COVID-19

Directive #1 for Health Care Providers and Health Care Entities

Issued under Section 77.7 of the Health Protection and Promotion Act (HPPA), R.S.O. 1990, c. H.7

WHEREAS under section 77.7(1) of the HPPA, if the Chief Medical Officer of Health (CMOH) is of the opinion that there exists or there may exist an immediate risk to the health of persons anywhere in Ontario, he or she may issue a directive to any health care provider or health care entity respecting precautions and procedures to be followed to protect the health of persons anywhere in Ontario;

AND WHEREAS, under section 77.7(2) of the HPPA, for the purposes of section 77.7(1), the CMOH must consider the precautionary principle where in the opinion of the CMOH there exists or there may exist an outbreak of an infectious or communicable disease and the proposed directive relates to worker health and safety in the use of any protective clothing, equipment or device;

AND HAVING REGARD TO the emerging evidence about the ways this virus transmits between people as well as the of illness it causes in addition to the declaration by the World Health Organization (WHO) on March 11, 2020 that COVID-19 is a pandemic virus and the spread of COVID-19 in Ontario, and the technical guidance provided on March 10, 2020 by Public Health Ontario on scientific recommendations by the WHO regarding infection prevention and control measures for COVID-19;

AND HAVING REGARD TO the recommendations provided by Public Health Ontario and the WHO as to the droplet and contact spread of COVID-19, the demonstrated need to ensure the adequate supply of personal protective equipment (PPE) for medical procedures where COVID-19 may become airborne to ensure worker health and safety, and ensuring adequate supply of personal protective equipment during the duration of COVID-19;

AND HAVING REGARD TO the precautionary principle, which in my opinion has been met, in that this directive will protect health care workers' health and safety in the use of any protective clothing, equipment and device and the failure to adhere to this directive may put worker health and safety at risk;

I AM THEREFORE OF THE OPINION that there exists or may exist an immediate risk to the health of persons anywhere in Ontario from COVID-19;

AND DIRECT pursuant to the provisions of section 77.7 of the HPPA that:

COVID-19 #1 for Health Care Providers and Health Care Entities

Date of Issuance: March 12, 2020

Effective Date of Implementation: March 12, 2020

Issued To: Health Care Providers, Health Care Entities

* Health Care Organizations must provide a copy of this directive to the co-chairs of the Joint Health & Safety Committee or the Health & Safety Representative (if any).

Introduction:

Coronaviruses (CoV) are a large family of viruses that cause illness ranging from the common cold to more severe diseases such as Middle East Respiratory Syndrome (MERS-CoV), Severe Acute Respiratory Syndrome (SARS-CoV), and COVID-19. A novel coronavirus is a new strain that has not been previously identified in humans.

On December 31, 2019, the World Health Organization (WHO) was informed of cases of pneumonia of unknown etiology in Wuhan City, Hubei Province in China. A novel coronavirus (COVID-19) was identified as the causative agent by Chinese authorities on January 7, 2020.

On March 11, 2020 the WHO announced that COVID-19 is classified as a pandemic virus. This is the first pandemic caused by a coronavirus.

Symptoms of COVID-19

Symptoms range from mild – like the flu and other common respiratory infections – to severe, and can include:

- fever
- cough
- difficulty breathing

Complications from the COVID-19 can include serious conditions, like pneumonia or kidney failure, and in some cases, death.

There are no specific treatments for coronaviruses, and there is no vaccine that protects against coronaviruses. Most people with common human coronavirus illnesses will recover on their own.

Required Precautions

- Droplet and Contact precautions for the routine care of patients with suspected or confirmed COVID-19, and
- Airborne precautions when aerosol generating medical procedures (AGMPs) are planned or anticipated to be performed on patients with suspected or confirmed COVID-19.

Health Providers and Health Care Entities must review and adopt the Technical Brief "Updated IPAC Recommendations for Use of Personal Protective Equipment for Care of Individuals with

Suspect or Confirmed COVID-19" dated March 10, 2020 prepared by Public Health Ontario. This comprehensive document reviews foundational Infection Prevention and Control & Occupational Health and Safety strategies; including the role of Personal Protective Equipment (PPE) within the Hierarchy of Hazard Controls and a description of what PPE should be used in different settings and for different activities.

Note: The guidance outlined in this directive is a change in current practices respecting COVID-19 based on a better understanding of the epidemiology of the virus and the spectrum of illness that it causes, three months into this COVID-19 outbreak. It has been made in close consultation with Public Health Ontario and I have considered the Precautionary Principle in issuing this directive.

As this outbreak evolves, there will be continual review of emerging evidence to understand the most appropriate measures to take. This will continue to be done in collaboration with health system partners and technical experts from Public Health Ontario and with the health system.

Questions

Hospitals and HCWs may contact the ministry's Health Care Provider Hotline at 1-866-212-2272 or by email at emergencymanagement.moh@ontario.ca with questions or concerns about this Directive.

Hospitals and HCWs are also required to comply with applicable provisions of the Occupational Health and Safety Act and its Regulations.

David C. Williams, MD, MHSc, FRCPC

Chief Medical Officer of Health

COVID-19

Directive #2 for Health Care Providers (Regulated Health Professionals or Persons who operate a Group Practice of Regulated Health Professionals)

Issued under Section 77.7 of the Health Protection and Promotion Act (HPPA), R.S.O. 1990, c. H.7

WHEREAS under section 77.7(1) of the HPPA, if the Chief Medical Officer of Health (CMOH) is of the opinion that there exists or there may exist an immediate risk to the health of persons anywhere in Ontario, he or she may issue a directive to any health care provider or health care entity respecting precautions and procedures to be followed to protect the health of persons anywhere in Ontario;

AND WHEREAS, On March 17th, 2020 an emergency was declared in Ontario due to the outbreak of COVID-19, pursuant to Order-in-Council 518/2020 under the *Emergency Management and Civil Protection Act;*

AND HAVING REGARD TO the emerging evidence about the ways this virus transmits between people as well as the potential severity of illness it causes in addition to the declaration by the World Health Organization (WHO) on March 11, 2020 that COVID-19 is a pandemic virus and the spread of COVID-19 in Ontario;

AND HAVING REGARD TO the potential impact of COVID-19 on the work of regulated health professionals, to protect regulated health professionals in their workplaces, and the need to prioritize patients who have or may have COVID-19 in the work that regulated health professionals undertake;

AND HAVING REGARD TO the need to ramp down elective surgeries and non-emergent activities in order to preserve system capacity to deal effectively with COVID-19;

I AM THEREFORE OF THE OPINION that there exists or may exist an immediate risk to the health of persons anywhere in Ontario from COVID-19;

AND DIRECT pursuant to the provisions of section 77.7 of the HPPA that:

COVID-19 #2 for Health Care Providers (Regulated Health Professionals or Persons who operate a Group Practice of Regulated Health Professionals)

Date of Issuance: March 19, 2020

Effective Date of Implementation: March 19, 2020

Issued To: Health Care Providers (Regulated Health Professionals or persons who operate a Group Practice of Regulated Health Professionals, defined in section 77.7(6), paragraph 1 of the *Health Protection and Promotion Act*

* Health Care Organizations must provide a copy of this directive to the co-chairs of the Joint Health & Safety Committee or the Health & Safety Representative (if any).

Introduction:

Coronaviruses (CoV) are a large family of viruses that cause illness ranging from the common cold to more severe diseases such as Middle East Respiratory Syndrome (MERS-CoV), Severe Acute Respiratory Syndrome (SARS-CoV), and COVID-19. A novel coronavirus is a new strain that has not been previously identified in humans.

On December 31, 2019, the World Health Organization (WHO) was informed of cases of pneumonia of unknown etiology in Wuhan City, Hubei Province in China. A novel coronavirus (COVID-19) was identified as the causative agent by Chinese authorities on January 7, 2020.

On March 11, 2020 the WHO announced that COVID-19 is classified as a pandemic virus. This is the first pandemic caused by a coronavirus.

On March 17th, 2020 the Premier declared an emergency in Ontario under the *Emergency Management and Civil Protection Act* due to the outbreak of COVID-19 in Ontario and Cabinet made emergency orders to implement my recommendations of March 16th, 2020.

Symptoms of COVID-19

Symptoms range from mild – like the flu and other common respiratory infections – to severe, and can include:

1. fever
2. cough
3. difficulty breathing

Complications from COVID-19 can include serious conditions, like pneumonia or kidney failure, and in some cases, death.

