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Communique

TO: **First Nation Leadership, Leadership Council**

FROM: **Chiefs of Ontario Health/Social Sector**

DATE: **April 16, 2020**

RE: **COVID-19 Weekly Update**

As COVID-19 continues to evolve, Chiefs of Ontario Health and Social Sectors will be providing updates concerning technical highlights and vital priority areas.

COO Health Sector

This week brought news of the potential for rapid response testing capabilities developed by two Canadian manufacturers in the fight against COVID-19:

1. Spartan Cube: Rapid Portable Swab Test, Spartan BioScience,Ottawa
   Health Canada has approved the Spartan portable testing cube for the rapid detection of the COVID-19 virus. Spartan's test involves inserting a cartridge containing a swab taken from the clients mouth into a machine the size of a coffee cup that analyzes DNA for the presence of the virus. The testing takes about 45 minutes to complete and only one test can be done at a time, and could be done in a number of settings. This portable cube is still undergoing validation but should be available in Ontario within 2 – 3 weeks as soon as manufacturing is able to meet demand. We will keep you updated as further information becomes available on ordering and procurement of this new testing tool.

2. COVID-19 Antibody Test: Rapid Response Serology Test-BTNX Markham
   This test has not yet been approved by Health Canada and is still under review although has been green lighted in the US. This test is specific to detecting antibodies which are present in the blood as a response to having the virus. It tests for immunity to the virus and could be helpful in determining whether individuals are safe to return to work, go back to school or re-integrate back into the community after having COVID-19. There are cautions with the test however in that you could test positive for antibodies (immunity) and yet remain positive for the COVID-19 virus. This screening test can provide results in 15 min at a cost of $10.00; once approved it could be used in parallel with other laboratory testing.

Long Term Care/ Senior Residence Guidelines:
It is essential that measures are put into place immediately to prevent the introduction of COVID-19 into Senior Residences and Long Term Care Homes. **Today** the Ministry of Health released a **Guidance Document (See Attached**) containing these measures:

- Active Screening of all Staff and of Essential Visitors (those providing palliative care) including temperature checks twice daily
- Active Screening of all Residents twice daily including temperature checks
- Ensure appropriate use of PPE
- Masking for source control at all times
- Review of ways to increase social distancing
- Review Senior Care Homes Outbreak Preparedness
- Triggering an Outbreak Assessment Guide
- Specimen Collection

Additional Health Human Resource Capacity (Surge Capacity)
Chiefs of Ontario Health Sector continues to support First Nations in the areas of expanded Health Human Resource Capacity and are working together with FNIHB and organizations such as the Registered Nurses' Association of Ontario (RNAO), Doctors without Borders and Inner City Health Associates (ICHA) to secure access to additional resources for FN in Ontario. Inner City Health Associates (ICHA) is Canada's largest healthcare organization for people experiencing homelessness with over 100 physicians and 50 nurses and case managers serving Toronto's 8000 homeless at over 60 clinical sites in Toronto. During the COVID-19 pandemic ICHA is working with Medecins Sans Frontieres/Doctors Without Borders to bring the most fulsome response possible to those without a home. ICHA's Vision is to bring a healthy end to homelessness. (See Attached Documents)

Personal Protective Equipment
Chiefs of Ontario Health Sector continues to advocate for a streamlined approach to the ordering and dispensing of all Personal Protective Equipment (PPE) to First Nation Communities. We will be working with our government partners to ensure access to the appropriate PPEs as quickly as possible.

Protecting Canadians Mental Health
In an effort to help Canadians struggling with mental health issues, the federal government has launched a new portal **"Wellness Together Canada"** dedicated to mental wellness. It can be found at Canada.ca/coronavirus and on the Canada COVID-19 app and serves to:

1. Connect Canadians to peer support workers, social workers, psychologists and other professionals for confidential chat sessions or phone calls; and
2. Make it easier to find credible information and help address mental health and substance use issues

Chiefs of Ontario: Social Sector

Provincial Child Welfare
Children's Aid Societies and Indigenous Child and Family Well-Being Agencies in Ontario ARE continuing their child protection services, they are NOT closed. Youth aging out of care during the COVID crisis will be eligible to maintain residential placement or other living arrangements and any financial support provided to the youth.

Indigenous Services Canada, First Nations Child and Family Services Program
ISC is ensuring that youth who age out of care continue to receive support. From March 9, 2020 to September 30, 2020 ISC will continue to cover eligible maintenance costs to FNCFS agencies. For Ontario Region the contacts are Catherine Thai, catherine.thai@canada.ca and Taia Tarvainen, taia.tarvainen@canada.ca.

Children's Aid Foundation of Canada
Children's Aid Foundation of Canada is providing grants of $1000 to support youth who have "aged out" of care. Unfortunately, the youth support fund is temporarily put onhold, to be notified when applications reopen, please visit the website.

