

SARS and Community Care: Impact and Opportunities

Prepared by the
Ontario Home and Community Care Council

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About the Ontario Home and Community Care Council

The Ontario Home and Community Care Council (OHCCC) was formed in October 2002 to create a common vision for the home and community care sector in Ontario. The OHCCC consists of the following members:

- Ontario Association of Community Care Access Centres (OACCAC)
- Ontario College of Family Physicians (OCFP)
- Ontario Community Support Association (OCSA)
- Ontario Home Health Care Providers' Association (OHHCPA)
- Ontario Federation of Community Mental Health and Addiction Programs (OFCMHAP)
- Ontario Pharmacists Association (OPA)

This report describes the impact that Severe Acute Respiratory Syndrome (SARS) had on primary care and community health services in Ontario, reinforces the importance of emergency preparedness, highlights the vital role of community care in future disease outbreaks or health emergencies, and underscores the serious public health risks of concentrating a broad range of non-acute services in acute care sites.

Council members wanted to document the community's experience with SARS, highlight the lessons learned, and recommend changes in the system to ensure any future health emergencies or infectious disease outbreaks are handled appropriately and effectively.

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SARS and Community Care: Impact and Opportunities is available in electronic format on all OHCCC members' websites:

OACCAC – www.oaccac.on.ca

OCFP – www.ocfp.on.ca

OCSA - www.ocsa.on.ca

OHHCPA – www.homecareontario.ca

OFCMHAP – www.ofcmhap.on.ca

OPA – www.ontpharmacists.on.ca

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Executive Summary

SARS was a reminder, a warning and an opportunity.

Dr. David Naylor, Chair of the National Advisory Committee
on SARS and Public Health, October 7, 2003

The health care system is more than bricks and mortar. It is people helping people.

Ontario College of Family Physicians, September 29, 2003

*The future health of the population of Ontario depends on our willingness to
re-engineer the way the system works together to deliver care.*

SARS and Community Care: Impact and Opportunities
Ontario Home and Community Care Council, November 2003

For several weeks in the spring of 2003, Ontario's health care system struggled to manage two outbreaks of Severe Acute Respiratory Syndrome (SARS). That experience taught us five key lessons:

1. Emerging infectious diseases are a serious health risk, and we cannot afford to become complacent about infection control. All people in all parts of the system must be appropriately trained and equipped to manage infectious diseases.
2. In Ontario's highly interdependent health care system, all parts are affected by a disease outbreak, and all parts must be prepared and involved from the beginning. Fast, effective, appropriate communication across the entire system is essential.
3. Infectious diseases spread easily in acute care settings. The ongoing trend to locate non-acute outpatient services – such as primary care, wound care, mental health and addiction services, health teaching for chronic illnesses (e.g., diabetes and asthma), cancer treatment, and laboratory testing – in acute care settings represents two serious and unnecessary risks to health:
 - When people whose health is compromised by chronic diseases access these services in an acute care setting, they can be exposed to infectious diseases, and become ill. They can also increase the risk of community spread.
 - When the acute care setting appropriately institutes a quarantine or limits access to its site during a serious infection outbreak, people who need these vital non-acute services can no longer access them, and the general health of the population suffers.
4. The trend for health care providers – particularly nurses, therapists, personal support workers, and volunteers – to work in both acute and non-acute settings in order to meet the needs of these facilities/organizations and generate full-time incomes, increases the risk of spreading infectious diseases from one setting to another. When, as was the case with SARS, providers and volunteers are limited to working in one setting only, the system's capacity to provide care is severely reduced, organizations

must struggle to meet the demand for services, the health and well-being of the public is threatened, and the health care providers suffer financially.

5. To protect public health and strengthen our public health system, Ontario should strive to keep people out of high-risk hospital environments by delivering more care in the home and community. When the primary health care system is strong and community services are allowed to provide the appropriate type/level of service for people in their homes, the need for hospitalization is reduced and the risk of exposure to infectious diseases can be avoided.
 - To ensure it is able to fulfill its role during infection control outbreaks, the home and community care system must have good access to public health staff and skills.

Given the recent trends in infectious diseases and the potential for a new influenza pandemic, Ontario ignores these lessons at its peril. Since the 1970s, more than 30 new diseases have emerged.¹ Old diseases are reappearing where they had been eliminated and appearing where they have never been seen before. Like previous generations, we now know what happens to a health care system when there is no quick antibiotic “fix”. We have to accept the fact that the days of relying on antibiotics to stop all infectious diseases are gone. In the wake of SARS, we need new thinking to address the threat that infectious diseases and other health emergencies pose to the integrity of the health care system.

As the Ontario Ministry of Health and Long Term Care moves to address the system weaknesses identified during SARS, the Ontario Home & Community Care Council (OHCCC) strongly urges a broad system-wide approach. To date, the “new normal” has focused on reviewing gaps in existing public health services and enhancing the ability of hospitals to manage infectious diseases; however, if the primary care and the community sectors are ignored, and we fail to change the way the whole system is organized and delivers care, Ontario will have lost a great opportunity to make significant change.

The future health of the population of Ontario depends on our willingness to re-think and re-engineer the way the system works together to deliver care. We know from the work of Dr. Barbara Starfield, University Distinguished Professor at John Hopkins School of Public Health, that the countries with the best health outcomes and the lowest expenditure of GDP have strong primary health care systems. SARS reinforced the vital role that family doctors play in our health care system, the potential role the community sector can play given

The system has to get over its “edifice” complex. The public sees hospitals as the centre, and the hospital is now housing everything, including coffee shops. But this is counterproductive to good infection control. To reduce the risk, we need more care in the community.

