Ministry of Health
and Long-Term Care

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May 30, 2003

Interim Healthcare Alliance
Infectious Disease Control and Management Plan

Preamble

We have all learned a lot about the control and management of SARS over the last eight weeks, as a system, as individual facilities, as healthcare providers as health planners.

In response to lessons learned, and to meet the needs that have been identified by the healthcare system, the Ministry of Health and Long-Term Care (MOHLTC) has developed an updated Infectious Disease Control and Management Plan. A core component of that plan is the immediate establishment of the Interim Healthcare Alliance.

The new Interim Healthcare Alliance is a coalition of four GTA hospitals who have agreed focus concentrated resources on the assessment and treatment of SARS across the GTA. Three of the hospitals will form, regional network hubs - with the GTA divided into three management sectors plus a fourth site offering tertiary level support to all GTA SARS cases – all sites are equipped with specialized units and will be provided with dedicated staff support as required. This approach consolidates our SARS management expertise and builds upon our experiences to date.

Each of the alliance facilities will formalize agreements on staffing, resources and supplies; ensure that stringent transfer protocols are in place with facilities within their catchment zone.

Staff in the four centres will be provided with the optimal dedicated specialized Infectious Disease support, Infection Control expertise; our goal is the optimal safety and supports for staff, patients and the broader community.

In concert with MOHLTC, the designated facilities will implement a plan to transfer appropriate patients into alternate levels of care; the three named general site locations will also re-open specialized SARS screening clinics co-located at their site.

Forming this alliance will help us protect the healthcare system as a whole, while ensuring services keep running safely and efficiently.

Objectives:

- Maximize patient, staff and community safety
- Concentrate and focus of system expertise
- Maintain maximum possible functionality across healthcare system in the GTA
- Provide optimal support to all levels of staff

Assumptions:

- That ALL hospitals in the GTA will provide support, assistance and compliance with the management plan. Successful implementation of this plan is dependent upon timely and effective system cooperation.

- General healthcare services must continue and be appropriately protected, however we all must recognize that these are unusual times and it is NOT business as usual.

Context

By taking a systems approach, the Infectious Disease Control and Management Plan covers the following key areas:

1. Delineating the core expectations of all facilities in the GTA service provider system so the management plan has maximum effect.

2. Ensuring clear lines of access and communication between MOHLTC, Public Health units, Alliance facilities and the field in general.

3. Broadening and strengthening the link between healthcare operations and the scientific advisors to MOHLTC.

4. Ensuring and supporting effective and consistent communications within the Alliance, to the public, to other hospitals/staff and to Ministry of Health and Long-Term Care.

5. Strengthening all key supports for optimal system response (HHR, compensation, policy, criticall, EHS, CCAC)

Description and Required Commitments

MOHLTC has reached agreement with four GTA hospitals to form an organisational alliance which will focus the assessment, management and treatment of SARS across the GTA.

Three of the sites will form a sub-regional network hub to:

- formalize agreements on staffing, resources and supplies;
- ensure transfer protocols are in place;
- establish specialized units with dedicated staff who are given the necessary financial and working conditions incentives;
- develop a plan for moving patients in to alternate levels of care; and
- re-open the specialized SARS screening clinics co-located at all three sites.

The fourth site will offer specialized tertiary level care for SARS across the GTA.

Emergency Rooms

The Plan is built on the assumption that people will continue to go to emergency rooms at all hospitals across the city. This approach enables hospitals to continue to accept patients at their emergency rooms, and provides them with the tools to manage them appropriately, effectively, and safely. While a SARS triage system is designed to assist with broader system functionality - **it is imperative that full protections as dictated by POC directives remain vigilantly enforced AT ALL SITES IN THE GTA.**

To support this area-based approach, **a specialized transportation system and transfer protocols** have been put in place to transfer SARS/suspected SARS patients to the appropriate designated hospital. This system will have designated staff and vehicles.

To receive patients, three designated sites have each established **SARS assessment clinics** separate from the emergency room to screen and appropriately triage SARS/suspected SARS patients.

A detailed clinical protocol has been developed for clinicians and healthcare workers on how to assess patients, and how and when to transfer patients safely and appropriately (see appendix A attached).

This protocol has been developed based on most recent scientific information available, and on the direct experiences learned from the first outbreak of SARS in March 2003.