There are no specific treatments for COVID-19, and there is no vaccine that protects against coronaviruses. Most people with COVID-19 illnesses will recover on their own.

Requirements for Health Care Providers (Regulated Health Professionals or Persons who operate a Group Practice of Regulated Health Professionals)

The following steps are required immediately:

1. All non-essential and elective services should be ceased or reduced to minimal levels, subject to allowable exceptions, until further notice. Allowable exceptions can be made for time sensitive circumstances to avert or avoid negative patient outcomes or to avert or avoid a situation that would have a direct impact on the safety of patients.
2. Clinicians are in the best position to determine what is essential in their specific health practice. In making decisions regarding the reduction or elimination of non-essential and elective services, regulated health professionals should be guided by their regulatory College, and the following principles:
    1. Proportionality. Decision to eliminate non-essential services should be proportionate to the real or anticipated limitations in capacity to provide those services.
    2. Minimizing Harm to Patients. Decisions should attempt to limit harm to patients wherever possible. This requires considering the differential benefits and burdens to patients and patient populations as well as available alternatives to relieve pain and suffering.
    3. Equity. Equity requires that all persons in the same category (i.e. at different levels of urgency) be treated in the same way unless relevant differences exist. This requires considering time on wait lists and experience with prior cancellations.
    4. Reciprocity. Certain patients and patient populations will be particularly burdened as a result of cancelling non-essential services. Patients should have the ability to have their health monitored, receive appropriate care, and be re-evaluated for emergent activities should it be required.

Decisions regarding the reduction or elimination of non-essential and elective services should be made using processes that are fair to all patients.

As this outbreak evolves, there will be continual review of emerging evidence to understand the most appropriate measures to take to protect health care providers and patients. This will continue to be done in collaboration with health system partners and technical experts from Public Health Ontario and with the health system.

Questions

Hospitals and HCWs may contact the ministry's Health Care Provider Hotline at 1-866-212-2272 or by email at emergencymanagement.moh@ontario.ca with questions or concerns about this Directive.

Hospitals and HCWs are also required to comply with applicable provisions of the Occupational Health and Safety Act and its Regulations.

David C. Williams, MD, MHSc, FRCPC

Acting Chief Medical Officer of Health

Ministry of Health
Assistant Deputy Minister
Emergency Health Services Division

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Ontario

Memorandum

To: Chief Executive Officers
Hospitals

From: Alison Blair
Assistant Deputy Minister
Emergency Health Services

Date: March 18, 2020

Subject: The Provincial Transfer Authorization Centre (PTAC) Updated requirements during the current Novel Coronavirus (COVID-19) Pandemic

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Due to the evolving situation regarding the Novel Coronavirus (COVID-19) pandemic, the Ministry of Health (the ministry) is releasing this memorandum regarding the Provincial Transfer Authorization Centre (PTAC).

Effective immediately, all interfacility patient transfers, including emergency transfers, between Ontario hospitals require a PTAC issued Medical Transfer (MT) Authorization Number before transport. This is required for all methods of patient transport (air ambulance, land ambulance and private transfer service).

There is one exclusion to this memorandum as noted below:

- Federal Nursing Stations do not require an MT Number. Ornge will transcribe the screening questions and enter it into PTAC on their behalf. An MT Number will not be issued to the Nursing Station but will be maintained in the database for tracking purposes.

For Ontario hospitals, prior to arranging a transfer the sending facility must:

1) Login to the online PTAC portal, which is administered by Ornge, at https://www.hospitaltransfers.com/transfer/login.aspx.

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PTAC Memo – All Ontario Hospitals

2) Complete the PTAC Screening Report. If the patient **does not** screen positive, an MT Number will be issued immediately.

3) If the patient is flagged positive, an MT Number will not be issued automatically. The sending facility is to contact the Ornge Operations Control Centre (OCC) to process the generation of an MT Number manually. Every effort to ensure a streamlined process will be made to avoid delay of an emergency transfer.

For more information, please refer to the Ornge PTAC Frequently Answered Question page at https://www.hospitaltransfers.com/Transfer/faqnew.aspx.

The ministry thanks you in advance for your compliance to this Memorandum which will further enhance Ontario's ability to track and manage COVID-19.

Sincerely,

Alison Blair
Assistant Deputy Minister

c: Dr. Homer Tien, President and CEO, ORNGE Air Ambulance
Stuart Mooney, Director, Emergency Health Program Management and Delivery Branch, Ministry of Health
Clint Shingler, Director, Health System Emergency Management Branch, Ministry of Health

Ministry of Health

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Ministère de la Santé

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MEMORANDUM

TO: Hospital Chief Executive Officers and Emergency Departments

RE: ACES/eCTAS COVID-19 surveillance

Dear Colleagues:

The purpose of this memo is to request your support to adopt the use of the Acute Care Enhanced Surveillance (ACES) system and the electronic Canadian Triage and Acuity Scale (eCTAS) application in your hospital as soon as possible to support enhanced surveillance as part of the provincial COVID-19 response effort.

As you are aware, Ontario continues to identify patients that have tested positive for COVID-19. Ontario's emergency departments (ED) will be the first stop for many symptomatic patients and the most severe cases will need inpatient care.

Improving the monitoring of ED visits for symptoms related to COVID-19 will assist to identify potential cases and enable earlier isolation to reduce the risk of person-to-person transmission and community spread of the disease. This can also provide an early signal of possible increases in prevalence locally and provincially. By providing more timely and robust updates to health care professionals, public health, and community service partners, we can take informed measures to direct our planning and response appropriately in our communities, with the purpose of protecting the health of Ontarians.

Your hospital currently transmits emergency department and hospital admission data to the ACES or eCTAS to identify abnormal acute care activity and alert public health authorities in real time. If your hospital or network of hospitals does not yet participant in ACES, please contact Dr. Kieran Moore (MOH, KFL&A Public Health and ACES Project Lead) and/or the ACES Team to expedite your enrollment. The ACES Team can be reached through Dr. Moore (kieran.moore@kflaph.ca or 613-549-1232×1121), Dr. Paul Belanger (paul.belanger@kflaphi.ca or 613-549-1121×1602), or its website (www.kflaphi.ca).

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A simple update to the triage/admissions notes will greatly improve the ability of ACES (in concert with eCTAS) to identify potential COVID-19 cases. The accompanying technical document outlines this update, which simply involves including specific key words in triage/admissions notes when COVID-19 is suspected. For further resources regarding COVID-19 and the enhanced surveillance available through ACES, see www.kflaphi.ca/covid.

I would like to request that you share this letter and the accompanying technical document with your appropriate emergency department managers and staff as soon as possible and implement this enhanced COVID-19 reporting immediately.

Should you have any questions regarding the technical aspects of this change, please contact Dr. Paul Belanger at paul.belanger@kflaphi.ca or 613-549-1121x1602.

To reduce the impacts of this (potential) epidemic, the entire health care system will need to work together. Thank you for your ongoing commitment and collaboration.

Yours sincerely,

Dr. David C. Williams
Chief Medical Officer of Health

Attachments

c. Dr. Shelley Deeks, Chief, Communicable Diseases, Emergency Preparedness and Response, PHO

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March 19, 2020

MEMORANDUM TO: All Public and Private Hospitals

FROM: Dr. David Williams
Chief Medical Officer of Health
Ministry of Health

SUBJECT: **COVID-19 Updates: Visitors at Acute Care Settings**

The Ministry of Health ("ministry") continues to coordinate the response to COVID-19 and to keep the sector updated as relevant recommendations and plans arise from these discussions.

As the situation in Ontario evolves, the ministry continues to be committed to maintaining the safety of vulnerable patients in acute care settings. In order to ensure a safe and secure environment for patients and staff, we strongly recommend that these settings only allow essential visitors until further notice. We will reevaluate this measure in the coming weeks and ensure consistency with my recent guidance on enhanced public health measures.

The ministry is identifying essential visitors as those who have a patient who is dying or very ill or a parent/guardian of an ill child or youth, a visitor of a patient undergoing surgery or a woman giving birth. These visitors must continue to be actively screened into these settings. Screening questions should include asking visitors about their symptoms, recent travel history outside of Canada, and close contact with a case of COVID-19 or close contact with a person with acute respiratory distress who has recently travelled outside of Canada. Further resources to assist in screening are available at the Ministry of Health website. Those who fail screening will not be permitted to enter. No other visitors should be permitted to enter these premises, instead they should be asked to keep in touch with loved ones by phone or other technologies, as available.