Support For Families
Families can apply if they have children who are not in school or child care because of COVID-19. Eligible parents can receive a one-time per child payment of $200 for children aged 0 to 12 or $250 for children or youth aged 0 to 21 with special needs. This funding can help parents with the costs of work books, educational apps, educational subscription services, and other tools to support learning at home. There is no income cap, all parents are eligible for the children mentioned above. You can submit one application per child, if you have more than one you must submit an additional application. Apply via the Ontario website, Support For Families.

Youth Mental Health Resources
Jack.org, School Mental Health Ontario and Kids Help Phone launch a COVID-19 Mental Health Resource Hub, to provide Canada's youth with easy-to-access education, tools, support and the reliable information in one place. https://jack.org/covid

Homelessness
Homelessness and pandemic response resources
COVID-19 Response Framework for People Experiencing Homelessness
Helpseeker health and social services resources
Covid-19 information and resource link http://cnh3.ca/resources/

Legal Assistance
Justice For Children and Youth services are available by phone and other technology during this time. Youth can call JFCY at 416-920-1633, or toll free at 1-866-999-5329 (JFCY). For youth learning more about their rights please refer to JFCY Legal Rights Wiki Webpage. JFYC has also created an infographic regarding COVID-19 Emergency measures Laws & Public Spaces in Ontario available in PNG and PDF. Legal aid announced changes in the criteria for accessing legal aid which include, for those experiencing- domestic violence- no criteria needed to access assistance (see Legal Aid Website), Child in a need of protection- no proof of income required, and summary advice line- no proof of income required. Click for Legal Aid Ontario clinics.

Financial Assistance
Individiuals can apply for Emergency Assistance at Ontario.ca/community
Canadians quarantined can apply for Employment Insurance (EI) sickness benefits. Application for EI sickness benefits. Telephone: 1-833-381-2725 (toll-free). Teletypewriter (TTY): 1-800-529-3742. For the Canada Emergency Response Benefit application visit the webpage. For More Information About Financial Benefits, contact Ontario, 1-888-789-4199. You may also contact the constituency office of your MPP. You can look up your MPP here: https://www.ola.org/en/members/current. You may also call 2-1-1 for information about support in your community.

Ontario Together: help fight coronavirus
Indigenous businesses can offer emergency products, services and innovative solutions to support the response to COVID-19. If your business can provide medical products, consider submitting to Ontario through the application to submit supplies or contact 1-888-777-0554

As information becomes available, we are posting updates and resources on the COO COVID19 website: https://www.coo-covid19.com/

We remain committed to working together with all of you in keeping our nations protected, supported and embraced. While not possible physically, then with our spirit, as we do everything possible to combat COVID-19 and its impacts.

Be Well.

Ministry of Health

COVID-19 Outbreak Guidance for Long-Term Care Homes (LTCH)

April 15, 2020

Note: This COVID-19 Outbreak Guidance for Long-Term Care Homes (LTCH) is intended to complement Directive #3 issued by the Chief Medical Officer of Health to LTCHs, dated April 15th, 2020 or as amended.

Where there is any conflict between this COVID-19 Outbreak Guidance and Directive #3 (or any other Directive issued by the Chief Medical Officer of Health) or any emergency order made under the *Emergency Management and Civil Protection Act* the Directive or emergency order, as the case may be, prevails.

Public health units (PHUs) should refer to the 2018 Control of Respiratory Infection Outbreaks in Long-Term Care Homes document as the foundational document for respiratory outbreak related guidance on the preparedness, prevention, and management of COVID-19 related outbreaks.

Emerging information on COVID-19 suggests older adults with underlying health conditions are at increased risk of severe outcomes. Therefore, early identification of cases associated with LTCHs and rapid implementation of outbreak control measures are essential to preventing spread within the home.

As per **section 1.1.1**. of the Control of Respiratory Infection Outbreaks in Long-Term Care Homes guidance document, COVID-19 is a new, emerging pathogen, and the following information is intended to provide any COVID-19 specific guidance not already addressed in the document.

Additional information on COVID-19 for LTCHs and for PHUs:

- Ontario COVID-19 for Health Care Providers
- Directive #3 for LTCHs under the Long-Term Care Homes Act, 2007

- Directive #5, issued by the Chief Medical Officer of Health
- Public Health Management of Cases and Contacts of COVID-19 in Ontario (available through the Ministry Emergency Operations Centre EOCOperations.MOH@ontario.ca)
    - These guidelines for PHUs contain information on exposure classifications (high, medium and low/no risk) and contact management definitions (self-monitoring and self-isolating)
- Public Health Ontario (PHO) IPAC Recommendations for COVID-19
- PHO Health Care Resources

Definition of "Staff"

This document uses the term "staff" to include anyone conducting activities in the LTCH, including but not limited to, health care workers.

Preventing the Introduction of COVID-19 into LTCHs and Preparedness Measures Before Detection of a Case in LTCHs

- All LTCH staff should follow the Ministry of Health's following recommendations and directives:
    - Directive #3, issued by the Chief Medical Officer of Health
    - Directive #5, issued by the Chief Medical Officer of Health
- **Active Screening of Staff and Essential Visitors:** LTCHs must immediately implement active screening of all staff, essential visitors and anyone else entering the home for COVID-19 except for emergency first responders, who should, in emergency situations, be permitted entry without screening.
    - Screening must include twice daily (at the beginning and end of the day or shift) symptom screening, including temperature checks. Anyone showing symptoms of COVID-19 should not be allowed to enter the home and should go home immediately to self-isolate. Staff responsible for occupational health at the home must follow up on all staff who have been advised to self-isolate based on exposure risk.