Pharmacist

¹ Outbreak: the climate connection. The Globe and Mail, August 30, 2003.

appropriate resources, and the critical importance of timely, sector specific information.

In its efforts to respond to SARS, the Ontario Ministry of Health and Long-Term Care (MOHLTC) should be commended for :

- its efforts to provide information
- its willingness to increase service levels and allow the home and community sector to provide the type and level of support required to keep people in their homes and avoid hospitalization
- the more simplified decision making process developed during the crisis, which allowed organizations to be innovative in their responses.

By supporting family doctors and allowing the community service sector to provide the support that people needed to stay in their homes, the MOHLTC demonstrated how effective the community can be in avoiding unnecessary visits to the Emergency Department and unnecessary hospitalization.

We must build on these lessons learned.

Recommendations

The OHCCC believes that some lessons learned during SARS point the way to more effective, efficient ways to maintain health and deliver care. The OHCCC recommends that Ontario build on that experience, and take concrete steps to strengthen and improve primary care and community-based services, and increase their capacity to respond effectively to health emergencies.

To Improve the Organization and Delivery of Services

1. The system should assess how health services and health education are organized, located and delivered in order to reduce the concentration / centralization of these services on acute care sites, and ensure that future hospital-based health emergencies do not affect access to primary care and non-acute, out-patient services, such as wound clinics, health teaching clinics for chronic disease, mobility clinics, and teaching sites for both health professional students and client instruction.
2. The Ministry of Health and Long-Term Care should create a Community Health planning group to:
 - analyze the shifts in service that occurred during the outbreak
 - identify the increase in community service visit maximums required to improve health and reduce the need for hospitalization
 - launch pilot projects to build on the experience gained during SARS and assess the capacity of community services to support people in their homes and the community
 - encourage all Ontario communities to establish local working groups of all health care providers to explore the potential to develop cost effective, efficient and safe ways to transfer non-acute care into the community.
3. The MOHLTC should work with colleges and universities to continue to expand and support teaching opportunities for health sciences students outside the acute care sector in order to ensure that their learning opportunities are not disrupted during an outbreak or health emergency.

To Improve Communications within the Health Care System

4. The Ministry of Health and Long-Term Care should:
 - establish a single authoritative source (“Command Centre”) for accurate, up-to-date information
 - develop an effective communication network that will connect **ALL** professionals and agencies in the health system, including home and community care providers
 - ensure all providers have the capacity within their budgets to purchase information/communication technology and equipment.
5. The Command Centre should ensure that people familiar with practice environments in the community are involved in developing guidelines and directives for these settings. To ensure consistency, the Command Centre should make it clear which directives are mandatory and for whom, and how the mandatory guidelines should be applied.
6. The Command Centre should identify leaders/respected authorities in each sector (e.g., a doctor who can speak to physicians, a therapist who can speak to therapists’ issues, a nurse leader for nursing issues) who can provide direction to their sector during a health emergency.
7. The system should identify the types of tasks that should be done centrally in a community in a health emergency (e.g., signage for clinic and office doors, purchasing and distributing supplies) as well as the organizations responsible for those tasks.

To Improve Supply Chain Management

8. All home and community care providers should maintain a one-week supply of personal protective equipment on site.
9. The health care system should develop a centralized supply chain management system for the home and community care sector that would:
 - provide supplies in a form and size appropriate for the care settings
 - include private health care providers
 - address access to gasoline and other supplies essential to the delivery of home and community care
 - reduce the pressure on individual practitioners and small organizations to source, distribute and manage infection control supplies.

To Improve Health Human Resources Capacity and Management

10. The system should assess the impact of current staffing practices on quality of care, client satisfaction, professional satisfaction, and the ability of the system to respond to health emergencies.
11. The community sector should work with the education system to ensure curricula for nursing, rehabilitation therapy, personal support worker (PSW), and supportive housing or case management staff provide the knowledge and skills to manage infection in home and community settings (e.g., containing an outbreak, maintaining infection controls in decentralized sites such as the home, where other people are living). Home and community providers should also develop a more collaborative, consistent approach to continuing education, infection control, and service delivery.
12. In the case of a health emergency, the Ministry of Health and Long-Term Care should examine the deployment and scope of practice of health human resources as well as administrative practices in order to ensure the system has the flexibility to use professional skills as required to meet needs.
13. The Ministry of Health and Long-Term Care should work with the community to review services and identify those that should be deemed essential during a disease outbreak.

To Increase Emergency Preparedness

14. The health care system should develop system-wide emergency preparedness plans that identify all the resources and skills in the system, how patients/clients will be managed, and how all partners will respond to any loss or limitations in one part of the system. As part of that plan, the system should consider designating specific hospitals within a geographic area to centrally manage infectious disease outbreaks. It should also develop flexible structures that will allow the system to shift people and resources from one part of the system to another to meet needs.
15. The system should develop standardized, integrated Emergency Response Protocols for home and community care. All community providers should be trained in the risks associated with communicable diseases and in infection control procedures. Organizations should have emergency response plans in place, that include access to appropriate supplies, information, education and support. The system should develop standardized client classifications for infection management in home and community care that family doctors, pharmacists in the community, service providers and CCACs can understand and use.
16. The system should identify the organizations at each level responsible for coordinating activities during a health emergency or outbreak, including: the proposed “Centre for Disease Control” at the national level, the Ministry of Health and Long-Term Care provincially, the District Health Councils in the regions, and organized emergency measures groups locally, which would include hospitals, CCACs, physicians, residential care facilities, schools, municipalities, and health care provider organizations.

