LEARNING FROM THE SARS EXPERIENCE

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PRESENTATION

BY

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TO

SARS COMMISSION INQUIRY

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Good Morning.

I am Karen Sullivan, Executive Director of the Ontario Long Term Care Association. With me are: Astrida Plorins, Director of Operations, Leisureworld Inc. and Nancy Cooper, Director of Policy & Professional Development at OLTCA.

On behalf of our members, the private, public, charitable and not-for-profit operators of some 400 long term care homes throughout Ontario, the 44,000 residents who live in these homes, and the approximately 44,000 nurses, personal support workers and others who work in these homes, we thank you for the opportunity to address the SARS Commission.

Long term care homes are part of Ontario's publicly funded and publicly regulated health care system. They provide 24 hour nursing and personal care services to our oldest and frailest citizens, over half of whom are afflicted by some form of dementia and suffer from chronic, and often complex, medical conditions. Homes work closely with hospitals, the community and other stakeholders to provide this care.

This is the context in which long term care homes played an important role in helping the province to prevent the further spread of SARS, and to support our partners, notably hospitals, in managing the front line. Our comments today are based on the experiences of our members in accomplishing this.

First, I want to take this opportunity to acknowledge the efforts of long term care providers and staff for the quality of their SARS response. The fact that SARS did not spread to long term care, while they supported our partners and continued to provide care, is testimony to their commitment to the residents and our healthcare system.

Appreciation for this commitment and accomplishment increases when you consider that their efforts occurred at over 150 different physical locations housing some 25,000 residents in the GTA and Simcoe County alone.

SARS had a close to paralyzing effect on our health care system. At an individual level the impact was, in some cases, tragic including for health care workers. I am not here to suggest that everything went smooth in long term care. We, like others, learned that there are things we would now do differently. We also learned where we can improve both crisis response capacity and the overall viability of our health care system.

We now turn our presentation to those learnings.

In the need to understand what went wrong, it is critical that we not lose sight of what went right.

I speak specifically of the value added to the system from the new roles, relationships and processes that emerged among health care providers in responding to SARS. The potential and benefit of a health care continuum was, perhaps, never more evident than as providers grappled alone, and then

with others, to prevent SARS transmission and to keep the system operational.

A criticism, and often frustrating reality, is that our health care system's parts do not interact well. The system is most often viewed as a collection of silos rather than as a continuum where patients and information flow seamlessly.

However, SARS demonstrated that it is possible for the system's individual parts to work together to provide more effective, appropriate and efficient care. It also demonstrated how long term care can make a tangible contribution to this process.

I would like to share the following example involving Alternative Level of Care, or ALC, patients. ALC patients are those patients who occupy acute care hospital beds, but who no longer receive acute care services. They are generally waiting for admission to a long term care, or a complex continuing care, bed.

During SARS, government directives closed affected hospitals to admissions and a large number of ALC patients were required to be transferred elsewhere. These directives galvanized hospitals, Community Care Access Centres, Public Health Units and long term care homes into an unprecedented coordination of services.

A shining example of this involved Leisureworld Brampton Woods, a 160 bed home that had just opened its doors to admit residents in the Halton-Peel

area. My colleague, Astrida Plorins, managed the home's participation in this collaborative effort and can answer any questions your Honour may have.

On March 25, 2003 the home was directed by the Ministry of Health and Long Term Care to convert to a SARS quarantine facility for ALC patients, primarily from Scarborough Grace and York Central hospitals. They were instructed to be prepared to keep residents on-site for the duration of the outbreak. The home was converted to operate under full SARS protocols and within a two-week period 58 ALC patients were admitted.

Two important factors contributed to the success of this initiative.

First, the assessment of the ALC patients in the affected hospitals revealed that two thirds of the patients had care needs that would typically be met in a long term care home.

Second, the system demonstrated that it could come together to prepare Leisureworld Brampton Woods to implement the Ministry's infection control requirements and, most importantly, to meet the higher care needs of the remaining one/third of the patients.

The health sector partners at Leisureworld, the Ministry, the Peel Region Health Unit and the William Osler Hospital planned and coordinated everything from staffing and supplies to support services including X-ray machines, access to hospital labs, emergency medications, etc.. A 20-bed critical care unit was set up on the ground floor Resident Home Area. This

unit was fully equipped to provide emergency care and staffed by critical care nurses contracted by the Ministry.

It is easy to postulate that as a newly opened and partially occupied home, Leisureworld Brampton Woods was more readily adaptable to a new role. This, however, overlooks the reality that it was stakeholder collaboration, not the building, that made the difference. This same collaboration placed over 200 ALC patients from hospitals to other homes in the GTA and Simcoe County.

This experience demonstrates that the continuum did and, more importantly, can work. In that continuum experience, long term care:

- Provided effective surge capacity;
- Worked effectively with others to more efficiently move patients to the appropriate level of care; and,
- Demonstrated the ability to build a care capacity that had not been previously explored.

