive is drafted, approvals are sought.
- Final approval and issued by CMOH.

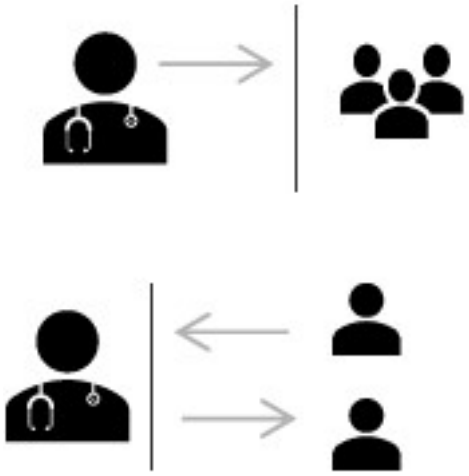
Directive 3: Versions and Chronology

- **Version 1 - March 22, 2020**
  - Based on MOH COVID-19 memos and other established guidance for respiratory outbreaks (Control of Respiratory Infection Outbreaks in Long-Term Care Homes, Institutional/Facility Outbreak Management Protocol, the Infectious Disease Protocol, PIDAC respiratory guidance and Environmental Cleaning).
- **Version 2 - March 30, 2020**
  - Required precautions and procedures expanded to include screening, repatriation, short stay absences, cohorting, management of a case, outbreak preparedness and response.
- **Version 3 - April 8, 2020**
  - Updated to strengthen screening, testing and outbreak management in long-term care homes.
- **Version 4 - April 15, 2020**
  - Updated to reflect the emergency order limiting working in only one location and to provide additional information on outbreak management and response.
- **Version 5 - May 21, 2020**
  - Updated to include direction related to hospital transfers; testing within 24 hrs of new admissions and re-admissions; minimizing work locations of volunteers and contractors; and sharing of IPAC assessment results and reports.

Directive 3: Versions and Chronology Continued

- **Version 6 - May 23, 2020**
  - Direction on new admissions, re-admissions, short stay absences and managing visitors expanded to provide clarification.
- **Version 7 - June 10, 2020**
  - Updates to: admissions and re-admissions from hospitals or community; short-stay absences for retirement home residents and transfer to hospital; visitors guidance; ending a suspect outbreak/outbreak assessment steps based on negative test results; advanced care planning.
- **Version 8 - August 28, 2020**
  - Updated direction on short stay absences and add direction for temporary absences.
- **Version 9 - September 10, 2020**
  - Updated direction on managing visitors to allow visitors from family visitors.
- **Version 10 - October 14, 2020**
  - Updated direction on absences, including approvals required for absences.
- **Version 11- December 7, 2020**
  - Updated direction to COVID-19 symptoms, admissions/transfers, medical absences, universal masking, visitor policies, testing, required steps in an outbreak

Universal Masking Policy



- **Definition:** Wearing a surgical/procedure mask at all times to protect others. from the wearer.

- **Timing:**
  - Directive #3, issued on April 8, 2020 implemented a universal masking policy in long-term care homes for both staff and essential visitors. It did not recommend the universal masking of residents.
  - In April 15, MOH developed a guidance that gave the in long-term care homes direction as to rationale for implementing universal masking policy.

- **Rationale for Universal Masking Wearing in LTCH:**
  - Source control: to prevent workers from spreading illness to others.

Document Reference: Guidance for Mask use in LTC and RH 2020-04-15

Cohorting

- Outbreak control measure adopted within congregate living settings to prevent and/or manage the spread of an infectious disease.
- Established practice for respiratory and seasonal influenza outbreak management.
- Directive 3, Version 2 (March 30) and corresponding guidance documents) requirements based on existing respiratory guidance:
  - 1) Residents
    - Placement and care of individuals who are infected in the same room/area; OR
    - Placing those who have been exposed together to limit risk of further transmission.
  - 2) Staff
    - Assigning specific health care workers to care only for residents known to be infected/exposed OR non-exposed residents, never both.
- LTCHs must have a plan for resident and staff cohorting as part of their approach to preparedness as well as to prevent the spread of COVID-19 once identified in the LTCH.

Document Reference: Healthcare Worker Personal Protective Equipment (PPE) Use and Cohorting in Long-Term Care and Retirement Homes; Directive 3 LTCH – Dec. 7 2020

Resident Cohorting

May include:

- Alternative accommodation to maintain spatial separation of 2m at all times.
- Cohorting of residents by their COVID-19 status.
- Utilizing respite and palliative care beds and rooms to provide additional accommodation.
- Utilizing other rooms as appropriate to help maintain isolation of affected residents (e.g., community and recreation rooms that have call bells).

Document Reference: Healthcare Worker Personal Protective Equipment (PPE) Use and Cohorting in Long-Term Care and Retirement Homes; Directive 3 LTCH – Dec. 7 2020

Staff Cohorting

May include:

- Designate staff to work in a defined cohort, such as symptomatic residents.
- If this is not possible, such as in smaller LTCHs or those where it is not possible to maintain physical distancing of staff and residents from each other:
  - All residents and staff should be managed as if they are potentially infected.
    - Staff should go first to rooms with unexposed well residents, then to well exposed residents and then symptomatic residents; and
    - Staff should use Droplet and Contact Precautions when in an area known to be affected by COVID-19.