- **Active Screening of All Residents**: Long-term care homes must conduct active screening of all residents, at least twice daily (at the beginning and end of the day) to identify, and test for COVID-19, if any resident has typical or atypical symptoms of COVID-19, including temperature checks, according to the COVID-19 Provincial Testing Guidance Update April 10, 2020, or as amended.
- **Ensure Appropriate Personal Protective Equipment (PPE)**
    - Follow Directive #1 for Health Care Providers and Health Care Entities
    - Follow Directive #3 for LTCHs under the Long-Term Care Homes Act, 2007
    - Follow 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

- **Masking for Source Control**
  Follow Directive #3 for LTCHs under the Long-Term Care Homes Act, 2007. All staff and essential visitors to wear surgical/procedure masks at all times for the entire duration of shifts or visits in the LTCH, whether the home is in outbreak or not.
        - The purpose of this masking is to prevent asymptomatic or presymptomatic transmission from staff or essential visitors.
        - During staff breaks, staff may remove their mask but must remain two metres away from others to prevent staff to staff transmission of COVID-19.

- **New admissions and re-admissions** should be screened for symptoms and potential exposures to COVID-19.
    - All new residents, including readmissions must be placed in isolation under **droplet and contact precautions** upon admission to the home and tested for COVID-19 within 14 days of admission.
        - If test results are negative, the resident must remain in isolation for 14 days from arrival and be re-tested for COVID-19 if they develop symptoms.
        - If test results are positive, refer to instructions on receiving positive test results and management of a single case in a

resident. As indicated in Directive #3, one case in a resident or staff is considered an outbreak.

- Hospitals are being asked by the ministry to temporarily stop transfers to long-term care and retirement homes. However, in the unlikely event that a transfer is still required, patients transferred from a hospital to a long-term care home or retirement home must be tested, and results received, prior to transfer. A negative result does not rule out the potential for incubating illness and all patients should remain under droplet and contact precautions for a 14-day isolation period following transfer.
- In consultation with the local public health unit, it may not be necessary to declare an outbreak if a new admissions or re-admission tests positive if they have been in isolation under contact and droplet precautions since entering the home.

- **Review Ways to Increase Physical Distancing in the LTCH**
  - Modify internal activities to promote adherence to physical distancing measures for residents and among staff.
  - In LTCHs where communal dining must continue, the LTCH must develop dining shifts and maintain physical distancing (>2 metres) in the dining room to reduce potential exposures. Environmental cleaning should also be undertaken between shifts and, as appropriate, during dining shifts.
  - Review use and cleaning schedule of staff common areas and staff break schedules to reduce the number of staff in break facilities at a time.
  - Review all residents' medication administration schedules to consolidate and streamline as much as possible to minimize the number of times staff need to enter a resident's room. Examples include:
    - Switching medications to less frequently dosed formulations or reducing dosing frequency, if safe.
    - Reassessing non-standard medication administration times.

        - Aligning medication administration times to coincide with timing of other resident care tasks.
        - Reassessing the need for non-essential medications.
        - Reassessing the use of nebulizer therapy.

- **Review LTCH's respiratory virus outbreak preparedness** (Section 2 in the Control of Respiratory Infection Outbreaks in Long-Term Care Homes document and the CDC Preparedness Checklist).
    - Ensure **sufficient PPE** is available and review staff PPE training (see Appendix for more information on acquiring PPE).
    - Ensure **sufficient swabs** are available to facilitate prompt testing, if needed.
    - Ensure that appropriate stewardship and **PPE conservation** is followed.
    - Review and summarize **advanced directives** for all residents as part of community planning with local acute care facilities and EMS.
    - Review **communications** protocols.
    - Review **staffing** schedules, staff who work in other locations, availability of alternate staff, and emergency contact numbers for staff.
        - Wherever possible, employers should work with staff, contractors and volunteers to limit the number of work locations that staff, contractors and volunteers are working at, to minimize risk to residents and other staff of exposure to COVID-19. Staff, contractos and volunteers should discuss with their employer if their other work location(s) are in outbreak for COVID-19.
        - In addition, with respect to employees, long-term care home employers must also comply with Ontario Regulation 146/20 made pursuant to the Emergency Management and Civil Protection Act.
    - Review **environmental cleaning protocols** and ensure frequent cleaning of high touch surfaces.
    - Develop plans to communicate with staff on COVID-19 updates, including providing information on where staff can get tested if they become symptomatic or are exposed to COVID-19.