We believe there is significant added value to patients, residents and our health care system from ensuring that this experience is not lost, and that the exploration continues. The experience of Leisureworld Brampton Woods demonstrated that building care capacity in long term care significantly supports the illusive goal of providing the right care, in right place, at the right time and at the best cost.

In order to ensure that the surge capacity is there, particularly staff, we recommend altering the requirement to maintain 97% occupancy in long term care in order to receive full funding.

In assessing long term care's response to SARS, there is no doubt that we benefited from our past experiences in managing infectious outbreaks. This includes implementing infection management protocols in a setting where daily living activities, family and other social interactions are a critical component of care.

It is well known that long term care residents have an increased vulnerability to many infectious diseases. Because of this, prevention and reduction of transmission is a priority. Indeed, it is an integral part of long term care's management and regulatory structure.

Every home is required to have effective infection control programs and outbreak protocols to prevent the spread of influenza, Norwalk Virus, etc. The Ministry of Health and Long Term Care monitors compliance with the standards.

In fact, living and working with these standards is a way of life for residents, staff and families.

SARS, however, was different. The requirements to use full protective gear (gowns, caps, goggles, gloves and the now famous "N95 masks") was not only a challenge for staff, it was also a disruptive sight for residents in their home, and a frightening sight for the many residents who are in the later stages of dementia.

This, to us, demonstrates a need for increased sensitivity to the realities of long term care in developing future directives.

As elsewhere, reassurance was a core SARS issue;

- reassurance for residents, families and staff;
- reassurance in the face of high public profile and concern; and,
- reassurance in the face of fear.

Long term care has had lots of experience in providing reassurance during outbreaks. However, never on this scale, for this length of time or in the context of such a pervasive level of community concern.

It added a new level of stress for residents, staff and their families. The need to respect outbreak protocols was understood and, indeed, many appeared to be very satisfied with the sector's timely response. Nevertheless the fear factor drove a need for ongoing reassurance, including during several important cultural and family-centered dates: Easter, Passover and Mother's and Father's Days.

Communication was key and it required stretching and building on what worked in the past to meet the unique challenges created by SARS.

Over the course of the four months of SARS enforced protocols, bulletins, signage, telephone calls and letters became the mainstay of a home's daily communication with families, staff, suppliers and the community. Homes helped residents maintain connection with their loved ones by welcoming

packages at the front door, setting up phone calls, writing letters, notes and e-mail and so forth.

Perhaps the biggest communication's challenge, however, was the expectation for providers, administrators and senior managers to interpret what was happening for residents, staff, families and others. There was a legitimate expectation that they would be in the know.

I think it is fair to say that the Provincial Operations Centre and the Ministry did a commendable job of putting information into the field. This process improved significantly once the electronic systems were in place to facilitate communication, and when a process was established to allow long term care providers to ask questions and obtain clarification.

The weekly Ministry conference calls, that sometimes included over 800 participants, were particularly important for seeking clarification on directives that imposed restrictions on visitors and altered previously acceptable routines and processes that were part of home life.

These routines and processes are hallmarks of quality long term care, hallmarks for residents, hallmarks for staff and hallmarks for families. Successfully managing this level of change meant having the capability to explain as well as communicate.

We hope that the importance of supporting long term care's capacity to do this as a first response capability will be recognized and incorporated in planning for the future.

Finally, I want to say a few words about resources.

It is generally accepted our health care system was not resourced or equipped to respond to SARS. The province's willingness to step forward at the outset to address funding was critical to the overall outcome.

However, during the initial outbreak stages, there was considerable disconnect between the expectations of directives and the capacity of homes to respond. Supply-chain issues across the system led to shortages of equipment – N-95 masks etc., that are not part of typical infection control management supplies. Coordination to assure system-wide distribution of key emergency supplies is an important lesson.

SARS also brought to light the fact that many health care workers have multiple employers, some in different sectors. This reality was brought home as some employers placed restrictions on where staff could work, leaving others scrambling. Future planning demands that staff be managed as a system, not a sector, resource.

SARS is likely only one of similar challenges we will face in the future. A reasoned approach to the resource question is therefore critical.

We suggest that a reasoned approach goes beyond the question of how many more dollars, to questions of where dollars could be more effectively applied. It goes to the development of policy and process resources that reflect that, while the interdependencies are obvious, it took a crisis to

galvanize the system to work together. It goes to a connected system infrastructure that provides access to the same information at the same time for all providers who are caring for the same person.
In the full analysis, the SARS experience does suggest some, perhaps non-typical, answers.

In conclusion, Honourable Commissioner, there is no doubt that SARS challenged Ontario's health care system and, as a crisis is likely to do, uncovered some of its weaknesses. Undoubtedly, these weaknesses will receive considerable analysis and attention over the coming months.

It would be a disservice, however, to the tremendous effort of long term care and our health care partners, if we don't give at least equal attention to instances where innovation, collaboration and commitment has already demonstrated what can be done to meet the health care needs of Ontarians in a changing, and unpredictable, environment.

Thank you.