Document Reference: **Healthcare Worker Personal Protective Equipment (PPE) Use and Cohorting in Long-Term Care and Retirement Homes; Directive 3 LTCH – Dec. 7 2020**

Rationale for Isolating Within Homes

- **Facilitate Occupancy Reduction and Social Distancing**
  - Many older homes have rooms with 3 or 4 residents. All homes have some rooms with double occupancy, which may limit options for isolation and containment of the virus in cases of outbreak.
  - A bed in a 3 or 4 ward room must be left vacant if a resident who occupied such a room is discharged, admitted to hospital or spends 2 or + nights in emergency, AND there are two or more residents who continue to occupy a bed in the ward room.

Directive #3 Isolating Requirements

Absences

Short Term Absence: Defined as leaving the LTCH's property for social or other reasons that does not include an overnight stay.	Upon return to the LTCH, residents must be actively screened (refer to Active Screening of All Residents above) but are not required to be tested or self isolate.
Temporary Absence: Defined as leaving the LTCH's property for social or other reasons that includes one or more nights.	Upon return to the LTCH, residents must be actively screened (refer to Active Screening of All Residents above) and self-isolate for 14 days.
Medical Absence: Defined as leaving the LTCH's property for medical reasons (i.e., outpatient visits, single night emergency room visit).	Upon return to the LTCH, residents must be actively screened (refer to Active Screening of All Residents above) but are not required to be tested or self isolate.

Management of Single Case in Resident:

- **Resident:** "The resident must be in isolation under appropriate Droplet and Contact Precautions, in a single room if possible."
- **Staff:** "Staff who have had a high-risk exposure to COVID-19 without appropriate PPE and are asymptomatic must self-isolate for 14 days and monitor for symptoms. In exceptional circumstances staff may be deemed critical, by all parties, to continued operations in the LTCH, and continue their duties under work self-isolation[…]"

Document Reference: Directive 3, December 7, 2020

Visitors and Essential Caregivers Policies

- **Visitors Policy:**
  - March 2020: MOH and MLTC imposed strict visitor policies to limit number of people entering LTCHs to only essential visitors to limit the spread of COVID-19. Knowledge about the nature of the virus and method of transmission was limited at this time.
  - Similarly, only essential visitors are allowed to enter LTCHs in an influenza outbreak.
  - As LTCHs became more familiar with IPAC protocols and the COVID-19 case counts in the province decreased, MLTC amended policies to allow more visitors to enter LTCHs.
- **Caregivers:**
  - Similar rationale applied to MLTC's response to family caregivers. Early in the pandemic, outside visitors entering LTCHs posed significant risk to residents within the homes. Concern at this time was that outside visitors were not trained on PPE use or IPAC precautions.
  - During the pandemic response, MLTC took steps to train essential caregivers in relevant PPE and IPAC precautions and relied on essential caregivers to act as caregivers for their family members in LTCHs.

APPENDIX 1 - Overview of CMOH Directives

Directive #	Title	Version	Date
Directive 1	For Health Care Providers and Health Care Entities	Version 1 Version 2	March 12, 2020 March 30, 2020
Directive 2	For Health Care Providers (Regulated Health Professionals or Persons who operate a Group Practice of Regulated Health Professionals)	Version 1 Version 2	March 19, 2020 May 26, 2020
Directive 3	For Long-Term Care Homes under the *Long-Term Care Homes Act*.	Version 1 Version 2 Version 3 Version 4 Version 5 Version 6 Version 7 Version 8 Version 9 Version 10 Version 11	March 22, 2020 March 30, 2020 April 8, 2020 April 15, 2020 May 21, 2020 May 23, 3030 June 10, 2020 August 28, 2020 September 9, 2020 October 14, 2020 December 7, 2020
Directive 4	For Ambulance Services and Paramedics under the *Ambulance Act*	Version 1 Version 2	March 24, 2020 March 30, 2020
Directive 5	For Hospitals within the meaning of the *Public Hospitals Act* and Long-Term Care Homes within the meaning of the *Long-Term Care Homes Act, 2007*	Version 1 Version 2 Version 3 Version 4 Version 5	March 30, 2020 March 31, 2020 April 10, 2020 October 5, 2020 October 8, 2020

APPENDIX 2 – Guidance Documents for LTC Sector

COVID-19 MOH/MLTC Document Resources, including Guidance, Directives and Memos for the LTC Sector

Date	Document
January 1, 2020 to August 31, 2020	Update to Aug 31, 2020
Updated to September 30, 2020	Update to Sept 30, 2020
Updated to October 31, 2020	Updated to Oct 31, 2020
Updated to November 30, 2020	Update to Nov 30, 2020
Updated to December 31, 2020	Update to Dec 31, 2020
Updated to January 31, 2021	Update to Jan 31, 2021

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