Managing Essential Visitors

- As LTCHs are now closed to visitors, accommodation should be considered for essential visitors who are visiting very ill or palliative residents, or those who are performing essential support care services for the resident (i.e., food delivery, phlebotomy testing, maintenance, family or volunteers providing care services, and other health care services required to maintain good health).
    - Essential visitors must be screened on entry for symptoms of COVID-19, including temperature checks and should not be permitted to enter if symptoms are present.
    - Essential visitors must wear a surgical/procedure mask during the entire duration of their visit to the LTCH.
    - Essential visitors must attest to not experiencing any of the typical and atypical COVID-19 symptoms.
    - Essential visitors should be limited to one person at a time for a resident.
    - Essential visitors must only visit the one resident they are intending to visit and no other residents. Visitors providing essential support care services for more than one resident should consult with the home.
    - Staff must support the essential visitor in appropriate use of equipment for source control (i.e. mask) and PPE if required, based on the health status of the resdient:
        - For source control, essential visitors must wear a mask while visiting a resident that does not have COVID-19.
        - Essential visitors in contact with a resident who has COVID-19 or suspected COVID-19, must use PPE as required in Directive #1 for droplet and contact precautions.
    - Paramedics and/or emergency personnel are screened at the beginning of their shifts and do not need to be screened on entry into the facility.
    - Other health care service partners, which are deemed critical to maintain the health of residents, such as laboratory services, should be screened and allowed entrance with appropriate source control equipment (i.e. surgical/procedure mask) and PPE, if required per health status of the resident.

Triggering an Outbreak Assessment

As part of active surveillance for residents and staff, new symptoms compatible with COVID-19, including atypical symptoms, should be rapidly identified, investigated and managed to prevent potential spread in the LTCH.

As soon as even one resident or staff presents with new symptoms compatible with COVID-19, the LTCH should immediately conduct an outbreak assessment and take the following steps:

For an Ill Resident:

- Place the symptomatic resident under Contact and Droplet Precautions in a single room, if feasible.
- Test the symptomatic resident for COVID-19 immediately.
- Test the roommate(s) of the symptomatic resident.
- Further testing on those identified should be assessed, in collaboration with the local public health unit, using a risk-based approach based on exposures.

For an Ill Staff/Essential Visitor:

- The staff/essential visitor should self-isolate immediately at home.
- Facilitate testing for COVID-19 for the staff/essential visitor.

Specimen Collection

Specimens from residents of institutions, including LTCHs, are prioritized for testing at PHO Laboratory provided "Institution" is clearly marked in the "Patient Setting" section of PHO Laboratory requisition. Specimens may be submitted using the PHO Laboratory COVID-19 Virus Test Requisition or the PHO Laboratory General Test Requisition. Clearly indicate on the test requisition form whether testing is requested for COVID-19 ONLY, or COVID-19 AND the multiplex respiratory virus PCR (MRVP). Inclusion of the MRVP should only be added if clinically warranted to investigate current symptoms.

If the LTCH receives negative test results on the initial person who was tested, the LTCH can end the suspect outbreak assessment related steps.

Outbreak Definition

LTCHs must consider a single, laboratory confirmed case of COVID-19 in a resident or staff member as a confirmed COVID-19 outbreak in the home. Outbreaks should be declared in collaboration between the home and health unit to ensure an outbreak number is provided.

In consultation with the local public health unit, it may not be necessary to declare an outbreak if a new admissions or readmission tests positive if they have been in isolation under contact and droplet precautions since entering the home.

Information on Outbreak Data Entry in Provincial Surveillance

- Guidance has been provided to PHUs in the form of an Enhanced Surveillance Directive from PHO which includes instructions on how to report a confirmed COVID-19 outbreak in the integrated Public Health Information System (iPHIS).

Outbreak Management

Assessing for Additional Cases

Once an outbreak has been declared, residents, staff or visitors, who were in close contact with the infected individual(s) should be identified and tested, if not already completed. This involves:

- Assessing for illness in those who had exposure to the case(s) in the 14 days prior to illness onset to identify potential source cases.
- Assessing for illness in those who had exposure to the case(s) while the case(s) were infectious and not in isolation with Contact and Droplet Precautions in place.

The **period of communicability** is considered to be from 48 hours before the onset of symptoms to 14 days from symptom onset. In the event of a positive test result in

an asymptomatic individual, the period of communicability is considered to be from 48 hours before the specimen collection date.

Specimen Collection and Testing for Outbreak Management

Note: At this time, usual practices for outbreak specimen testing (up to 4 per outbreak) have been changed to ensure early detection of COVID-19 and outbreak management. The changes are described below:

- Testing for COVID-19 should be conducted for **every symptomatic resident** in the LTCH:
    - This includes testing every resident whether linked to a COVID-19 outbreak or not, including deceased residents who were not previously tested.
    - Health units are responsible for following usual outbreak notification steps to the PHO Laboratory. If submitting specimens from persons being tested during a laboratory confirmed COVID-19 outbreak, this should be documented on the PHO Laboratory requisition.
    - Up to four outbreak specimens will be tested at PHO Laboratory for respiratory viruses other than COVID-19 by MRVP. There is little utility in testing more than four outbreak specimens for such viruses (see Control of Respiratory Infection Outbreaks in Long-Term Care Homes). MRVP should be ordered on the laboratory requisition if required.
- **All Symptomatic Staff Should be Tested for COVID-19.**
  When specimens are submitted for laboratory testing from staff "Healthcare Worker", and if relevant, the outbreak number must be documented on the PHO Laboratory COVID-19 Virus Test Requisition in order to prioritize and expedite testing.
    - At this time, symptomatic staff should follow guidance included in the COVID-19 Quick Reference Public Health Guidance on Testing and Clearance.
- There should be a low threshold to test residents and health care workers within the home for COVID-19; even one compatible symptom should lead to testing (see COVID-19 Provincial Testing Guidance from April 8, 2020). If specimens are submitted to PHO Laboratory for testing before an outbreak number has been issued, clearly indicate on the requisition the setting as "Institution".

- Once an outbreak is declared , any additional compatiable illness in residents should be managed as a probable case (symptoms and close contact with a confirmed case) and presumed COVID-19, while waiting for their testing results.
- Testing of **asymptomatic residents or staff** for outbreak management purposes:
    - Testing of asymptomatic residents and staff is generally not recommended.
    - In the context of a confirmed outbreak, and in consultation with the local public health unit, the following asymptomatic individuals should be tested to inform outbreak management by identifying potential asymptomatic source cases and extent of current spread at the time of outbreak declaration:
        - All residents living in adjacent rooms
        - All staff working in the outbreak unit/care hub
        - Any essential visitors that attended the outbreak unit/care hub
        - Any other contacts deemed appropriate for testing based on a risk assessment by local public health
    - A negative test does not rule out the potential for the individual to still be incubating illness, and all close contacts should be under isolation for 14 days following last unprotected exposure.
    - Residents and staff who initially tested negative may need to be re-tested if they develop symptoms.
    - Re-testing residents and staff who continue to be asymptomatic is not recommended.

Outbreak Control Measures

Steps in an Outbreak: If an outbreak is declared at the long-term care home, the following measures must be taken:

- Consult Control of Respiratory Infection Outbreaks in Long-Term Care Homes to **define the outbreak area** (i.e., affected unit(s) vs. whole facility).
    - Consider all residents in the outbreak area to be either infected or exposed and potentially incubating.

    - Cohort or "group together" all residents in the outbreak area as much as possible, and staff should use Droplet and Contact precautions for all resident interactions in the outbreak area.
- Continue **enhanced monitoring** of all residents and staff in the home for new symptoms.
- Quickly **identify, initiate Droplet and Contact Precautions, and test for COVID-19 for** any resident with symptoms compatible with COVID-19 (including atypical symptoms) and assess for expansion of outbreak areas.
- Institute **staff and resident cohorting** to prevent spread (see *Cohorting* below under Additional Outbreak Measures).
- **No new resident admissions are allowed** into the outbreak areas until the outbreak is declared over.
- **No re-admission of residents** who were not part of the outbreak line list into the outbreak areas until the outbreak is over;
    - Re-admission of residents who were part of the outbreak line list may be considered with a risk assessment/discussion.
- If residents are taken by family out of the home, they may not be readmitted until the outbreak is over.
- For residents that leave the home for an essential out-patient visit, the home must provide a mask for the resident. If tolerated the mask must be worn while out of the home and the resident should be screened upon their return.
- Discontinue all non-essential activities. For example, pet visitation programs must be stopped for the duration of the outbreak.
- If possible, discontinue all communal activities/gatherings, school programs and on-site day cares or intergenerational programming for the duration of the outbreak;
    - Where possible, provide in-room tray service to avoid communal dining.
- Long-term care homes must not permit residents to leave the home for short-stay absences to visit family and friends. Instead, residents who wish to go outside of the home must be told to remain on the home's property and maintain safe physical distancing.
- Report regular updates on ill residents or staff to the local PHU.

- See PHO PPE document for guidance on Droplet and Contact Precautions (Fact Sheets).
- Environmental cleaning is particularly important for COVID-19 and should follow Ontario PIDAC Best Practice Guidance.
- Review infection prevention and control practices including proper glove use, and hand hygiene with with all staff including kitchen and housekeeping staff.

Additional Outbreak Control Measures

In addition to the IPAC measures found in the Recommendations for the Control of Respiratory Infection Outbreaks in LTCHs, the following IPAC measures should be initiated for a COVID-19 outbreak. Visit the PHO website for the most current recommendations and guidance.

- Ensure EMS and hospitals are informed when residents are to be transferred from the home.
- Arrange for the use of portable equipment to help avoid unnecessary resident transfers (e.g., portable x rays, dialysis, etc.).
- Maintain ongoing assessment of contingency plans for procurement of essential supplies (e.g., stock rotation, ordering, alternatives, etc.).
- Consider cultural, ethnic and indigenous needs as well as religious practices and determine acceptable alternatives as indicated.
- Consider alternative measures to be taken for residents with cognitive disabilities (e.g. increase one on one programs, use of preventative wandering barriers, dedicate resident time for sensory stimulation activities, take advantage of High Intensity Needs Funding if available).
- Ensure that isolation of residents and restriction of visitors takes into consideration the detrimental physical, emotional and social impacts on the residents. As such, consideration for alternative options for support should be considered (e.g. exercise programs for the room, one on one programs , use of technology to allow visual and auditory contact with family and friends, distracting activities that meet the needs of individual residents). See PIDAC's Best Practices for Prevention and Control Infections in all Health Care Settings for more details.