Introduction

While hospitals were the focus of media reports about SARS, they were not the only part of the system deeply affected by SARS. Hospitals do not exist in a vacuum. They are part of a highly interdependent network of health programs and services. The same patients who are treated in hospital are also seen in physicians' offices, outpatient clinics, community-based programs, and receive home care services. The same nurses, therapists, personal support workers and volunteers who provide care in hospitals may also work for community care organizations or long-term care facilities. The same family physicians who see patients in their offices, at home or in long-term care facilities also see patients in hospital, work in emergency departments and deliver babies in hospital. Many pharmacists working in hospitals also work in community settings, and patients discharged from hospital and their family members seek advice and information from pharmacists. When a disease like SARS affects one part of this interdependent network, the repercussions are felt everywhere.

Challenges in Home and Community Care

During the outbreaks, the home and community care sector – family physicians, Community Care Access Centres, organizations that provide home health care services, community support services, pharmacists and community mental health and addiction services, faced six main challenges that highlight the need for broad systems thinking:

1. The impact on demand for care – both for those affected by SARS and for those who could no longer access hospital-based services affected by SARS
2. Access to information and applying that information in community settings
3. Supply chain management
4. The impact on human resource
5. The financial impact
6. Emergency preparedness

I. Impact on the Demand for Home and Community Care

SARS had four main direct impacts on the demand for home and community care:

1. More requests for information

Physicians, pharmacists, home care providers and community-based organizations received many SARS-related calls from clients and members of the public, and had to devote many hours to answering questions and reassuring people.

2. Demand for services from people in quarantine or recovering from SARS at home

Home care services provided nursing and/or homemaking services for people in quarantine and people recovering from SARS at home. Supportive housing programs and community mental health and addiction agencies had to adjust their programs to cope with clients who were in quarantine.

3. Demand for services to replace hospital-based outpatient and other services that were no longer available

During the outbreaks, a number of hospitals closed out-patient services and severely restricted access to their sites. This proved to be a particular problem for:

- people with mental health problems who were unable to access regular psychiatric services and medications provided by hospital-sponsored clinics
- people with chronic illnesses, such as cancer, heart disease and diabetes, who could no longer receive out-patient services at affected hospitals
- patients scheduled for hospital-based therapy
- people recovering from surgery who would usually go to the hospital for wound care
- residents of long-term care facilities who go to hospital emergency departments for treatment of health problems
- clients seeking withdrawal management and other addiction services -- at least 15 of 42 addiction programs in Toronto and the surrounding regions, closed or withdrew some services during the outbreaks
- health care professionals in training who lost access to hospital-based training programs.

Clients who couldn't get services in hospital were calling for supports, so we had to provide more care. We found that by increasing service levels we could keep people at home. It worked so well, we wonder why it isn't normal practice.

Home health care provider

In many cases, community-based programs and providers filled the gaps. For example, community laboratories provided testing services for hospital outpatients who could no longer access hospital labs. Family physicians extended their office hours, and saw more people with urgent health problems who were afraid to go to hospital emergency departments. Some family physicians organized to provide care for residents of long-term

care facilities who had urgent health problems (e.g., fevers, falls, lacerations, urinary tract infections) so they could avoid hospital emergency departments. Many used their connections with physicians in hospitals not affected by the outbreaks to make alternatives arrangements for their patients. Supportive living services had to isolate clients who were exposed to SARS from the rest of the residents in collective living situations. Pharmacists went to extraordinary lengths to source supplies of masks for professionals and members of the public. They also offered space for physicians and other programs whose offices were affected by the hospital quarantines. Community-based mental health services organized alternative psychiatric services for their clients.

4. An increase in services to reduce the need for hospitalization

During the peaks of the outbreaks, hospital admissions were restricted to high priority acutely ill patients. All others were cared for in the community. During this period, the Ministry of Health and Long-Term Care is to be highly commended for quickly (within the first days of the outbreak) approving a request from community care providers to exceed normal service maximums in order to provide the level and type of services required to avoid hospitalization. For example, the Scarborough CCAC provided enhanced personal support and nursing services to approximately 20 clients who had their surgeries or medical interventions delayed. In York Region, the CCAC provided enhanced services to 21 individuals, including a child who had complex health problems and required IV, palliative clients who needed additional personal support services to be cared for at home, clients who could not be admitted to long-term care facilities, and a dependent client whose caregiver was quarantined and not able to provide the usual level of care. These are excellent examples of how the system can react quickly and responsively to address health needs.

Lessons Learned

- In contrast to acute care services, home and community care is not episodic in nature. Home and community care providers – physicians, pharmacists, home care agencies, community-based organizations, and mental health and addiction agencies – have developed long-standing relationships with the people they serve. During a health emergency, the public relies on community care providers for information, reassurance and care.
- Non-acute services located in acute settings are highly vulnerable during disease outbreaks.
- Many services now delivered in hospital settings can be provided effectively and efficiently in other settings and in other ways.
- Providing higher levels of community care -- particularly in nursing, therapies, drug counseling, medical care, personal and practical support, personal hygiene, meals and transportation -- is a highly cost effective and efficient way to care for people at home and avoid/reduce the need for hospitalization.

Recommendations:

1. The system should assess how health services and health education are organized, located and delivered in order to reduce the concentration / centralization of these services on acute care sites, and ensure that future hospital-based health emergencies do not affect access to primary care and non-acute, out-patient services, such as wound clinics, health teaching clinics for chronic disease, mobility clinics, and teaching sites for both health professional students and client instruction.
2. The Ministry of Health and Long-Term Care should create a Community Health planning group to:
 - analyze the shifts in service that occurred during the outbreak
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 - launch pilot projects to build on the experience gained during SARS and assess the capacity of community services to support people in their homes and the community
 - encourage all Ontario communities to establish local working groups of all health care providers to explore the potential to develop cost effective, efficient and safe ways to transfer non-acute care into the community.
3. The MOHLTC should work with colleges and universities to continue to expand and support teaching opportunities for health sciences students outside the acute care sector in order to ensure that their learning opportunities are not disrupted during an outbreak or health emergency.