Long-Term Care

To enable the system to continue to operate in accordance with this Plan, MOHLTC is enforcing a move to 1a for discharges to long-term care sector asking clients appropriate for LTC facilities, to **move to first available bed** (select choice to LTC facility from there)

For those patients being transferred out to ALC who require 10 days quarantine, capacity has been arranged at the Brampton Leisureworld (Brampton Woods) site.

We are moving to co-locate SARS patients in order to free up other hospitals and to ensure an optimal system response capacity is in place.

REQUIREMENTS OF NON-DESIGNATED SITES WITHIN THE ORGANIZATIONAL ZONE

- Continue to accept and provide emergency services to all patients including initial assessment of suspect patients with SARS-like symptoms and then triage only in accordance with the patient transfer directive attached.

- Ensure full safety measures set out in the appropriate POC directives remain vigilantly enforced.

- Provide needed support to designated sites, as required, including, where required, staff support, expert advice and consultation, supplies and administrative support as needed.

- Provide timely Health Human Resource support to designated centers as requested. These commitments must be planned in advance and be stable - where additional resources are required for a designated centre MOHLTC is recommending **a minimum** commitment period for non-designated sites providing nursing supports to designated sites of 3 shifts (1 cycle, 37.25 hours).

- Non-designated sites must anticipate and respond to increased emergency volumes (ambulance and walk-in volumes) that will be re-routed from designated Alliance sites.

- To maintain surgical volumes across the system, hospitals may be required to decrease volume of non-essential services to their catchment area to accommodate increased surgical volumes from designated sites. MOHLTC will actively monitor system volumes and make adjustments as required.

- Ensure ongoing training for mask fitting – assistance with coordinating access to mask fitting services is available through 1-866-212-2272.

- Ensure the timely and accurate completion of all legally required reporting requirements to Public Health. ALL SITES ARE EXPECTED TO REINFORCE THE IMPORTANCE OF TIMELY AND ACCURATE REPORTING TO PUBLIC HEALTH.

REQUIREMENT FOR ALL ALLIANCE SITES

- Prior to full initiation of this plan each designated site in the alliance is to have a safety and readiness review undertaken with appropriate Infectious Disease and Infection Control expertise.

- All alliance sites are expected to ensure the availability of Employee Assistance Programs and appropriate staff supports to staff and their family members.

REQUIREMENTS OF THE 3 DESIGNATED GENERAL SITES

- Continue to provide intake and medical management of SARS and suspected SARS clients from the hospital catchment area and from the designated management zone for the facility. Transfers to be only undertaken in accordance with the transfer protocol.

- Establish and staff a dedicated SARS assessment clinic at each site.

- Ensure that full precautions are consistently enforced for all staff, ensure that mask fitting is in place as required.

- Ensure that the coordination and supports required are identified clearly to the support group established for each site and for the ZONE as established.

- Ensure that effective and coordinated communications plans are in place for all staff levels, community and zone facilities – communications should be coordinated with MOHLTC as appropriate.

- Ensure that all ALC patients are discharged to the designated catchment facility (Leisureworld, Brampton site).

- If designated hospital is a multi-site facility, ensure physicians are permitted to work at one of the other sites as long as there is adequate coverage maintained at designated facility

- Ensure that reports are provided regularly, quickly and accurately to Public Health. MOHLTC will be setting formal regular times by which data must have been provided to Public Health.

SUPPORT SYSTEMS FOR THE DESIGNATED SITES

- **Dedicated Infectious Disease specialist support availability**. MOHLTC will ensure that all I.D. support required by the designated sites is available on a 24/7 basis.

- **Dedicated Infection Control expertise on-site**. MOHLTC will ensure that all required Infection Control resources required are in place on an as needed basis. Levels will meet or exceed those recommended by the CDC.

- **Dedicated PTAC line and support for designated sites.** In order to improve the turn around time for facilitating transfers a dedicated line is available for questions at 416-392 -0939, FAX transfer requests 416 – 392 – 0954. Overall process remains unchanged per the Directive dated May 12, 2003.

- **Three Resource support groups** will be established to provide dedicated advice to each of the three sites – support group will encompass range of appropriate skill sets and be available to provide expert advice. Zone support groups will be chaired with by a partner CEO from within the zone.

    - Rationale: We recognize the stress and pressure on all levels involved in the containment of this outbreak and it is our collective to ensure that backup resources, advice and support is available to designated sites.

- All designated sites will have a single dedicated contact point at the Ministry of Health and Long-Term Care. Hugh MacLeod, Assistant Deputy Minister.