The safety and well-being of our patients and staff is our top priority. We will continue to monitor this situation closely and provide further guidance or direction where needed.

We thank you for your attention to this matter.

Yours truly,

Original signed by

David Williams, MD, MHSc, FRCPS
Chief Medical Officer of Health

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March 19, 2020

Re: Managing Health Worker Illness and Return to Work COVID-19

Ontarians rely on our health system everyday to stay healthy and sustain life – this is true now more then ever. As we continue to implement enhanced public health measures to mitigate the spread of COVID-19 in Ontario, it is vital that health services, and the workers who contribute to these areas, continue to provide care to the people of Ontario.

To protect the health system and its workers from COVID-19, we must balance public health measures and the need to control the spread of disease with appropriate flexibility to ensure that critical health services continue to operate.

I am therefore making the following recommendations to all parts of the health sector:

Travel and Return to Work

Where employees have travelled outside of Canada within the last 14 days and are seeking to return to work, it is important to balance the protection of the health system and the continued operation of these settings.

Consistent with my earlier recommendations, it is very important that all health system organizations and employers immediately cease all non-essential business travel outside of Canada until further notice and likewise discourage employee travel.

I am recommending that Health Care Workers who have travelled outside of Canada within the last 14 days self-isolate for a period of 14 days starting from their arrival in Ontario. Health Care Workers should not attend work if they are sick. If there are particular workers who are deemed critical, by all parties, to continued operations, I recommend that these workers undergo regular screening, use appropriate Personal Protective Equipment (PPE) for the 14 days and undertake active self-monitoring, including taking their temperature twice daily to monitor for fever, and immediately self-isolate if symptoms develop and self-identify to their occupational health and safety department.

Practice Social Distancing and Facilitate Virtual Arrangements

Everyone in Ontario should be practicing social distancing of 2 meters to reduce their exposure to other people. Employers should facilitate arrangements to ensure that this is practiced in the workplace to every extent possible.

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While other services are decreasing their operations, in health care you are being called upon to care for patients and to be ready for surge. I am asking, where there may be an opportunity, for all health system employers to facilitate work arrangements that enable appropriate employees to work from home or to work virtually, if not re-deployable.

Health system employers should also consider a review of their services and practices to identify how they can provide services to patient groups virtually or remotely.

Ongoing Screening, Self-Monitoring and Self-Isolation

The ministry has provided recommendations and tools to specific sectors for both active and passive screening – these are available on the ministry's COVID-19 website. Each workplace should have a comprehensive strategy for screening and symptom monitoring where there are inpatients or residential or institutional settings and tailor their approach to screening to their unique setting. Screening activities should be focused on patients/residents, volunteers, visitors and staff, and should be done over the phone, upon arrival, at entrances and on a regular basis throughout the day. The goal of screening programs should be to ensure that no person with clinical symptoms consistent with COVID-19, whether they are visitors, caregivers or staff, enters the building – except where they are identified and being clinically assessed by an appropriate provider.

The symptoms of COVID-19 include fever, new cough and difficulty breathing, and these may occur within 14 days of an exposure to a case.

All health care providers and health care entity workplaces should monitor for signs of illness. Health system employees should diligently monitor themselves for signs of illness over the course of the pandemic and identify themselves to their manager and/or occupational health and safety departments if they feel unwell. If a health worker begins to feel unwell while at work, they should immediately don a surgical mask and notify their manager and/or occupational health and safety department. It is imperative that we keep hospitals, long-term care homes, health care offices and other health settings free of illness to protect vulnerable patients and residents and other workers in these settings.

Public Health Ontario has excellent fact sheets on how to self monitor and self isolate.

Multiple Locations

We appreciate the unique circumstances of health workers who may work in different care settings and may have different employers.

Health workers who work in multiple locations should identify themselves to their managers and develop an individualized plan to manage their employment across these settings over the course of the pandemic. In some high-risk settings, it may be possible to coordinate arrangements for staff to only work in one institution.

Continuity of Operations and Curtailing Non-Essential Services

All health sector organizations should have a Continuity of Operations plan to redeploy resources, whether human resources, equipment or space, to protect critical services. This may include cross training, cross credentialing or formal redeployment to different functions. As part of these plans, organizations should also have minimum thresholds of staffing in place to ensure that critical services continue to operate.

Employees with comorbidities should also identify themselves to their employers and consider ways to redeploy away from duties associated with COVID-19.

Return to Work after Illness

Health workers should consult their local public health unit and their manager/occupational health and safety department to plan their safe return to work.

Thank you for all of your support. This will be an important part of keeping our health system and its workers protected during this outbreak.

Yours truly,

Original signed by

David Williams, MD, MHSc, FRCPS
Chief Medical Officer of Health

Ministry of Long-Term Care

Assistant Deputy Minister
Long-Term Care Operations Division

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Ministère des Soins de longue durée

Sous-ministre adjointe par intérim
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Ontario

March 24, 2020

MEMORANDUM TO: Regional Leads and Bill Hatanaka

FROM: Brian Pollard
Assistant Deputy Minister, Long-Term Care Operations Division
Ministry of Long-Term Care

SUBJECT: **Amendments to Ontario Regulation 79/10 under the *Long-Term Care Homes Act, 2007* related to the COVID-19 Pandemic – Admissions and Discharge**

The Ministry of Long-Term Care and the Ministry of Health are working closely with our partners in both the long-term care sector and other health care sectors to ensure the continued safety and well-being of residents, families and staff. We have taken proactive measures, and we continue to look at all possible courses of action to limit the spread of COVID-19.

As you may be aware, hospitals are experiencing severe capacity pressures and there are alternate level-of-care patients awaiting discharge to a long-term care home. In response, the Ministry has amended provisions in Ontario Regulation 79/10 (O. Reg 79/10) under the *Long-Term Care Homes Act, 2007* pertaining to admissions and discharge from homes during the pandemic.

Effective March 24, 2020, amendments to O. Reg 79/10 will:

1. Facilitate placement in long-term care homes to help address severe capacity pressures faced by public hospitals through a truncated placement process.
    - These applicants may be placed in preferred accommodation if they requested basic accommodation and the licensee must offer the accommodation as basic accommodation. In these circumstances, the Ministry will reimburse licensees for the cost-difference.
    - Permitting placement of people waiting for basic into preferred would help move patients out of hospital beds faster.

2. Support placement co-ordinators and long-term care homes in being able to facilitate placement of applicants seeking long-term care home placement from outside of a hospital through more nimble placement requirements.

3. Prevent community applicants from being penalized for refusing to move into a long-term care home during the pandemic by eliminating the requirement that they be removed from all waiting lists (hospital applicants are already exempt from this requirement).

4. Enable current residents to leave a long-term care home if they wish to do so due to COVID-19 and expedite their return to the long-term care home when they need to go back. The resident will be discharged and the bed will then be available for occupancy by another person.

These changes provide a framework for long-term care home staff and placement co-ordinators to assess, admit, re-admit and discharge residents during the COVID-19 pandemic.

Full details about these amendments can be found in the FAQs included with this package.

Should you have any questions, please contact the Licensing and Policy Branch of the Long-Term Care Operations Division at LTC.Info@ontario.ca.

Thank you for your continued support as we work together to address the COVID-19 emergency.

Brian Pollard
Assistant Deputy Minister
Ministry of Long-Term Care

cc:

Mr. Richard Steele, Deputy Minister, Ministry of Long-Term Care
Mr. Dan Kaniuk, Chair, Board of Directors, Ontario Long-Term Care Home Association
Ms. Jane Sinclair, Chair, Board of Directors, Advantage Ontario
Ms. Michelle-Ann Hylton, Director, Licensing and Policy Branch
Ms. Stacey Colameco, Director, Long-Term Care Inspections Branch
Ms. Janet Hope, Assistant Deputy Minister, Long-Term Care Policy Division

Attachments:

Frequently Asked Questions

Amendments to Ontario Regulation 79/10 (Regulation) under the *Long-Term Care Homes Act, 2007* (LTCHA) pertaining to long-term care home admissions and discharge during the COVID-19 pandemic

FREQUENTLY ASKED QUESTIONS

Q1: Why are regulatory amendments urgently needed for the long-term care sector to address the COVID-19 pandemic?