II. Information and Communication Issues

The community faced two main communication challenges: getting information about SARS and applying that information in community settings.

1. Getting accurate information

In the early days of the first SARS outbreak, some home and community professionals and organizations found it extremely difficult to get accurate information. Early communication efforts focused on the public health and hospital sectors, and did not recognize the implications for community services or the potential to use community providers (e.g., pharmacists, physicians, community organizations) to help communicate with the public. As a result:

- Professionals and organizations in the community could not find a single authoritative source for information and directives that applied to the home and community care system.
- Community professionals and organizations received conflicting information from a number of different sources. This meant there was no consistent approach to infection control procedures in the community (i.e., some physicians wore masks, other didn't), which affected both public and provider confidence.
- Family physicians, pharmacists and community organizations were unable to get through on the public health lines set up to handle their calls.
- Service providers found the Provincial Operations Centre (POC) website difficult to use.²
- Early information, guidelines and directives were developed for the acute care sector, and were not always appropriate or useful in a community setting.
- Public health did not track or monitor people in quarantine in the community. Providers and organizations had trouble getting information about when quarantines could end, and when highly restrictive precautions and protocols were no longer required.
- Patients rely heavily on the Telehealth line, but the information provided by that line was not always consistent with that provided by the public health line.
- The Telehealth service was overloaded with SARS-related calls so people calling about other health problems couldn't get through.

The public health department line often gave out information that didn't match the most recent directives. This caused confusion for staff and clients.

Community service provider

² Evaluating the Effectiveness of the 10 GTA and Surrounding Area CCACs' Response to the SARS Emergency, July 2003.

A communication success story

While many working in the community were frustrated by lack of clear communication, some had a different experience. By day three or four of the first SARS outbreak, those community-based programs and services that were publicly funded and had a direct relationship with the Ministry of Health and Long-Term Care (i.e., CCACs) had mobilized to develop a more effective communications strategy. For example:

- The MOHLTC staff at the POC and the CCACs organized daily conference calls with representatives of the 10 CCACs in the Toronto area to discuss the impact of directives, daily issues and strategies; they also organized weekly teleconferences with other CCACs across the province. The Ontario Association of Community Care Access Centres (OACCAC) provided administrative support for the teleconferences (i.e., preparing and distributing minutes).
- Executive directors of the CCACs adapted SARS directives for use in the community and developed draft guidelines, which were then reviewed and approved by the POC scientific committee.
- A CCAC representative was added to the POC scientific committee.
- CCACs issued daily electronic communiqués to all their service providers to keep them informed and ensure that all agencies in the GTA providing services funded by the Ministry were getting the same information.
- The MOHLTC arranged teleconferences with community support service representatives so they could get information and have their questions answered.
- The CCACs participated in teleconferences with long-term care facilities and played a pivotal role in helping to transfer more than 600 people from hospital to long-term care settings.
- The CCACs helped link other providers into their network, including Children's Treatment Centres, supportive housing providers and programs for people with physical disabilities.
- The different CCACs also worked co-operatively together and divided up responsibilities.
- The CCACs developed training in infection control, and ran training programs for community support service providers.
- Some CCACs translated SARS information and directives into different languages and shared their translations with other organizations.

The CCACs acknowledge that it was extremely helpful to have someone in the POC who understood the needs of the community, and was able to help them get the information and tools they needed.

There were also other efforts to keep community professionals informed. For example, the MOHLTC worked with the Ontario Medical Association (OMA) to communicate with physicians, and a family physician was added to the POC scientific committee. The MOHLTC also worked with the Ontario Federation of Community Mental Health and

Addiction Programs (OFCMHAP) and Ontario Community Support Association (OCSA) to ensure transfer payment organizations received basic information.

Experience in the private sector

Other community providers (e.g., pharmacists, community organizations, community mental health and addiction services, and agencies that provide private nursing and support services, physiotherapy, occupational therapy, speech-language pathology, dietary and social work services) continued to have difficulty getting information – despite that fact that many were serving clients who attended programs at the affected hospitals and were either in quarantine and/or unable to get the outpatient services they needed. Many of these key home and community care providers had to listen to news reports on local radio and TV stations to determine how to act to protect clients and staff. Some were even told “not to worry” about the possibility of transmitting or contracting infection. Fortunately for patients and the broader community, home and community care providers in the private sector did not heed this advice. Instead, they sought ways to find information that would allow them to demonstrate due diligence in infection control and containment. Without their responsible behaviour, the situation could have had much more serious public health consequences.

When many organizations had problems getting information, their health care associations (in particular, members of the OHCCC) stepped in to fill the communication gap. For example:

- The Ontario Home Health Care Providers’ Association (OHHCPA) posted all ministry directives on its website and held weekly teleconferences with members outside the 905 GTA area to help them prepare for any spread of SARS.
- Family Physicians Toronto (FPT), an organization that represents 2000 family doctors in the Toronto area, developed guidelines and improved communication.
- The Ontario Pharmacists Association (OPA) used its extensive, well-developed communication system to keep all its members informed.
- The Ontario Federation of Community Mental Health and Addiction Programs (OFCMHAP) obtained legal advice for members and posted all information related to SARS on its website. The association supported members in areas affected by the outbreak.

Although pharmacists are one of the most accessible health care providers, we were the least effective during the crisis because we weren’t given information or used as a means of communicating with other providers or the public.