- All issues concerning compliance by other facilities with the requirements of the designated facilities, transfers etc are to be brought to the attention of Hugh Macleod.

REQUIREMENTS OF THE TERTIARY SUPPORT CENTRE

- The tertiary support centre shall provide tertiary and quaternary care as required to all GTA SARS cases requiring this level of care and to SARS transfers from non-GTA areas requiring tertiary care.

- Admissions, transfers and repatriations are only to be managed as outlined in the protocol.

- The tertiary support center shall also continue to provide primary care for SARS clients from the hospital catchment area.

- Ensure ongoing training for mask fitting is in place.

REQUIREMENTS OF THE CCAC SECTOR

- The CCAC sector is required to immediately enact emergency discharging for the designated facilities.

- Patient transfer is to proceed in the following priority order:
  - Etobicoke first – remaining three sites to follow based on assessment of ALC needs.
  - Rest of GTA system.

GENERAL SUPPORTS AVAILABLE TO ALL FACILITIES AND PROVIDERS

- **1-866 212 2272** line is available to provide a direct link to the **MOHLTC medical support group**. This line can provide you with direct advice on infection control, patient transfer,directive clarifications.

- **Mask Fitting:** MOHLTC is able to facilitate access to mask fitting agencies and organizations to assist your facility or agency. Contact the number above for further information.

- **Categorization Levels:** Centralized process is in place to review and approve any modifications and or changes to the categorization of given facilities. Contact is Alison Stuart at 1-866-212-2272.

- **Science Group:** MOHLTC is establishing a provider reference group to provide input and guidance to the Science Committee. Hospital representation on the Science group is being initiated. The purpose of this approach is to allow the Science group to obtain timely input and advice from the field regarding protocol development and refinement and to provide a field perspective to the scientific advisers to MOHLTC.

- **Web-Site.** MOHLTC is immediately upgrading web-based resources available to all facilities/agencies and will be establishing a dedicated electronic forum for the designated facilities. Site will provide web-based hyper-link for healthcare providers to Science Committee, World Health Organization, Health Canada, US Centres for Disease Control, etc.

- **Dedicated Public Health Support Line:** A dedicated phone line for hospitals needing to contact Toronto Public Health has now been established that number is **416 - 338 - 1119**

- **Mobile Response Team:** MOHLTC has established a critical care mobile response team. This team has mobile critical care capacity and the potential to be

deployed anywhere in the province within 24 hours. This capacity is in addition to the mobile teams in place to provide public health assistance.

- **Connection between PH and acute care system including:** MOHLTC is creating a strengthened internal capacity to undertake daily analysis of data re # patients with SARS

- MOHLTC is also providing additional supports on an urgent basis to Toronto Public Health to achieve two goals a) ensure faster data validation and review b) ensure timely response to all telephone enquiries.

Identifying Needs

Facilities and agencies are to be provided with a detailed template for capturing on a daily basis, capacity, volume and associated issues. These templates are the vehicle for the field to flag resource issues and to provide the Ministry a real-time picture of service levels. Templates are currently under development and will be distributed shortly. MOHLTC will provide more detailed reporting requirements in the near future.

Enforce need with the field – direct, provide template to id what's wanted, and monitor it's coming in, define categories (within definition – here are reporting requirements and time requests)

Exceptional circumstances will be addressed by MOH

Ministry of Health Structure and Support

- Protocols signed by the Deputy Minister and the Chief Medical Officer issued by MOHLTC are the source of direction for facilities and agencies. All other advice, recommendations, commentary are to be considered secondary to the issued protocols.

- For all the designated sites there is a direct contact – Hugh MacLeod, Assistant Deputy Minister

- For all non-designated sites – the contact line for SARS related questions and assistance is available at 1-800 212 2272. **This line is to be used by ALL facilities for reporting.**

DAILY COMMUNICATIONS

In order to formalize the communications flow between the field and MOHLTC effective Friday 30th the following daily schedule will be in place for field communications.

07.30 Science Group plus hospital representative

08.00 Hospital Submission of Data to Medical Support Group
Hospital Categories confirmed

08.30 SARS Executive meeting

09.30 Updated clinical data categorized and consolidated. Posted to MOHLTC website.

09.30 Teleconference – Four Alliance Hospitals and MOHLTC. Standing Agenda and Hugh Macleod to Chair.

10.00 Teleconference – GTA hospitals. CCAC CEOs, Lead LTC administrator, MOHLTC. Standing agenda, consistent chair – one hour max.