Answer:

The Ministry of Long-Term Care (Ministry) is making amendments to admissions and discharge processes to support applicants, residents, long-term care homes and placement co-ordinators in responding to the COVID-19 pandemic.

The Ministry has already made amendments to ensure sufficient nursing and personal support care staff are available to support long-term care home residents in light of the current issues raised by COVID-19.

Long-term care residents are older, more frail, and more medically complex than the general population. Therefore, protecting the safety and health of long-term care residents during this pandemic is imperative.

Q2: What is the purpose of these changes?

Answer:

The Ministry is actively working with our partners at all levels in the health care system to implement enhanced measures and supports to ensure that we are prepared to protect the health of our most vulnerable. The health and well-being of all Ontarians, including long-term care residents, their families, and staff, is our government's number one priority.

As part of these enhanced measures, the Ministry has made urgent amendments to Ontario Regulation 79/10 (Regulation) under the *Long-Term Care Homes Act, 2007* (LTCHA) pertaining to long-term care home admissions and discharge during the COVID-19 pandemic. These amendments will:

1. Help address severe capacity pressures faced by public hospitals by expediting placement into long-term care homes of eligible patients through a truncated placement process;
2. Support placement co-ordinators and long-term care homes in being able to facilitate placement of applicants seeking long-term care home placement from outside of hospital through more nimble placement requirements;

3. Enable community applicants to not be penalized for refusing to move into a long-term care home during the pandemic by removing the requirement that they be removed from all waiting lists for refusing to move in (hospital applicants are already exempt from this requirement); and
4. Enable current residents to leave a long-term care home if they wish to do so due to COVID-19 and expedite their return to the long-term care home when they need to go back.

Q3: How have stakeholders responded to this proposal?

Answer:

These proposed amendments directly respond to the feedback received by our sector partners.

The Ministry has received input and taken into consideration the feedback from key stakeholders in the long-term care sector, including the Ontario Long-Term Care Association (OLTCA) and AdvantAge Ontario when considering these amendments. In addition, the Ministry has been collaborating with placement co-ordinators to understand their current situation and requirements.

Placement co-ordinators have requested that the Ministry modify the placement requirements, as they are already experiencing challenges with facilitating placement during the pandemic. Similarly, the OLTCA and AdvantAge Ontario have asked the Ministry to reduce administrative burdens for long-term care homes to allow them to dedicate more time to front-line care.

Q4: What amendments were made to the Regulation?

Answer:

The Ministry has made the following amendments to the Regulation to help support the health care system in being better positioned to care for individuals who require health care services during the COVID-19 pandemic:

1. <u>Amendments to help address severe capacity pressures faced by public hospitals by expediting placement to long-term care homes of eligible patients through a truncated placement process:</u>
    - For hospital patients, the placement co-ordinators shall determine eligibility for long-term care home placement based on as much information as is available in the circumstances (as opposed to, for example, being required to fill out forms from the Ministry and requiring that two separate regulated health professionals fill out the forms).

- Hospital patients awaiting long-term care home placement will be offered admission to a long-term care home selected by the placement co-ordinator (as opposed to applicants selecting the long-term care home).
    - In selecting the long-term care home, the placement co-ordinator is required to take into account several factors including the any preferences of the applicant relating to the proximity of the home to applicant's family, home and community and support networks.
    - An application for authorization of admission is not required so long as the patient consents to the disclosure of all necessary information for the placement co-ordinator to handle the application.
- Placement shall be authorized only with consent from the applicant (or their substitute decision-maker, if applicable).
    - If the applicant does not consent, the placement co-ordinator would identify other long-term care homes for the person.
- Long-term care homes are required to notify the placement co-ordinator whether they approve or withhold approval for the applicant's admission either orally or in writing within five days of receiving information about the patient (as opposed to being required to submit written notices only, within five business days).
- These applicants shall be placed in category 1 ("crisis") on the waiting list.
- To facilitate the transfer of these persons to their preferred home, once the capacity pressures in the heath care system arising from the pandemic are improved there would be a truncated process for transfer to their preferred home, and these persons would:
    - Be placed in category one ("crisis") on the waiting list for their first choice home
    - Have a higher spot on the waiting list for their other homes by allowing the date they were admitted to the first home count as the date by which they are ranked on the other waiting lists (e.g. categories 3B or 4B) instead of the date they sought admission to their home or homes of choice, if beneficial to the person.

2. <u>Amendments to support placement co-ordinators and long-term care homes in being able to facilitate placement of applicants seeking long-term care home placement from outside of hospital through more nimble placement requirements:</u>
    - As with hospital patients, the placement co-ordinators shall determine eligibility for long-term care home placement based on as much information as is

available in the circumstances (as opposed to, for example, being required to fill out forms from the Ministry and requiring that two separate regulated health professionals fill out the forms).

- Long-term care homes shall make the decision whether to approve or withhold approval based on this information and notify the placement co-ordinator of that decision either orally or in writing (as opposed to being required to submit written notices only) within five days of receiving the information.

3. Amendments to enable community applicants to not be penalized for refusing to move into a long-term care home during the pandemic by removing the requirement that they be removed from all waiting lists (hospital applicants are already exempt from this requirement).

    - Placement co-ordinators shall skip over these applicants on the waiting list and offer admission to the next highest-ranking applicant.

4. Amendments to enable current residents to leave a long-term care home if they wish to do so due to COVID-19 and expedite their return to the long-term care home when they need to go back.

    - Before the resident leaves the long-term care home, the licensee is required to provide specified information, including information on the resident's care requirements and that the resident (or the resident's substitute decision-maker, if applicable) assumes full responsibility for the care, safety and well-being of the resident.
    - During the time the person is away, the bed will be available for occupancy by another person.
    - The process for returning to the home they were discharged from differs according to the time the resident was away from the home:
        - For absences that are three months or less, the resident would be deemed eligible and accepted for admission by the licensee, and simply placed into the "re-admission" category (this category is the highest-ranking category for vacant beds; it ranks higher than the "crisis" category).
        - Longer absences require a truncated assessment by the placement co-ordinator with the ability for the licensee to refuse the admission if the circumstances for refusing an admission in the LTCHA exist. If accepted, the person would be placed into the "re-admission" category for that long-term care home.

Q5: Would these proposed amendments pose any risk to the long-term care sector?

Answer:

These amendments are being proposed in order to address a public health emergency.

As these amendments provide greater flexibility for assessments prior to long-term care home placement, licensees may not have as much detail about an applicant's health and care needs prior to accepting them as they would under non-pandemic circumstances. Licensees will need to obtain missing information by ensuring that appropriate measures are taken upon the admission of applicants (e.g. assessments are done immediately following admission) to ensure appropriate care plans are developed.

Q6: How will these changes impact applicants who are already waiting for placement in long-term care homes?

Answer:

Placement for all applicants, including those coming from the community, will become more streamlined as placement co-ordinators determine eligibility based on as much information as is available in the circumstances (as opposed to, for example, being required to fill out forms from the Ministry and requiring that two separate regulated health professionals fill out the forms).

These changes will lead some applicants to be reprioritized on the waiting list, as applicants from hospitals are placed in long-term care homes more quickly. Placement co-ordinators will continue to manage crisis placements, whether in hospital or in the community, based on urgency of need. In addition, these changes eliminate the requirement that community applicants be removed from all waiting lists if they refuse admission. Instead, placement co-ordinators would offer admission to the next highest-ranking applicant.

Q7: Will applicants from hospital still get to choose their preferred homes?

Answer:

Due to the urgent need to free up public hospital beds and reduce the risk to vulnerable ALC patients of contracting COVID-19, placement co-ordinators are permitted to select homes for eligible patients to promote the expeditious movement of these patients out of hospital.

Consent is still required for admission into the home selected by the placement co-ordinator. If the patient refuses to consent to admission, the placement co-ordinator would have to find another long-term care home.

Q8: How is the Ministry supporting long-term care applicants who have financial barriers?

Answer:

Long-term care homes will be required to make preferred accommodation available as basic to persons who are waiting for placement in a basic bed. The maximum daily rate is $88.82 for private and $62.18 for basic accommodation (older long-term care homes may charge less for preferred accommodation). This will also enable people who cannot afford to pay the full basic rate to apply for a rate reduction. The Ministry is seeking necessary approval to be able to reimburse the licensee for the cost-difference.