Pharmacist

- In an effort not to add to the number of different, conflicting sources of information, the Ontario College of Family Physicians (OCFP) and the Ontario Pharmacists Association (OPA) put links on their web sites to connect members to key information sites (e.g., Health Canada, the MOHLTC, the Toronto Department of Public Health and, in the case of physicians, the Ontario Medical Association).
- OCSA posted the directives and issued daily messages.

Associations report that not only did they try to address the information gap for their members in the GTA areas, they were also busy answering calls from members outside the GTA who were trying to prepare for any spread of the infection. In the future, this kind of responsible step on the part of providers must be supported by a more effective information and communications system for the whole home and community care sector.

Many of the communication problems between sectors stem from changes in the health care system, which have had an impact on traditional lines of communication and roles. For example, as a result of hospital restructuring, many family physicians have given up their hospital privileges³ and, therefore, are no longer connected with a hospital and do not have access to information distributed through hospitals. In the community care sector, many providers expected to have direct contact with public health, and to have public health nurses monitoring and following people in quarantine. However, at a time when the community needed access to a strong public health system, public health did not have the resources to fulfill this role as expected.

For the first few weeks, SARS outwitted us and managed to stay a few steps ahead of us. Our communication system was too slow. Essential information did not get to the right people quickly enough.

Family physician

2. Applying SARS directives in community settings

When trying to apply SARS information in the community, organizations faced the following challenges:

- **communicating information in a highly decentralized system.** Home care providers are not always able to reach all staff within a certain length of time. Most rely on voice mail systems to leave messages for staff, which is adequate for communicating scheduling information but may not be appropriate for communicating changing infection control directives. Some organizations developed a system of issuing updates at certain times each day, so staff would know when to check in for the most recent information.
- **adapting directives to a community setting.** The first directives were developed for hospital settings and did not necessarily reflect community practice. For example, the early directives did not give CCACs guidance on how to manage placements. The initial SARS screening tool had to be revised to facilitate appropriate transfer of clients from hospitals to community providers. There was confusion about the

³ With restructuring, clinical programs have been concentrated in different hospitals so family physicians may have patients in four or five different sites. Some physicians gave up their privileges because they were no longer able to cover so many sites. Some were asked by hospitals to choose only one site.

appropriate precautions to use with patients diagnosed with SARS who were discharged from hospital. Those who required CCAC services were required to be in quarantine, while those who did not were not advised of the need for quarantine. Protocols for removing protective equipment (i.e., one person undressing another) and for disposing of the equipment after use were not practical in a community setting where providers work alone and have no access to incineration. This situation improved when, at the urging of primary care physicians and community providers, the POC added people with experience in community settings (i.e., a family physician and community care representative) to the scientific committee.

- **coping with variations in how directives were interpreted.** Although all organizations received the same information and directives from the POC, they would interpret them differently. For example, some physicians would wear masks, others wouldn't. Signage on doctors' doors would be different. The same kinds of variations occurred among home health providers. This variability highlighted the need for implementation guidelines, standard signage, information for clients/patients, and standard screening forms that would ensure all community providers use the same procedures. It also highlighted the need for directives that reflect all aspects of community care, including Meals-on-Wheels, volunteers, and homemaking services. Consistency is essential to reassure both staff and clients.
- **dealing with information overload.** Over the course of the SARS outbreak, the system went from no information to information overload. It became increasingly difficult for organizations to sift through the volume of information provided by the POC to find what they needed to know. Continual updates made it more difficult to keep staff informed, and contributed to staff anxiety. As the outbreaks progressed, some community providers became more strategic in their communication efforts and would issue revised protocols/directives only when the new information required a change in practice.

Lessons Learned

- In a disease outbreak or other health emergency, the entire health care system must have easy, fast access to clear, accurate information.
- Technology needs to be in place to allow MOHLTC and providers to communicate rapidly, and the cost of this technology must be reflected in the funding for health services.
- There should be one single authoritative source of information.
- During infection control outbreaks, the home and community care system needs better access to public health staff and skills.
- Community care providers need directives that reflect their practice and are appropriate for their setting

Recommendations

4. The Ministry of Health and Long-Term Care should:
 - establish a single authoritative source (“Command Centre”) for accurate, up-to-date information
 - develop an effective communication network that will connect **ALL** professionals and agencies in the health system, including home and community care providers
 - ensure all providers have the capacity within their budgets to purchase information/communication technology and equipment.
5. The Command Centre should ensure that people familiar with practice environments in the community are involved in developing guidelines and directives for these settings. To ensure consistency, the Command Centre should make it clear which directives are mandatory and for whom, and how the mandatory guidelines should be applied.
6. The Command Centre should identify leaders/respected authorities in each sector (e.g., a doctor who can speak to physicians, a therapist who can speak to therapists’ issues, a nurse leader for nursing issues) who can provide direction to their sector during a health emergency.
7. The system should identify the types of tasks that should be done centrally in a community in a health emergency (e.g., signage for clinic and office doors, purchasing and distributing supplies) as well as the organizations responsible for those tasks.

III. Supply Chain Management

Although access to supplies and personal protective equipment was an issue in all parts of the health system, it was a particular problem in the community. This is because the community sector is largely made up of small organizations and practices, which do not necessarily have the capacity to manage highly specialized supplies. The shift to ‘just-in-time’ inventory control also meant that adequate supplies of the personal protective equipment simply weren’t available.