13.00 MOHLTC Executive meeting – Phil Hassen Chairs

14.30 Pre-brief for Media Release. MOHLTC and others as designated.

15.00 Media Briefing: MOHLTC and others as required.

18.00 Teleconference 4-lead hospitals and MOHLTC – HUGH Macleod

20.00 Communique Issued - MOHLTC

NOTE: ALLIANCE HOSPITALS ARE ONLY REQUIRED ON THE 9.30 and 18.00 UNLESS OTHERWISE NOTIFIED BY MOHLTC.

PROTOCOL

Systems Model – Current SARS Toronto Crisis

Interim Healthcare Alliance

Groupings:	**Ontario Support Network:**
North York General Hospital	London / Ottawa

- Sunnybrook and Women's College Health Sciences Centre (T)
- Southlake Regional Health Centre
- Baycrest (R)
- St. John's Rehabilitation Hospital (R)
- Centre for Addiction and Mental Health
- Westpark Healthcare Centre (R)
- Markham-Stouffville Hospital
- York Central Hospital

William Osler Health Centre – Etobicoke Campus — Hamilton / Niagara

- University Health Network – all sites (T)
- Halton / Peel Hospitals (all four Corporations)
- Humber River Regional Hospital
- St. Joseph's Health Centre
- (supports Pearson airport)
- Transfer from non-GTA centre hospitals requiring in-patient care

Scarborough Hospital - General Division — Kingston

- Mount Sinai Hospital (T)
- Lakeridge Health
- Toronto East General Hospital
- Rouge Valley Health System
- Scarborough Hospital – Grace Division
- Bridgepoint Hospital (R)
- Providence Centre (R)

St. Michael's Hospital

- Casey House and local walk-ins

Additional provincial components include the provision of Paediatric SARS care at the Hospital for Sick Children and SARS autopsy capacity at the University Health Network.

A. Patient Access to the Alliance

Patients identified using the MOHLTC-approved screening tool will be transferred to their designated Alliance hospital institution for admission. Transfer should occur by appropriate means (ambulance or non-ambulance) using personal protective equipment and appropriate infection control measures.

If the designated Alliance institution does not have sufficient in-patient capacity, the patient will be transferred to another institution in the alliance. CritiCall should be contacted in order to find a suitable bed within the alliance for this patient.

Once the bed is located, the Provincial Transfer Authorization Centre (PTAC) should be contacted to carry out the transfer.

Patients who present for SARS screening at other health care facilities will be assessed using the same assessment and screening tools.

Patients requiring admission due to SARS will be transferred from these facilities to a member of the Alliance for admission.

CritiCall should be contacted in order to find a suitable bed within the alliance for this patient. Once the bed is located, the Provincial Transfer Authorization Centre (PTAC) should be contacted to carry out the transfer.

B. Patient Transfers within the Alliance

St. Michael's Hospital will act as a Tertiary Care referral centre for other Alliance Hospitals, providing the full range of tertiary care. The decision to transfer a patient to a critical care bed at St. Michael's Hospital will take into account the complex patient care needs not currently available at the sending institution.

When the patients needs no longer require a tertiary care setting, the patient can be transferred back to the originating facility. Coordination of transfers will occur using CritiCall to locate the appropriate bed, and physician-to-physician contact to ensure appropriate transfer of patient care.

C. Patient Transfers from the Alliance to non-Alliance Hospitals

Under rare and exceptional circumstances a patient admitted to an Alliance Hospital may need to be transferred to a non-Alliance Hospital to obtain a health care service on an emergent basis.

The emergent patient transfer should utilize the existing patient transfer process, including bed location via CritiCall, transport coordination via the PTAC, and physician-to-physician contact to ensure appropriate transfer of patient care.

The receiving hospital must ensure that all appropriate precautions are in place to prevent further spread of SARS within the hospital. The patient should return to the originating facility as soon as medically appropriate.

D. Critically Ill Patients

Currently, the following patients are more likely to need critical care resources: advanced aged (age over 65), co-morbid illnesses (in particular diabetes), and bilateral infiltrates on chest x-ray. Given that these patients may pose a particular risks to health care workers, it is recommended that early transfer to the critical care unit may allow for a more controlled approach to high risk procedure such as endotracheal intubation.