Ministry of Health **Ministère de la Santé**

Ontario

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March 26, 2020

Re: March 24, 2020 Green Phase Advisory (Continued) from the National Emergency Blood Management Committee – Impact of COVID-19

Dear Hospital Colleagues,

On March 24, 2020 a notice of continuation of the Green Phase Advisory for all fresh blood components and plasma protein products from the National Emergency Blood Management Committee (NEBMC) was sent to your hospital. The impacts of COVID-19 continue to affect blood supply planning and forecasting from the Canadian Blood Services continues to predict a potential for shortages.

We strongly encourage all hospitals to continue implementing the recommendations brought forth in the March 19, 2020 letter. In addition to these recommendations, members of the Ontario Emergency Blood Management Committee (OEBMC) are advising hospitals to consider the following:

- Hospitals should review their current red cell inventory levels and reduce their target Green Phase levels by 10-20% to help preserve inventory, avoid overstocking, outdating and the need for redistribution. We are starting to see lower red cell demand due to reductions in elective surgeries and other hospital activities;
- As Canadian Blood Services is focusing on producing platelet pools to support hospital inventory, hospitals are encouraged to accept platelet pools that are close to outdate so that these products have a greater opportunity of being transfused before outdating;
- Hospitals that have not yet developed policies and procedures for substituting fibrinogen concentrate for cryoprecipitate are advised that they are now required to do so. While Canadian Blood Services continues to produce cryoprecipitate, there may be a need in the future to discontinue cryoprecipitate production to prioritize platelet production. In the event that this occurs, hospitals must have the capacity to order fibrinogen concentrate; and

…/2

- To minimize patients' or their designates' exposure to the hospital environment, hospitals are advised to evaluate protocols for home infusion patients picking up product. As recommended by the NEBMC, hospitals should not allow more than a maximum refill volume of 3-months of product for sustainability of the product supply (Please see attached the March 24, 2020 Green Phase Advisory for more guidance for hospital blood banks).

Our goal is to conserve blood and blood products for those most in need in light of the many efforts Canadian Blood Services is taking to mitigate against the pressures COVID-19 could have on the blood supply, along with the efforts being taken within our hospitals to respond to the rapidly changing situation.

If you have any questions, please feel free to contact Thomas Smith, Team Lead, Drugs Programs Policy and Strategy at Thomas.Smith@ontario.ca.

Sincerely,

Angie Wong
Director, Drug Programs Policy and Strategy

Attachment

c: Patrick Dicerni, Assistant Deputy Minister, Drugs and Devices Division, Ministry of Health
Ontario Emergency Blood Management Committee Members

Ministry of Health

Assistant Deputy Minister's Office
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Ontario

March 26, 2020

To: Ontario Public Hospitals

From: Mike Heenan, Assistant Deputy Minister, Hospitals and Capital Division

Re: General approval under subsection 4(2) of the *Public Hospitals Act* for COVID-19 capacity expansion

As efforts continue across Ontario to manage and contain the outbreak of COVID-19, there is a critical need for public hospitals to maximize their capacity to provide care to their communities. The Ministry of Health (the "Ministry") is aware that many of the province's hospitals are seeking opportunities to expand the space they have available to care for patients suffering from COVID-19 and to minimize exposure risks for other hospital patients.

With a view to providing hospitals with the necessary flexibility to meet rapidly evolving service demands, the Ministry is waiving the submission requirements set out under the Section 4 Approvals Protocol relating to approval requests under subsection 4(2) of the *Public Hospitals Act* (PHA).

Pursuant to delegated authority, I am also granting general approval to all public hospitals under subsection 4(2) of the PHA to operate and use an institution, building or other premises or place ("premises") for the purposes of a hospital, provided that the following conditions are met:

- The hospital is leasing, licensing or otherwise acquiring a temporary right to occupy the premises after **March 26, 2020** to address the hospital's need to create greater capacity for the treatment of patients arising from the COVID-19 virus;
- The term of any lease entered into does not exceed **June 30, 2020**.
- The premises are selected with due regard to their suitability for the intended purpose (in view of current exigencies and system challenges) and for the safety of patients, hospital staff and others;
- The hospital agrees to provide to the Ministry as soon as reasonably practicable any information that the Ministry may request relating to the premises including, without limitation, the address, specific premises or portions of premises that are being occupied (e.g. floor(s), unit(s)), purposes for which the premises are being used, number of beds being operated on the premises, details respecting rents, copy of lease or licence agreement, etc.

Be advised that the foregoing does not constitute approval to enter into an agreement of purchase and sale. Any hospital proposing to purchase premises is required to seek Ministry approvals in accordance with the standard process.

. . . /2

Ontario Public Hospitals

This approval remains in effect until **June 30, 2020** unless it is revoked earlier.

Sincerely,

Mike Heenan
Assistant Deputy Minister

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Ontario

March 15, 2020

MEMORANDUM TO: **Ontario Health and Hospitals**

SUBJECT: **Ramping Down Elective Surgeries and Other Non-Emergent Activities**

We appreciate that hospitals are already leveraging existing pandemic plans to carefully consider how to maximize resources and prioritize services. As you may have seen in the Minister's Statement earlier this evening, we are requesting that you build on these efforts by taking a careful, planned approach to ramp down elective surgeries and other non-emergent clinical activities.

This approach recognizes the importance of protecting our provincial programs/tertiary care for urgent and emergent care, while also preserving hospital capacity as cases of COVID-19 continue to grow in Ontario. The approach is supported by Dr. David Williams, Ontario's Chief Medical Officer of Health, and was arrived at through consultations with the Ontario Hospital Association.

Guiding Principles

While hospitals will continue to have the necessary discretion to make decisions based on local circumstances, it will be important that decisions to reduce non-emergent activities are guided by common principles that reflect the shared priorities of our hospitals and the Ontario health system broadly. We ask that you follow the three guiding principles below as you move forward with the implementation of your pandemic plans and operational decisions:

1. **An ethical framework should be used to guide decision-making**.
2. **Prevent high risk and occult transmission.** This includes extending the principle and value of social distancing. Elective surgeries will not only increase social contact but will do so in a potentially elevated risk manner (with the possibility of aerosol generating procedures).
3. **Develop and preserve capacity within our system**; and in particular, resources such as space, ICU capacity, personal protective equipment (PPE), and personnel.

In this regard, existing frameworks for prioritization of surgical activity should be applied immediately to determine which activities should be preserved to the greatest degree possible. Patients who meet these urgency thresholds and have travel or symptom history should still be treated, using PPE.

Operating Principles

We also request that you follow the principles below to operationalize the above guiding principles:

- **Planning for reduction in non-emergent activity should commence immediately,** however the trigger to implement such reductions may vary from organization to organization based on capacity, influx of COVID-19 patients, local trends in cases, and other factors.

- **Each hospital, health system, and physician should review all scheduled elective procedures with a plan to postpone or cancel electively scheduled operations, endoscopies, or other invasive procedures** until such time that hospitals are able to accommodate these additional procedures.

- **Immediately adopt a stewardship approach to minimize use of essential items needed to care for patients**, including but not limited to: ICU beds, PPE, cleaning supplies, and ventilators.

- **Non-emergent activity should be reduced in a step-wise manner in order to preserve, to the greatest degree possible, access for time-sensitive care.** This would include, but is not limited to:
    - Time-related disease like certain cancers, particularly if the outcome is treatment-related;
    - Cardiac procedures for which there is risk of significant morbidity or mortality if delayed; and
    - Non-emergent activity that will or may convert to emergent.

- **A regional approach should be taken wherever possible for specialized services, such that to the greatest degree possible, some capacity is preserved within a region for a given service.** This may mean that patients may receive their care at a centre other than their usual site of care in order to maximize the available capacity in the system.

- **Hospitals should consult with their Ontario Health Regional Lead or Regional Planning table before they implement operational decisions to ramp down non-emergent clinical activities.**

As the COVID-19 pandemic continues to evolve, it is critical that our health system response continue to be dynamic to ensure that it can be ready for any scenario to protect the health and well-being of Ontarians. We will continue to monitor the COVID-19 impacts across Ontario and should it be warranted based on evidence, may issue more prescriptive orders and/or directives on this matter in the future.

We thank you for your continued preparations to ensure readiness for business continuity within your organization and for your contributions to the health system's readiness.