- Where possible, encourage visitors to keep in touch with loved ones by phone or video chat or other technologies, as available. Care packages from families/friends are encouraged (but remind family/friends that if they are ill with cough, sneezing, or runny nose they should not prepare/send packages).

Mask Use, Personal Protective Equipment (PPE), Hand Hygiene and Signage

- Ensure that the right PPE is available and accessible for use by those who require use of PPE based on Directives and current recommendations.
- All LTCH staff and essential visitors must wear surgical/procedure masks at all times for the duration of their shift or visit in the LTCH as a measure of source control to prevent asymptomatic/presymptomatic transmission from the staff/essential visitors. This applies whether the home is in outbreak or not.
    - During breaks, staff may remove their mask but must remain two metres away from other staff to prevent staff to staff transmission.
- Ensure availability and accessibility of hand hygiene products (e.g. alcohol-based hand rub) throughout the home.
- Ensure signage is clear and that education for staff, visitors and families, outsourced workers and companies is to be provided. Examples include:
    - Non-medical: delivery people, construction, environmental cleaning contracts or,
    - Medical: special care providers, chiropodist, respiratory therapy, physiotherapy.

Aerosol Generating Medical Procedures

- Ensure appropriate measures are taken when performing aerosol generating medical procedures (AGMPs) in LTCH (e.g. tracheotomy care with suctioning). Collection of nasopharyngeal swabs are not aerosol generating procedures.
- The use of an N95 respirator is recommended instead of a mask as part of precautions for AGMPs on patients with known or suspect COVID-19.

Environmental Cleaning

- At this point, there is no requirement to enhance or change the use of cleaning products and hospital grade disinfectants that are normally used for environmental cleaning in LTCHs.
- Additional environmental cleaning is recommended for frequently touched surfaces, including trolleys and other equipment that move around the home, and consideration given to increasing the frequency of cleaning.
- Policies and procedures regarding staffing in Environmental Services (ES) departments should allow for surge capacity (e.g., additional staff, supervision, supplies, equipment). See PIDAC's Best Practices for Prevention and Control Infections in all Health Care Settings for more details.

Cohorting

- LTCHs must use staff and resident cohorting to prevent the spread of COVID-19.
    - Resident cohorting may include one or more of the following:
        - Alternative accommodation to maintain spatial separation of 2 metres;
        - Cohorting of the well and unwell residents;
        - Utilizing respite and palliative beds/rooms to provide additional accommodation; and,
        - Utilizing other rooms as appropriate to help maintain isolation of affected residents (e.g., community and recreation rooms that have call bells).
    - Staff cohorting may include:
        - Designating staff to either ill residents or well residents (in smaller long-term care homes or in homes where it is not possible to maintain physical distancing of staff or residents from each other, all residents or staff should be managed as if they are potentially infected, and staff should use droplet and contact precautions when in an area affected by COVID-19.); and,
        - Wherever possible, employers should work with staff, contractors and volunteers to limit the number of work locations that staff, contractors and volunteers are working at, to minimize risk to residents and other staff of exposure to COVID-19.

- In addition, with respect to employees, long-term care home employers must also comply with Ontario Regulation 146/20 made pursuant to the Emergency Management and Civil Protection Act.

Units/LTCHs with Resident Mixing

- In smaller long-term care homes or in homes where it is not possible to maintain physical distancing of staff or residents from each other, all residents or staff should be managed as if they are potentially infected, and staff should use droplet and contact precautions when in an area affected by COVID-19.
- More frequent cleaning of high-touch surfaces, and staff assistance of hand hygiene for residents.

Work Self-Isolation:

In exceptional circumstances asymptomatic staff critical to operations, but who have been advised to self-isolate (either from travel, high-risk exposure, or testing positive), "work self-isolation" means continuing to work (where appropriate) while using appropriate personal protective equipment and undertaking active self-monitoring, including taking their temperature twice daily to monitor for fever, and immediately self-isolating if symptoms develop.

- Staff under work self-isolation need to identify themselves to their occupational health and safety department.
- Staff must follow self-isolation recommendations outside of the workplace.
- During work, at a minimum, a mask must be worn at all times, including in common areas.
- Staff under work self-isolation should not work in multiple facilities.
- See information on clearance testing.
- See fact sheet on work self isolation.

Communications

- LTCHs must keep staff, families and residents informed about COVID-19. Staff must always be reminded to monitor themselves for COVID-19 symptoms, and to immediately self-isolate if they develop symptoms.