In addition to the usual criteria for critical care admission, early transfer to a critical care unit should be considered for patients with dyspnea (respiratory rate >30) or a high inspired oxygen requirement (FiO2 > 0.6 to maintain SpO2 > 90%).

E. Patient Discharge from Hospital

Patients admitted to an Alliance Hospital who have recovered and who are ready for discharge can be discharged in keeping with existing MOHLTC Directives. The exception to the existing directives is in the case of patient discharge from a category 2 or 3 hospital to a Long-Term Care Facility. These patients cannot be discharged into the general Long-Term Care population. A designated Long-Term Care Facility will be identified to except these patients. If a patient in a category 2 or 3 hospital requires transfer to an Alternate Level of Care facility, please contact the Ministry of Health and Long-Term Care at (416) 326-8564 between 9:00 am and 5:00 pm.

F. Resource Requirements

The creation of the Alliance involves significant resource allocation to the Alliance members in order to meet the needs of SARS patients while maintaining a safe working environment for the Alliance's health care staff. The MOHLTC will assist

Alliance members to recruit and retain staff required to achieve this goal (see below).

The Alliance will also require modifications in existing physical plants, as well as additional supplies and equipment. The MOHLTC will also facilitate this in order to ensure SARS patients can obtain the care they require in a timely manner.

G. Human Resource Planning

Hospitals within the alliance will need to identify the human resource requirements that they have based on the model they propose to manage SARS patients in the following areas: SARS assessment unit, ER, SARS ward and Intensive Care Unit.

Experience has shown that repeated infection control training, regular and frequent breaks, places to have the breaks and psychological support are key elements to staff health and well being.

H. Physician Resources

Below are proposed models to manage the physician component of each SARS area listed above.

- <u>SARS Assessment Unit:</u> Physicians to staff this unit can be drawn from Family Medicine, General Practice, Emergency Medicine and General Internal Medicine. It is essential that these physicians have infection control training and constant infectious disease backup; public health contact is also crucial. These physicans will have triage protocols to refer to for appropriate patient disposition. They will have one number to call for a SARS bed if such a bed is not available in their own institution (the first priority is to send a new SARS patient to their own institution).

- This will be managed through CritiCall (1 800 668-4357) for both Critical Care beds and SARS ward beds. CritiCall will be responsible for managing an ongoing real-time SARS bed availability for the alliance hospitals. Alliance hospitals will be provided with on site facilities.

- Ideally these units will have adjoining facilities for staff breaks. In addition radiology should be provided portably in the assessment unit, alternatively in the institution with adequate infection control precautions.

- <u>SARS Ward:</u> Physicians to care for patients admitted to the SARS wards can be made up of General Practitioners, Family Practitioners, General Internal Medicine, Respiratory Medicine, Emergency Medicine and others as determined by the Chief of Staff. During days, patients ideally should be managed in a ratio of 10 patients to 1 physician. The physicians should

work in 8-12 hour shifts with 24 hour Infectious Diseases and Infection Control backup. The Infectious Diseases consultant ideally will meet with the physician in charge daily to review all patient issues. In addition infection control training needs to be available before any physician works in the area and on an as needed basis. This training across the institutions should follow a consistent standard model. A mobile infection control training team will be made available to assist the on site infection control individuals with this issue.

- Infectious Diseases and Infection Control: Depending on hospital size and patient volume, there should be 2-3 infectious disease specialists / consultants available on site. In addition 1.0 FTE infection control physician with adequate infection control nursing support. As a relief support, there should be a pool of 2-4 infectious disease consultants to relieve site specific individuals.

- Critical Care Areas: As outlined above, patients should ideally move to critical care areas sooner rather than later so that high risk procedures can be preformed in a safe and timely fashion. Hospitals within the Alliance currently have a grouping of fulltime intensivists working within a closed ICU model. Ideally, 1 intensivist should cover 12 beds on a 8-12 hour basis. The hospital will need a 24 hour "intubation team" available to support the Critical Care group as per previous directives; many institutions have done this through the anaesthesia department. It is crucial that members of this team have adequate and repeated training of personal protection systems.

- Public Health: All SARS hospitals must have one public health physician and/or available on site as a resource for public health issues. As well, a public health RN will be required at each site.

I. Identification of Physician Resources

A registry of physicians available to work in these alliance institutions as needs arise must be developed. This should be accomplished by contacting the Chief Medical Leaders at institutions outside the GTA and asking them to provide lists of physician volunteers in key specialties, these institutions should be directed by the MOHLTC to allow volunteers to go to Alliance hospitals, as needed. MOHLTC will continue to actively pursue physician resources from outside GTA and other jurisdictions as required.