Thank you for your ongoing care and support of your patients and communities.

Sincerely,

(original signed by)

Helen Angus Deputy Minister Ministry of Health	Dr. David Williams Chief Medical Officer of Health Ministry of Health	Matthew Anderson President and CEO Ontario Health

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Ontario

March 9, 2020

MEMORANDUM TO: **Health System Organizations and Providers**

SUBJECT: **Update on COVID-19 Preparations and Actions**

As we committed last week, we will be sharing frequent communications from the provincial Command Table, as we prepare for and address COVID-19.

The Command Table met this morning and discussed key topics to focus our preparations, including:

- Agreement on principles that will guide the design of all our operational work on COVID-19, including:
    - Where possible, we will make services and access to screening more accessible to **patients in their homes**, to reduce the spread of illness
    - Core **clinical capacity** (generally inpatient and critical care beds) will be protected for ongoing care of the sickest patients for COVID-19 and non COVID-19 related issues
    - **New capacity will be created** to provide COVID-19 specific assessments and care (virtual and in person)

- Review and endorsement of plans for **Assessment Centres**. Assessment Centres sites will divert patients from hospital Emergency Departments, starting with sites in Toronto, and then elsewhere in the province as need arises. As Assessment Centres are ready for operation, some in the coming days, we will provide direction and information to health system providers and to the public.

- Review of plans to enhance surveillance activities, including the **expansion of laboratory capacity** in conjunction with Assessment Centres.

- Review of a **COVID-19 Self-Assessment**, which will be refined in consultation with experts and then posted to the ministry's public-facing website. This self-assessment will support patients who are concerned about COVID-19 and want to understand how to seek assessment and care.

- Review and approval of **virtual care capacity** to be leveraged in our COVID-19 response, including Telehealth expansion to support people at home and supports to encourage virtual care uptake.

- Review of evidence-based **guidance on use of Personal Protective Equipment (PPE)**, which will be discussed with health system organizations and providers in the coming days, and then shared broadly. Our goal is the health and safety of health care workers and patients.

- **Initiation of a PPE Table** to report to the Command Table to address PPE supply and distribution, and system initiatives that will preserve PPE.

- Direction on measures for visitors and staff for implementation at **long-term care homes and retirement homes**.

- Discussion of **Health Human Resource strategies** for employers, with a Question and Answer document to be posted shortly. We continue to monitor the Government of Canada's travel advisories and advice from federal and provincial counterparts on travel and return to work.

As stated previously, we appreciate the continued focus on preparations that you are making within your organization, including planning and readiness for business continuity.

We will provide updates after our next Command Table meeting, scheduled for Thursday, March 11, 2020.

Thank you for your ongoing care and support of your patients and communities.

Sincerely,

(original signed by)

Helen Angus	Dr. David Williams	Matthew Anderson
Deputy Minister	Chief Medical Officer of Health	President and CEO
Ministry of Health	Ministry of Health	Ontario Health

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Ontario

March 16, 2020

MEMORANDUM TO: **Health System Organizations and Providers**

SUBJECT: **Update on COVID-19 Preparations and Actions**

In follow-up to our last communication, we are pleased to share the following updates from the provincial Command table on key preparations that are being taken to address COVID-19:

- To further preserve the capacity of Ontario's hospitals to respond to the COVID-19 pandemic and in follow-up to the Minister's statement on **elective surgeries and non-emergent activities** yesterday evening, we issued a memo to Ontario Health and hospitals with additional principles to guide operational decision-making in their planned approaches to ramp down of these activities.
    - We are also actively considering opportunities to provide targeted and aligned guidance to other health care professional sectors (e.g., dentistry) on routine/elective and urgent procedures.
- Formal recommendation from the Chief Medical Officer of Health to the Ontario Lottery and Gaming Corporation was released yesterday to **suspend casino operations** for the next few weeks.
- An **online self-assessment tool** was finalized and posted yesterday at Ontario.ca.
- Additional guidance will be formalized through the Chief Medical Officer of Health on **expanding self-isolation and social distancing measures** and clarifying advice that has been provided by the various levels of government.
- Augmenting Telehealth capacity with **additional call lines** to address increasing call volumes and implementing **additional measures to increase capacity**, including further hiring of clinical staff, directing callers to the use of the self-assessment tool and identifying capacity across settings/sectors to support assessment and triage.

- OH Regional Tables accelerating capacity planning **to maximize acute care bed availability,** reduce ALC, and maximize long-term care and home care placements.

- Looking at opportunities to **accelerate virtual care options** to increase capacity and alleviate pressure in hospitals, home and community, and long-term care.

- Twenty-five **Assessment Centres are now operational**, with additional centres to come on line on an accelerated timeline.

- Continuous efforts to **procure PPE and other supplies and equipment**, as well as assess and monitor critical needs to enable the safe delivery of care by our health care professionals.

We are also pleased to welcome Dr. Thomas Stewart, CEO & President of St. Joseph's Health System and CEO of Niagara Health to the Command Table. Dr. Stewart is a well-known and highly-regarded health system leader and critical care doctor whose knowledge and experience will contribute immensely to our planning efforts.

We will continue to communicate progress on these actions as they are implemented.

Thank you for your ongoing engagement with your local partners to prepare for business continuity and for COVID-19's impact on the health system.

Sincerely,

(original signed by)

Helen Angus
Deputy Minister
Ministry of Health

Dr. David Williams
Chief Medical Officer of Health
Ministry of Health

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Ontario

March 18, 2020

MEMORANDUM TO: Health System Organizations and Providers

SUBJECT: Update on COVID-19 Preparations and Actions

In follow-up to our last communication, we sharing the following updates from the provincial Command Table on key preparations that are being taken to address COVID-19:

- Additional guidance is to be released by Ontario's Chief Medical Officer of Health concerning (as soon as possible):
    - Public health measures for health care workers returning from travel outside of Canada, including those who work in long-term care homes
    - Restriction of visitors to hospitals, with some exceptions (similar to the restrictions effective in long-term care homes)
    - Ramp-down of elective and non-emergent activities for Regulated Health Professionals or group practices of Regulated Health Professionals

- A team from Ontario Health, the Ministry of Health, the Ministry of Long-term Care and others will centralize and continue the work of assessing additional spaces in the community, such as hotels and retirement homes, which could be safely utilized to alleviate immediate hospital and long-term care capacity pressures.

- Augmented capacity to respond to COVID-19-related calls at Telehealth coming online, including doubling the number of call lines and increasing the number of Registered Nurses, as well as working with a broader network of organizations to support call response and triage.

- Focused efforts to rapidly expedite procurement continuing, including centralized procurement of additional ventilators; purchased personal protective equipment including gloves and surgical masks to support the COVID-19 response.

- A team will be dedicated to identifying and removing legislative, regulatory and policy barriers to enable health care providers to quickly and effectively deliver the care and services needed during this emergency period.

We will continue to communicate progress on these actions as they are implemented.

Thank you for your ongoing engagement with your local partners to prepare for business continuity and for COVID-19's impact on the health system.

Sincerely,

(original signed by)

Helen Angus	Dr. David Williams	Matthew Anderson
Deputy Minister	Chief Medical Officer of Health	President and CEO
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Ontario

March 20, 2020

MEMORANDUM TO: Health System Organizations and Providers

SUBJECT: Update on COVID-19 Preparations and Actions

In follow-up to our last communication, we are pleased to share the following updates from the provincial Command Table on key preparations that are being taken to address COVID-19:

- Accelerating actions to **reduce the backlog of laboratory tests** and **increase testing capacity,** working in partnership with Public Health Ontario, Ontario Health, the Federal government, and local health system organizations.
    - This includes increasing the current system's capacity from 3,000 tests per day to 5,000 tests per day by next week.

- **Investing in enhanced bed capacity in hospitals**, supporting regional decisions on activation opportunities for new beds, and continuing work across ministries and sectors to identify additional bed capacity in long-term care homes, retirement homes and other spaces in the community.

- **Further mobilizing primary capacity** in the response to, and triage of calls related to COVID-19.

- Launched the next version of the **online Self-Assessment tool** on Ontario.ca to help the public understand their risks and their options for care.

- **Significantly increased Telehealth capacity** to ensure Ontarians receive timely responses to their concerns and are triaged to the appropriate setting to receive the care they need.
    - This includes quadrupling its call lines and doubling the number of nurses who are calling back people with COVID-19 related questions.