- Signage in the LTCH must be clear about COVID-19, including signs and symptoms of COVID-19, and steps that must be taken if COVID-19 is suspected or confirmed in staff or a resident.
- Food and product deliveries should be dropped in an identified area and active screening of delivery personnel should be done prior to entering the home.
- Communicate with local acute care hospital regarding outbreak, including number of residents in the facility, and number who may potentially be transferred to hospital if ill based on advanced care directives.
- Communicate with local public health and Ministry of Labour, Training and Skills Development throughout an outbreak to collaborate and for support in the investigation and response.
- The Ministry of Long-Term Care and/or the Ontario Long Term Care Association will also be in communication with the facility experiencing an outbreak.

Declaring the Outbreak Over

- In collaboration with the local public health unit, the outbreak may be declared over when there are no new cases in residents or staff after 14 days (maximum incubation period) from the latest of:
    - Date of isolation of the last resident case; OR
    - Date of illness onset of the last resident case; OR
    - Date of last shift at work for last staff case.

Appendix 1 – PPE Recommendations for Staff on Work Self Isolation

All **symptomatic** staff must be tested for COVID-19. When specimens are submitted for laboratory testing from healthcare workers "Healthcare Worker", and if relevant, the outbreak number must be documented on the PHO Laboratory COVID-19 Virus Test Requisition in order to prioritize and expedite testing. Other staff who have had high risk exposures (direct contact with residents in affected area without appropriate PPE) should self-isolate, but may **"work self isolate"** under the following conditions:

Resident/ Cohort	Symptomatic Resident: Confirmed or Suspect Case	Asymptomatic Resident: Contacts of a Case (e.g., roommate, tablemate, friend)	Asymptomatic Resident: Not Exposed to a Case	Comments
Who Should Provide Care? Preferred option	Exposed but asymptomatic staff exposed to ill residents in affected area.	Exposed but asymptomatic staff exposed to ill residents in affected area.	Asymptomatic staff not exposed to ill residents in affected area. Alternate option: Exposed but asymptomatic staff.	
Precautions When Providing Direct Care	Routine Practices plus Droplet/ Contact Precautions.	Routine Practices plus Droplet/ Contact Precautions.	Routine Practices, unless whole area/facility under outbreak precautions use Routine Practices plus Droplet/Contact precautions.	
What PPE is Required?	Procedure Mask at all times. Add eye protection, gloves, and gowns for direct care.	Procedure Mask at all times. Add eye protection, gloves, and gowns for direct care.	Ideally, exposed staff are not providing care to asymptomatic residents outside of the affected area.	Gloves are to be changed between residents; between soiled and aseptic tasks on same resident. Hand hygiene performed between glove use.

			If required, to wear Procedure Mask at all times* and as per Routine Practices.	
Staff Screening and Monitoring	Screen twice per shift for respiratory symptoms including Temperature checks. This applies to everyone entering and leaving the facility.			All staff who develop symptoms are to immediately report symptoms to their supervisor/occupational health and safety representative and should not be in the workplace.

Appendix 2 – PPE Acquisition Contacts

All LTCHs should make efforts to adquire PPE through their usual source. In cases where this is not possible, LTCHs can contact their regional PPE and critical supplies lead(s).

Region	Regional Leads - PPE and Critical Supplies
Toronto	Co-Leads: 1. Rob Burgess (Robert.Burgess@sunnybrook.ca) 2. Nancy Kraetschmer (Nancy.Kraetschmer@tc.lhins.on.ca)
Central	1. Susan Gibb (Susan.Gibb@lhins.on.ca)
West	Lead: 1. Toby O'Hara (HMMSCOVID19@hmms.on.ca) – SW Sub-Leads: 2. Doug Murray (Doug.Murray@grhosp.on.ca) – WW 3. Sue Nenadovic (Sue.Nenadovic@niagarahealth.on.ca) – HNHB 4. Katelyn Dryden (Katelyn.Dryden@transformsso.ca) – ESC
North	Co-Leads: 1. Matthew Saj (sajm@tbh.net) 2. Michael Giardetti (giardetm@tbh.net)
East	Co-Leads: 1. Leslie Motz (lmotz@lh.ca) 2. Paul McAuley (Paul.McAuley@3so.ca)

ICHA | Inner City Health Associates

ICHA to deliver unique model of care during COVID for people experiencing homelessness in Toronto

March 31, 2020, Toronto -- Inner City Health Associates (ICHA) has assembled a diverse team to address COVID-19's disproportionate impact on Toronto's homeless population, drawing on provincial and multi-partner support.

ICHA's plan to identify, protect, care for and support people experiencing homelessness who are COVID-19 positive is being funded by the Ontario government. It is a carefully designed model of preventive and clinical nursing, peer and medical care. Clinical and emergency response professionals and people who have experienced homelessness will channel their expertise towards a common goal under an inter-connected effort, collectively known as *Safe Spaces & Care for the Homeless* (SCH).

ICHA is working with partners from government, the city's shelter system, community organizations and health system organizations to deliver targeted services within a safe environment that meets the highest possible health protection standards. Each partner has its own responsibilities. In addition to the model of care, ICHA is deploying physician services, nursing services (RN, RPN, Managers and a Director), peer support workers and case manages.