J. Coordination process for Non-Physician Resources

Non–Physician Resources within each grouping will be by facilitated through a coordinating group of physicians, nurses, and support staff from that grouping. The chair of the coordinating council will be a representative from another grouping (e.g. Chair for the Etobicoke group is from North York group). This

coordinating will discuss all staffing needs for their group, taking into consideration the overall needs of the Alliance, and develop strategies to manage their needs. The authority within the group rests with the Chair, with final authority resting with the Ministry of Health and Long-Term Care. It is crucial that organizations within the grouping release staff (e.g. Nursing, Respiratory Therapy, Environmental Services, Pharmacy etc.) who volunteer to be redeployed to the required facility.

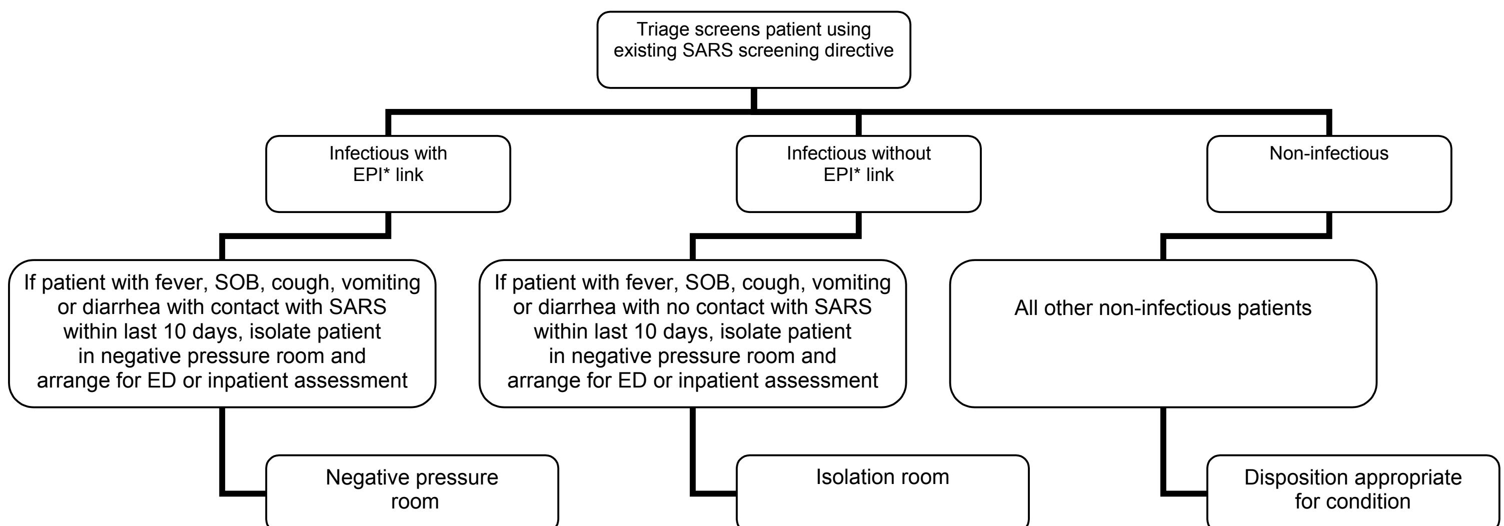
K. Process of Human Resources

It is expected that alliance member hospitals will identify human resource needs into the future and review them on a daily basis. Concerns will be brought forward to the governance council for help as required. The governing council will have a staffing coordinator who will match needs with availability of staff. This process (i.e. which site provides staff support) will be decided through consensus. In the event of lack of consensus the view of the chair will prevail. Staff movement is expected to occur within the grouping first and perhaps across groupings as needs arise.

L. Physicians working in Designated SARS Facilities

Physicians working in designated SARS organizations whose incomes are reduced because of restricitions for infection control purposes will receive a top up to their billings to 100% of their adjusted average monthly income for the time the organization is designated SARS Facility. They will be required to be identified by the organization's CEO and registered for that purpose with OHIP.

Figure 1. Triage Process Flow Chart for Patients Presenting for SARS Assessment



*epidemiologic links: close contact with a SARS patient or travel to affected area of endemic within last 10 days, health care worker, family member is health care worker, or with person with pneumonia