- Working with suppliers, distributors, local partners and the Federal Government to **address shortages in critical supplies and equipment**.
    - This includes procurements of gloves, masks, and eye protection to date, with many other opportunities being pursued.
    - The ministry is actively working with the Ministry of Economic Development, Job Creation and Trade to leverage opportunities with industries, businesses and innovators to source the necessary supplies and equipment, including Personal Protective Equipment (PPE).
    - The ministry and Ontario Health are also supporting the development of guidance on the use of PPE outside of the health care sector.

- **Enabled virtual professional home care services** through the introduction of new billing codes and guidance.

In follow-up to a meeting of the **Collaboration Table yesterday**, the ministry is examining the suggestions, concerns and comments brought forward by stakeholders, actioning each item across government and tracking progress in addressing these areas. We will continue to report progress at Collaboration Table meetings and through these updates. Please see the attached document for a summary of issues identified by the Collaboration Table.

Thank you for your ongoing engagement with your local partners to prepare for business continuity and for COVID-19's impact on the health system.

Sincerely,

(original signed by)

Helen Angus	Dr. David Williams	Matthew Anderson
Deputy Minister	Chief Medical Officer of Health	President and CEO
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Ontario

March 23, 2020

MEMORANDUM TO: Health System Organizations and Providers

SUBJECT: Update on COVID-19 Preparations and Actions

In follow-up to our last communication, we are pleased to share the following updates from the provincial Command Table on key actions that are being taken to address COVID-19:

- Accelerating activities to **reduce the backlog of laboratory tests** and **increase provincial testing capacity** by:
    - Establishing a **provincial diagnostics coordination network** immediately lead by Ontario Health to provide integrated coordination of resources, procurement and test routing;
    - **Evaluating innovative testing approaches** in the next 2 days; and
    - Actioning new capacity creation ideas by creating a provincially coordinated **intake/assessment function** separate from current delivery resources.

- Developing guidance from Ontario's Chief Medical Officer of Health (CMOH) regarding the appropriate use of Personal Protective Equipment (PPE) for non-health care workers.

- Continuing to pursue all options to **secure additional supplies and equipment**, with a priority focus on masks and ventilators, in the quantities needed to meet current and projected demands, including significant procurements. Progress is being made as federal and provincial governments mobilize to source and find innovative approaches.

- Launching a **volunteer website** to mobilize available workforce capacity towards the provincial response to COVID-19.

    - The website focuses on health care providers, former health care providers who are retired, or on inactive status with their regulatory college and other types of volunteers.

- Next steps will focus on creating a central matching platform that will allow health care providers in each of the five regions to access rosters of available providers.

- **Augmenting Telehealth's intake and response capacity** including:
  - Continuing to increase the number of nurses at Telehealth to complement Telehealth Ontario's existing 200 Registered Nurses.
  - Increasing non-clinical intake support capacity to support improve response times.

Concerning the Premier's announcement today ordering the mandatory closure of all non-essential workplaces, further information will follow in the coming days.

Thank you for your ongoing engagement with your local partners to prepare for business continuity and for COVID-19's impact on the health system.

Sincerely,

(original signed by)

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Ontario

March 25, 2020

MEMORANDUM TO: Health System Organizations and Providers

SUBJECT: Update on COVID-19 Preparations and Actions

In follow-up to our last communication, we are pleased to share the following updates from the provincial Command Table on key actions that are being taken to address COVID-19:

- Continued activities to **increase provincial lab testing capacity** and **reduce the backlog of tests,** including:
    - Implementation of a provincial coordination network – 2,300 tests from Public Health labs are being reallocated across the network today to reduce the testing backlog.
    - Acceleration of assessments of new testing options to unlock a potential 4,000 additional tests per day.
    - Increasing lab capacity by leveraging hospital, community, and research labs for clinical testing purposes.
    - Through the rapid implementation of all of these actions, it is forecasted that the total daily provincial COVID-19 testing capacity could be over 15,000 tests per day by April 17th.

- **Augmenting capacity in supplies and equipment** by **managing the current demand** and coordinating with OH to ensure the priority distribution of PPE to the areas that need it most urgently, **conserving** the existing available supply of PPE based on scientific and clinical evidence, and **actively sourcing** supplies from vendors, the Federal government and voluntary donations.
    - More than 125 leads are actively being pursued and a number of procurements were confirmed in the last 72 hours.
    - For example, Ontario has recently secured millions of surgical gloves, N95 respirators, and surgical masks, and more procurements are being completed all the time.

- **Adding 100 Registered Nurses** to augment Telehealth capacity by next week and actions to improve return call times.

- Introducing **new regulations** to **ease the movement of hospital ALC patients into long-term care homes** and provide more direction on the issue of patient choice for long-term care home placements.

- Mobilizing health human resources capacity throughout the system – to date**, 5,000 volunteers** have signed up through the central website and are available to be matched to health care providers and organizations that need additional support. The development of tools and processes are underway to match regional needs with available capacity.

- **Identifying additional bed capacity** in alternative community settings to support individuals who are homeless or in shelters and health care workers who need temporary housing arrangements.

We are also improving our approach to tracking and addressing stakeholder issues and concerns, as identified on the 9 a.m. stakeholder calls and at the Collaboration Table. In advance of the **Collaboration Table** tomorrow, we have sought updates and questions in advance, to support a productive discussion on needs and concerns that are top-of-mind for our stakeholders.

We will continue to keep you apprised of actions taken in these key areas and work with you to develop solutions as our pandemic response unfolds.

Thank you for your ongoing engagement with your local partners to prepare for business continuity and for COVID-19's impact on the health system.

Sincerely,

(original signed by)

Helen Angus	Dr. David Williams	Matthew Anderson
Deputy Minister	Chief Medical Officer of Health	President and CEO
Ministry of Health	Ministry of Health	Ontario Health

Ministry of Health

COVID-19 Guidance: Acute Care

Version 3 – March 19, 2020

This guidance provides basic information only. It is not intended to take the place of medical advice, diagnosis or treatment.

- Please check the Ministry of Health (MOH) COVID-19 website regularly for updates to this document, case definition, FAQs, and other information: http://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/2019_guidance.aspx

Screening

1. The latest case definition for screening is available on the MOH COVID-19 website.
2. All acute care settings should undertake active and passive screening. Visitors should be limited to only those who are essential.
3. Signage should be posted on all entry points and at triage areas in acute care facilities. Signage should prompt visitors, health care workers (HCW), volunteers and patients to self-identify to a specific location/person if they screen positive using the case definition.
4. HCWs conducting screening should ideally be behind a barrier to protect from Droplet/Contact spread. A plexiglass barrier can protect reception HCWs from sneezing/coughing patients.
5. Acute care settings must instruct all HCWs, students and volunteers to self-monitor for COVID-19 at home. All HCWs should be aware of early signs and symptoms of acute respiratory infection (such as fever, cough or shortness of breath). HCWs, students and volunteers with symptoms of an acute respiratory infection must not come to work and must report their symptoms to the acute care setting.

Positive Screening: What to do

6. Provide the patient with a surgical/procedure mask. Place the patient in a room with the door closed on arrival (do not cohort with other patients), where possible, to avoid contact with other patients in a common area of the acute care facility (e.g., waiting rooms). Encourage the patient to use respiratory hygiene/cough etiquette, and provide surgical/procedural masks, tissues, alcohol-based hand rub and a waste receptacle.
7. HCWs should provide routine care or obtaining specimens from patients with suspect or confirmed COVID-19 using Droplet and Contact Precautions. These precautions include wearing the following Personal Protective Equipment (PPE) - gloves, gown, surgical/procedure masks and eye protection (goggles, face shields) for routine care.
8. HCWs should carry out aerosol generating medical procedures (AGMP) using Droplet, Contact and Airborne Precautions. These precautions include wearing the following PPE – gloves, gown, N95 fit tested respirators and eye protection (goggles/face shields).
9. Detailed precautions for HCWs, by activity and procedure are listed in PHO's Technical Brief on Updated IPAC Recommendations for Use of PPE for Care of Individuals with Suspect or Confirmed COVID-19.
10. In acute care settings, airborne infection isolation rooms (AIIR) should be used, if available, for AGMP. Negative pressure should be validated daily. Should an AIIR not be available, a single room may be used with the door closed.
11. HCWs who must wear PPE should be properly trained in appropriate donning (putting on) and doffing (taking off) of PPE with emphasis on ensuring hands are clean before any contact with their face.