The clinical population health model is based upon emergency management principles and includes three essential, evidence-based components.

- *Preventive Isolation Facility:* A rapid roll-out of interprofessional nurse-led care teams with physician supports at a 200-room isolation facility to help people experiencing homeless who are awaiting COVID-19 test results over one to two days. This measure prevents the spread of potential COVID cases within the shelter system.

- *COVID Positive Isolation Facility:* A distinct COVID+ isolation facility for up to 400 people experiencing homelessness for up to 14 days to provide care, including mental health and harm-reduction services.

- A risk-guided social distancing and support intervention which will identify members of the homeless population based on their personal care and health protection needs. Information will inform care supports and rehousing strategies for the most vulnerable.

The values underpinning the *Safe Spaces & Care for the Homeless (*SCH) project include:

- **Safety** for those receiving and providing care and services; public protection against the risk of increased spread.
- **Inclusion, equity and sensitivity** - a commitment to reaching as many people experiencing homelessness as possible to provide health protection and dignified care with particular concern for those at greatest risk.
- **Compassion and empathy** – a commitment to provide care that is consistently dignified, deeply human, and truly personal.
- **Effective and Efficient** models of care to deliver the kind and quality of care that people who are experiencing homelessness deserve and that our resource-constrained health system requires and can deliver.
- **Collaboration and partnership** with a wide array of contributors in governments, the city's shelter system, community organizations and health system organizations.
- **Transparency and accountability --** open, honest and direct communication about our operations and stewardship of resources.

ICHA notes that people experiencing homelessness are more than two-to-four times more likely to require critical care than the general population and are two-to-three times as likely to die as the general population.

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For more information, please contact: Sine MacKinnon, Director of Communications, Inner City Health Associates, 647.201.7369, sinemackinnon@gmail.com or Matt Kellway, Director of Public Affairs, Inner City Health Associates, kellway@rogers.com 647.987.5917.

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ICHA's COVID-19 Response Mission and Management Principles

COVID-19 is an unprecedented health threat for people experiencing homelessness. Like many health providers, ICHA was not fully resourced or prepared to face this challenge. In a few weeks, every aspect of ICHA's operations and efforts have adapted to respond to COVID-19, with rapid growth, restructuring, redeployment, and new partnerships. We are bringing all of our organizational capacity and resources to this effort, including population health, clinical care, community and agency relationships, program development, management and advocacy.

ICHA's Strategic Plan will continue to guide our work. Our organizational vision is a healthy end to homelessness. We believe that all people experiencing homelessness must have the option for peaceful, secure and dignified housing. ICHA's response to COVID-19 is unified under the following mission and management principles.

2020-2023 Strategic Plan

Vision
A healthy end to homelessness.

Mission
1. To set the standard of excellence in the delivery of homeless health services.
2. To address and confront the social determinants of health and homelessness.
3. To advocate for peaceful, secure and dignified housing for all.

Values
Respect / Responsibility / Creativity / Courage / Humility / Compassion

ICHA's COVID-19 Response Mission is to prevent and reduce morbidity, mortality, suffering and inequity from COVID-19 among people experiencing homelessness in Toronto.

MANAGEMENT PRINCIPLES FOR THE COVID-19 PANDEMIC

For our patients and clients:

1. All people experiencing homelessness must have access to sufficient housing, physical space and supports to achieve appropriate and dignified social distancing and isolation as needed to protect health.
2. All people experiencing homelessness must have equitable access to interdisciplinary clinical care when diagnosed with COVID-19, and appropriate and dignified settings to convalesce and recover if not requiring hospitalization.
3. Protections and services must accommodate and respond to a diversity of strengths and needs among people experiencing homelessness.
4. We will preserve our commitment to continuity of care, harm reduction and trauma-informed principles to the greatest extent possible throughout our COVID-19 response.
5. COVID-19 creates concerns and threats specific to the needs and histories of Indigenous communities. ICHA's COVID-19 interventions will respond to the needs of Indigenous people experiencing homelessness, in reference to the Indigenous Definition of Homelessness.

For staff, including health-care workers and our partners:

1. We will not compromise the safety of our workers, nor ask our workers to compromise their own safety, to achieve our mission.
2. All caregivers must have access to a safe working environment that offers appropriate standards for infection prevention and control and occupational safety.
3. Safety standards must protect all workers equally and as appropriate to their work. This includes health-care providers, homeless service sector staff, administrators, peers, and others.
4. We will provide timely information to ensure our staff and partners are positioned to provide the highest possible level of care for our clients/patients.

For the community:

1. We will communicate and listen, and foster dialogue with frontline providers, community agencies, and directly affected individuals and communities.
2. Reducing infections among people experiencing homelessness is in everybody's interest. COVID-19 infection, outbreaks and transmission among people experiencing homelessness is essential to flatten the curve for all Torontonians.
3. Addressing COVID-19 requires teamwork and new partnerships. Our mission, and the needs of our patients and community, will determine when we lead, when we partner, and when we follow.

APRIL 2020