Over the course of the SARS outbreak, some organizations were able to establish effective supply management and distribution systems very quickly. For example:

- The 10 CCACs in and around Toronto, developed a centralized supply ordering and distribution system for all their service providers, which the service providers found very helpful – although the service providers continued to have problems distributing the supplies to their multiple branches.
- At the request of physicians, the POC agreed to provide personal protective equipment for family physicians in Toronto and affected areas around the city. Originally, physicians were asked to pick up their supplies from a central distribution centre. However, this was not practical, so the MOHLTC supported the physicians’ request to use its vaccine distribution system to deliver the supplies to physicians’ offices. While this distribution system was effective, it only existed within the boundaries of Toronto. The vaccine distribution systems in other areas (most of which are run by public health) were supposed to provide the same service, but this did not happen. As a result, family physicians in the areas surrounding the city (e.g., Mississauga) were responsible for purchasing their own supplies, and some had to go as far as Buffalo to pick up equipment. This created an additional financial burden on their practices.
- Pharmacists helped source supplies for some providers and organizations.

Professionals and organizations not linked into these distribution systems were less fortunate. They had to source their own supplies, which was very time consuming. Even when supplies were available, they were often not in a form that community providers could easily use. For example, hand disinfectant is packaged in industrial size containers for hospital use. Home health care providers had to source small containers, decant the solution into the small containers, and label them to comply with WHMIS standards. They also had to repackage huge containers of

Dealing with supplies was a challenge. We had bags disappear from outside people’s doors. Staff had to be trained how to carry equipment with them and still ensure it was usable. Given that the virus survives for three hours in droplets, we were very concerned about disposal in a home setting but had no directives to work from.

Home health care provider

Managing supplies had a huge impact on management staff, especially in small organizations. We called every available person in to help package supplies, and everything else was deferred.

Home health care provider

protective gear into single packages that could be taxed to clients' homes. This took hours, and added significantly to agency cost, time and administrative workload.

Some supplies left at clients' home were taken inside the house, or handled by family members, rendering them unusable. Because supplies were limited, organizations went to great lengths to ensure they were used appropriately (e.g., identifying the clients with whom staff should use personal protective equipment).

Supply chain management was even more complicated for agencies that serve both CCAC and private clients. These organizations would purchase private supplies for their non-CCAC clients and receive supplies from the CCAC for the CCAC clients. The two inventories had to be kept and managed separately.

Disposing of used protective equipment properly was also an issue in the community.

During the SARS outbreak, access to gasoline to drive to and from work was an issue for hospital staff who were in "working quarantine" and had to avoid contact with people. Although it was not an issue for community care providers during SARS, it did become an issue during the power outage that occurred in August 2003. Organizations suddenly became aware that they are dependent on a steady supply of gasoline to deliver care.

Recommendations:

8. All home and community care providers should maintain a one-week supply of personal protective equipment on site.
9. The health care system should develop a centralized supply chain management system for the home and community care sector that would:
 - provide supplies in a form and size appropriate for the care settings
 - include private health care providers
 - address access to gasoline and other supplies essential to the delivery of home and community care
 - reduce the pressure on individual practitioners and small organizations to source, distribute and manage infection control supplies.

Lessons Learned

- The highly decentralized community care environment would be best served by a centralized supply chain management system that would provide supplies in the appropriate size/form to all providers throughout the province as needed, as well as common signage.
- Community providers should maintain an adequate supply of personal protective equipment in case of another health emergency.

IV. The Impact on Human Resources

SARS had a dramatic impact on health care providers who not only had to provide care, but were quarantined and fell ill in alarming numbers. Community care providers had to manage a number of complex human resource issues, including:

- staff and volunteers who were concerned about being exposed to SARS and about taking the infection home to their families.
- staff who did not perceive themselves to be at risk, which affected their motivation to implement directives and protocols.
- many home health care providers lost staff due to illness and quarantine (e.g. three of four physicians in a family practice in Toronto fell ill with SARS).
- staff unavailable to work because they were restricted to working in one setting (e.g., community, long-term care or acute care). Workers who had to choose between a community agency and a long-term care facility usually chose the long-term care facility, because wages there are higher and more predictable. On the other hand, staff who had to choose between the hospital and community tended to choose community where they believed the risk of exposure to SARS was lower.
- rigidity and lack of “surge” capacity in the health care system. Existing back-up programs are too rigid to meet urgent community needs (e.g., when the Toronto family practice decimated by SARS requested assistance from the Ontario Medical Association/ Ministry of Health and Long-Term Care locum program, they were initially told that the program was only available to remote and underserved parts of the province).
- the need to train a wide range of regulated and unregulated workers (many of whom have different language and literacy needs and who start with very different base knowledge of risk and infection control) in SARS protocols. While hospitals have communications systems in place to bring physicians and staff together to teach and reinforce infection control techniques, this is much harder to do in the community where health care providers work independently.
- the need to change attitudes towards infection control. Most health care providers have been taught to glove and gown to protect vulnerable patients from exposure to germs or diseases – not to protect themselves from exposure. The very real risk to health care providers from SARS highlighted the need for a different attitude towards infection control and risk in the workplace. We were fortunate that volunteers who usually move back and forth between institutions and community services were barred from hospitals and LTC facilities, creating a natural firewall.

We didn't know where else our staff worked. When we asked, some PSWs wouldn't tell us because they needed the money and didn't want to give up their income. Many did not seem to understand the risk.