Reporting of Positive Screening

12. COVID-19 is a designated disease of public health significance (O. Reg. 135/18) and thus reportable under the *Health Protection and Promotion Act*.

13. The hospital should contact the local public health unit to report a suspect or confirmed case of COVID. If the suspect case has been tested, with results pending and the person does not require hospital admission, please notify/consult with the hospital infection prevention and control department and the local public health unit prior to discharge.

14. Laboratory results will be communicated through routine processes for reportable diseases in Ontario which include the local public health unit and the ordering physician.

Testing for COVID-19

15. Naso-pharyngeal (NP) swabs are the preferred sample but throat swabs can be used (less yield). NP swab collection is not considered an aerosol generating procedure and should be collected by applying Droplet/Contact Precautions. PPE to be worn for this procedure include – gloves, gowns, surgical/procedure mask and eye protection (goggles/face shield).

16. Specimens are to be sent to Public Health Ontario Laboratory (PHOL) or where applicable, a hospital laboratory with testing capacity.

HCW Safety Measures

17. Assess availability of PPE and other infection prevention and control supplies that would be used for the safe management of suspected and confirmed COVID-19 patients. These supplies would include: gloves, gowns, surgical/procedure masks, eye protection (goggles, face shields), N95 respirator (for AGMP only), hand hygiene supplies (e.g. alcohol-based hand rub).

18. Train all HCWs who are required to wear PPE in the use, care and limitations of the PPE; HCWs must use the PPE appropriately for their own health and safety to treat and screen patients, with emphasis on ensuring their hands are clean before contact with their face.

19. Have written measures and procedures for worker safety, developed in consultation with the joint health and safety committee, including measures and procedures for infection prevention and control.

20. Persons in a shared clinic space at a distance greater than 2 metres away from the patient do not require PPE.

21. Where possible, dedicated equipment should be provided for use in a room where a confirmed or suspect patient is being cared for. At minimum, dedicated equipment must be thoroughly cleaned/disinfected using an approved hospital-grade disinfectant prior to being used elsewhere. Further details on disinfection are provided below.

Cleaning and Disinfection

22. Acute care settings must clean and disinfect any areas that the patient occupied. HCWs should use an approved hospital-grade disinfectant. The disinfectant is to have a Drug Identification Number (DIN). Follow the manufacturer's recommendations use. Equipment used to clean and disinfect contaminated areas should be disposable. Particular attention should be paid to high touch surfaces in both patient and common spaces (i.e., bed rails, remote controls, handles).

Occupational illness

23. In accordance with the Occupational Health and Safety Act and its regulations, an employer must provide a written notice within four days of being advised that a worker has an occupational illness, including an occupationally-acquired infection, or if a claim has been made to the Workplace Safety and Insurance Board (WSIB) by or on behalf of the worker with respect to an occupational illness, including an occupational infection, to the:

- Ministry of Labour,
- Joint Health and Safety Committee (or health and safety representative), and
- trade union, if any.

24. Occupationally-acquired infections and illnesses are reportable to the WSIB.

Work restrictions for healthcare workers

25. If COVID-19 is suspected or diagnosed, the HCW must remain off work until symptoms are fully resolved and negative laboratory tests have been confirmed. The acute care facility should consult with the local public health unit to determine when the HCW can return to work. HCWs should also report to their Employee Health/Occupational Health and Safety department prior to return to work. Detailed general occupational health and safety guidelines for COVID-19 are available on the MOH COVID-19 website.

Ministry of Health

COVID-19 Guidance: Occupational Health and Safety and Infection Prevention & Control

March 20, 2020

Routine Practices with Additional Precautions

The ministry recommends the use of Routine Practices and Additional Precautions when a care provider treats a confirmed case or probable case.

Patients screening positive should be given a surgical/procedure mask and placed in a room with the door closed on arrival (do not cohort with other patients), where possible, to avoid contact with other patients in common area of the practice (e.g., waiting rooms). Patient to perform hand hygiene at point of entry. Encourage the patient to perform respiratory hygiene/cough etiquette, and provide surgical/procedural masks, tissues, alcohol-based hand rub and a waste receptacle. Limit visitors to only those who are essential.

Health Care Workers (HCWs) should carry out aerosol generating medical procedures (AGMP) using Droplet, Contact and Airborne Precautions. These precautions include wearing the following PPE – gloves, gown, N95 fit tested respirators and eye protection (goggles/face shields).

Detailed precautions for HCWs, by activity and procedure are listed in PHO's Technical Brief on Updated IPAC Recommendations for Use of PPE for Care of Individuals with Suspect or Confirmed COVID-19.

In acute care settings, airborne infection isolation rooms (AIIR) should be used, if available, for AGMP. Negative pressure should be validated daily. Should an AIIR not be available, a single room may be used with the door closed.

HCWs who must wear PPE should be properly trained in appropriate donning (putting on) and doffing (taking off) of PPE with emphasis on ensuring hands are clean before any contact with their face.

Cleaning and Disinfection

Where possible, dedicated equipment should be provided for use in a room where a confirmed or suspect patient is being cared for. Dedicated equipment must be thoroughly cleaned/disinfected prior to being used elsewhere.

Equipment used to clean and disinfect contaminated areas should be disposable. Particular attention should be paid to high touch areas in both patient and care provider environments (i.e. bed rails, remote controls, handles).

For more information please see: PIDAC Routine Practices and Additional Precautions In All Health Care Settings and PIDAC Environmental Cleaning.

Additional precautions for Paramedics

If the initial assessment and triage by Emergency Department (ED) staff indicates that COVID-19 is suspected, the paramedics should continue airborne precautions until environmental cleaning and decontamination of the ambulance have been completed. These environmental cleaning and decontamination processes will be conducted according to local paramedic service policies.

HCW Safety Measures

Assess availability of PPE and other infection prevention and control supplies that would be used for the safe management of suspected and confirmed COVID-19 patients. These supplies would include: gloves, gowns, surgical/procedure masks, eye protection (goggles, face shields), N95 respirator (for AGMP only), hand hygiene supplies (e.g. alcohol-based hand rub).

Train all HCWs who are required to wear PPE in the use, care and limitations of the PPE; HCWs must use the PPE appropriately for their own health and safety to treat and screen patients, with emphasis on ensuring their hands are clean before contact with their face.

Have written measures and procedures for worker safety, developed in consultation with the joint health and safety committee, including measures and procedures for infection prevention and control.

Persons in a shared clinic space at a distance greater than 2 metres away from the patient do not require PPE.

Where possible, dedicated equipment should be provided for use in a room where a confirmed or suspect patient is being cared for. At minimum, dedicated equipment must be thoroughly cleaned/disinfected using an approved hospital-grade disinfectant prior to being used elsewhere. Further details on disinfection are provided below.

Occupational illness and work restrictions

If an HCW is suspected to have (i.e. symptoms AND relevant contact or travel) or diagnosed with COVID-19, the HCW must remain off work until symptoms are fully resolved and negative laboratory tests have been confirmed.

The employer should consult with the local public health unit to determine when the care provider can return to work. HCWs providers should also report to their Employee Health/Occupational Health and Safety department prior to return to work.

If the care provider's illness is determined to be work-related: In accordance with the Occupational Health and Safety Act and its regulations, an employer must provide a written notice within four days of being advised that a worker has an occupational illness, including an occupationally-acquired infection, or if a claim has been made to the Workplace Safety and Insurance Board (WSIB) by or on behalf of the worker with respect to an occupational illness, including an occupational infection, to the:

- Ministry of Labour;
- Joint health and safety committee (or health and safety representative); and
- Trade union, if any.

Any instances of occupationally-acquired infection shall be reported to WSIB within 72 hours of receiving notification of said illness.

All health system organizations and employers immediately should cease all non-essential business travel outside of Canada until further notice and likewise discourage employee travel.

HCWs who have travelled outside of Canada within the last 14 days should self-isolate for a period of 14 days starting from their arrival in Ontario. HCWs should not attend work if they are sick. If there are particular workers who are deemed critical, by all parties, to continued operations, these workers should undergo regular screening, use appropriate PPE for the 14 days and undertake active self-monitoring, including taking their temperature twice daily to monitor for fever, immediately self-isolate if symptoms develop, and self-identify to their occupational health and safety department.