Home health care provider

- problems fitting masks in the community (e.g., highly decentralized staff and time consuming process).
- the screening procedure. The necessary screening protocol took time away from care. This was an issue for visiting nurses, therapists and personal support workers who are paid by the visit or hour. Because clients would often receive services from two or more agencies, they would be screened repeatedly, which both clients and providers found frustrating. This was also a problem in physicians' offices. The way screening was done, patients were already inside the offices before they were screened. For the screening to be effective, it should have been done outside the building. The screening also took staff time away from other tasks and increased costs, leaving many physicians questioning who should be responsible for doing screening and for paying for it.
- the impact of infection control procedures in the community and in family practices. Wearing heavy masks, gowns and gloves made it difficult and more time-consuming to deliver community care. Working in an environment with heavy infection control requirements over a long period of time was also physically and emotionally demanding. Professionals reported difficulties breathing and talking to people through masks, and problems with shortness of breath after several hours of working under those conditions. Receiving care from people in full protective gear was particularly difficult for clients who are cognitively impaired.
- the loss of volunteers. Many community services, including meals-on-wheels and transportation services, are highly dependent on volunteers. During SARS many organizations stopped using volunteers in order to avoid any risk of becoming infected and to free up staff who normally supervise volunteers. This made it more difficult to maintain essential services.

Effective community practice is based on the ability to communicate with patients. Being covered up in masks and gowns separated us from our patients and created a cold sterile environment that does not support good care.

Family physician

Community organizations had to take extraordinary steps to educate and support staff in dealing with these issues. This was extremely difficult for physician practices and small community agencies, which do not have the resources or capacity to provide training required in infectious diseases or health emergencies.

In their efforts to meet care needs with fewer staff, several agencies collaborated and shared caseloads. Faced with a crisis, organizations worked together to build relationships. The community sector has also identified other ways to collaborate in the future (e.g., pharmacies could have assisted service providers with some of their supply and packaging/labeling needs).

While there is a great deal that organizations

Lessons Learned

- The reliance of the entire health care system on part-time and casual workers, the wage disparities between sectors, and the lack of full-time job opportunities for nurses and personal support workers limits the system's ability to respond to a health crisis.
- With the current shortage of health care providers, there is no "surge" capacity within the system.

themselves can do to collaborate and make effective use of their health human resources, there are steps the system itself should take to ensure that it is flexible enough to respond to a crisis. For example, surgeons and operating room nurses who were not able to work during the outbreaks could potentially have been redeployed to provide other needed services. The system could also relieve pressure on health care providers by changing some administrative procedures during an outbreak. For example, pharmacists could be allowed to bill the Ontario Drug Benefits (ODB) plan for non-prescription medications that require a prescription to be covered by ODB (e.g., Metamucil). This would free up time now spent by both the pharmacist and the physician confirming or writing the prescription, which could then be spent dealing with the crisis. In a health emergency, it may also be appropriate to expand the scope of practice of some providers to increase access to care, or to deem certain community services, such as supportive housing and meals programs, as critical to public health safety.

Recommendations

10. The system should assess the impact of current staffing practices on quality of care, client satisfaction, professional satisfaction, and the ability of the system to respond to health emergencies.
11. The community sector should work with the education system to ensure curricula for nursing, rehabilitation therapy, personal support worker (PSW), and supportive housing or case management staff provides the knowledge and skills to manage infection in home and community settings (e.g., containing an outbreak, maintaining infection controls in decentralized sites such as the home, where other people are living). Home and community providers should also develop a more collaborative, consistent approach to continuing education, infection control, and service delivery.
12. In case of a health emergency, the Ministry of Health and Long-Term Care should examine the deployment and scope of practice of health human resources as well as administrative practices in order to ensure the system has the flexibility to access and use professional skills efficiently and effectively to meet needs.
13. The Ministry of Health and Long-Term Care should work with the community to review services and identify those that should be deemed critical during a disease outbreak.

V. The Financial Impact

The full cost of SARS in the community has not yet been calculated. Some family physicians report that the outbreaks had a significant impact on their workloads and hours, but no impact on their income (i.e., no increases or decreases). Others, particularly those whose offices were located in hospitals or who had a hospital-based practice, experienced a significant loss in earning power. Nurses and other workers who were restricted to working in one setting also experienced a loss of income.

Direct organizational costs related to SARS included:

- supplies and equipment
- salaries for staff who were in quarantine
- additional staff added to fill temporary vacancies
- additional staff required to screen patients, staff and visitor
- reduced productivity due to the delays caused by screening
- the loss of revenues for uninsured testing services (i.e., because patients stayed away from health facilities for fear of being exposed to SARS).

We thought public health would supply masks for our clients who were in quarantine but it took too long, so we had to buy supplies ourselves.

Community mental health and addiction service provider

Lessons Learned

- Health emergencies create extraordinary costs that cannot be absorbed by community providers and organizations, which are already working within rigid and limited budgets.

VI. Emergency Preparedness

SARS highlighted gaps in emergency preparedness in the community, and in the broader system. For example:

- Most organizations did not have comprehensive emergency response or communication plans to deal with a disease outbreak and its impact on staff and clients.
- Most organizations did not routinely maintain risk information related to how long each client could go safely without care, and had to search through caseload files and develop a system for triaging clients.
- There are no common criteria for triaging clients, and no standard classification of clients for infection management that can be used as clients move from one part of the system to another.
- Most organizations did not know where else their staff were working, and had to contact staff to get that information. This issue will remain challenging given the new federal privacy legislation.
- Despite the fact that health services are interdependent, emergency planning that does occur in the home and community sector is not co-ordinated with other parts of the health care system, or vice versa.

“When we were trying to triage our clients and determine how long they could go without service, we found 43 different variations in how patients were coded by different health care agencies.”

Home health care provider

Since 2002 (post 9/11), municipalities in Ontario are required by law to have emergency plans and to test those plans each year. They are also required to identify possible risks and develop plans to mitigate or reduce those risks. However, most emergency or disaster planning focuses on the role of emergency services (e.g., police, firefighters) in responding to traditional “natural” disasters (e.g., fires, floods, ice storms, tornados) and, more recently, to potential terrorist threats. Planning for emergencies related to public health threats is often either overlooked or confined to the public health department.

Lessons Learned

- Ontario’s health care system is not adequately prepared to comprehensively respond to health emergencies that affect the health of the population.

Recommendations

14. The health care system should develop system-wide emergency preparedness plans that identify all the resources and skills in the system, how patients/clients will be managed, and how all partners will respond to any loss or limitations in one part of the system. As part of that plan, the system should consider designating specific hospitals within a geographic area to centrally manage infectious disease outbreaks. It should also develop flexible structures that will allow the system to shift people and resources from one part of the system to another to meet needs.
15. The system should develop standardized, integrated Emergency Response Protocols for home and community care. All community providers should be trained in the risks associated with communicable diseases and in infection control procedures. Organizations should have emergency response plans in place, that include access to appropriate supplies, information, education and support. The system should develop standardized client classifications for infection management in home and community care that family doctors, community pharmacists, service providers and CCACs can understand and use.
16. The system should identify the organizations at each level responsible for co-ordinating activities during a health emergency or outbreak, including: the proposed “Centre for Disease Control” at the national level, the MOHLTC provincially, the District Health Councils in the regions, and organized emergency measures groups locally, which would include hospitals, CCACs, physicians, residential care facilities, schools, municipalities, and health care provider organizations.

Call to Action

Despite the challenges, family physicians and community health services responded effectively to the needs created by the SARS outbreaks. This was due primarily to the dedication of physicians, managers and staff, and to the goodwill of organizations and agencies. Everyone was willing to share tasks and pool resources to meet needs.

The Ontario Ministry of Health and Long-Term Care should also be commended for:

- its efforts to provide information
- its close collaboration with CCACs
- its decision to put people who understood community care in the POC
- its willingness to increase service levels and allow the home and community sector to provide the type and level of support required to keep people in their homes and avoid hospitalization
- the more simplified decision making process developed during the crisis, which allowed organizations to be innovative in their responses.

In the course of dealing with SARS, the community identified strengths and capacities, which can be used to respond effectively to future health emergencies, and have the potential to make the health care system more efficient and effective. Many of the service innovations developed during SARS should become standard practice.

The OHCCC's concern is that Ontario's response to SARS – the “new normal” – will focus only on addressing the weaknesses identified in the hospital and public health sectors, will ignore the community and, as a result, fail to see how the way we currently organize and deliver care is threatening our health.

SARS has taught us a hard lesson and given us a warning that we must not ignore.

Hospitals are very vulnerable to outbreaks of uncontrollable infection. Over the past few years, strains of antibiotic resistant bacteria that can infect healthy people (e.g., MRSA and VRE) have shut down hospital wards for weeks. Given our recent experience, we must question the wisdom of concentrating people and so many non-acute health care services in hospital settings. The OHCCC notes, with interest, that many hospitals are now restricting the number of visitors and visiting hours. But we believe the system must go further. It must consider focusing the hospital system on acute health care episodes only, and seriously look at the potential to enhance community services which we know work to keep people in their homes and significantly reduce the need for hospitalization. Community providers have the knowledge, skills and capacity to delay or prevent the need for hospitalization and to provide the care required on hospital discharge, but this capacity is not being fully utilized. With appropriate and

The system has to get over its “edifice” complex. The public sees hospitals as the centre, and the hospital is now housing everything, including coffee shops. But this is counterproductive to good infection control. To reduce the risk, we need more care in the community.

Dharmaoist

stable funding for home and community care services and some re-working of the relationships between community-based services and acute care institutions, it is possible for Ontario to develop new, effective, cost-efficient models of care.

While Ontario did manage to deal with the SARS outbreaks, the Ontario Home and Community Care Council stresses that, if the virus had spread outside Toronto or into the community, the current system could have been overwhelmed.

To ensure Ontario is prepared for the next health emergency, the system must change, and those changes must begin now.

About The Ontario Home and Community Care Council

The Ontario Home and Community Care Council (OHCCC) was established in 2002 and is currently the only working group of its kind consisting of many of the major community care provider associations in Ontario including:

- Ontario Association of Community Care Access Centres (OACCAC);
- Ontario College of Family Physicians (OCFP);
- Ontario Community Support Association (OCSA);
- Ontario Home Health Care Providers' Association (OHHCPA);
- Ontario Pharmacists Association (OPA); and
- Ontario Federation of Community Mental Health and Addiction Programs

The Council's agreed upon definition of Home and Community Care is:

- A wide range of health care and social support provided for an individual and/or caregiver in their home and/or community by health professionals, community agencies and volunteers.

Health care and social support is provided in order to achieve the following outcomes:

- Maximize the independence, well-being and quality of life for the individual in the community
- Support individuals' informed choice to receive care and support in their own home
- Meet individuals' need for continuing medical care and social support either following discharge from acute care hospital or as an alternative to placement in a long-term care facility

The Council's shared vision for home and community care includes the following:

- Home and community care is understood and valued by the public and government and funded by government as a foundation of Ontario health care system
- The public is well-informed on how to access home and community care
- Home and community care is an integral part of the continuum of health and social support, ensuring the right services in the right place at the right time
- Organizational silos serving as barriers between components of home and community care are replaced by structures and processes to facilitate collaboration
- Clients, family physicians, pharmacists, home and community care providers and community volunteers work together as a care team to ensure the integration of care and support.
- Co-ordination and integration of home and community care requires:
 - Shared ownership of home and community care by all members of the care team and information systems which link members of the care team
 - Shared knowledge, understanding and advocacy for the role of each member of the care team
 - Effective working relationships among members of the care team

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