

# **COVID-19 Guidance: Use of Hotels and Retirement Homes**

Ministry of Health

Ministry of Long-Term Care

Ontario Health

**April 2, 2020**

## **Introduction**

The Ministry of Health (MOH), the Ministry of Long-Term Care (MLTC), and Ontario Health (OH) has been asked by a variety of stakeholders about the use of alternate health facilities to assist in hospital COVID-19 strategies. These inquiries have included questions related to spaces such as hotels and retirement homes.

This guidance document has been formatted to include information on these two areas:

### ***Section 1: Hotels***

### ***Section 2: Retirement Homes***

Each section will provide an overview of options and conclude with a set of Frequently Asked Questions (FAQs) pertaining to that area.

This guidance should not be considered mandatory requirements. It is designed to offer suggestions and advice to help hospital decision-making in creating additional capacity and related implementation.

If hospitals wish to increase capacity by utilizing any of these opportunities, we ask that hospitals please work with your Ontario Health regional planning table to ensure any added capacity aligns with regional planning and any associated costs can be tracked. We ask that you also be ensure that any new beds that are opened are reported in the daily bed census.

## Section 1: Hotels

## Section 1: Hotels

There are two methods hospitals may wish to pursue the use of hotels: as temporary housing for healthcare workers or as alternate health facilities for expanded hospital capacity.

### Temporary Housing

Hospitals may wish to enter into contractual arrangements with hotels and other accommodation centres to provide housing support for physicians, staff or volunteers. This would support healthcare workers who may need accommodation close to the hospital or to support healthcare workers in self isolation. Many hospitals have these arrangements already in place as part of their pandemic planning and we encourage you to continue making these arrangements locally.

### Alternate Health Facilities

Hospitals may wish to enter into contractual arrangements with hotels and other accommodation centres to act as patient care centres that allow for the transfer of low acuity patients such as those designated as Alternate Level of Care (ALC). As hospitals consider hotels for patient care purposes, we ask that you work within OH regions to exhaust capacity opportunities within hospitals, long-term care homes and retirement homes first. If hospitals determine this to be an appropriate capacity opportunity, hospitals are encouraged to enter a lease with a hotel to designate the hotel property as a hospital premises. This will enable hospitals to transfer patients to these settings and provide care in these settings using current hospital staff. There are factors in these arrangements that must be considered including but not limited to patient transfer protocols, insurance, food service delivery, equipment, environmental cleaning, infection control and security.

To assist you in pursuing any leasing opportunities, we have attached a copy of the Ministry's memorandum on subsection 4(2) of the *Public Hospitals Act* and hospital classifications under subsection 32.1(1) of the *Public Hospitals Act*.

## **Guidance: Temporary Housing**

Hospitals may wish to enter into contractual arrangements with hotels and other accommodation centres to provide housing support for physicians, staff or volunteers. The purpose of this is to accommodate any healthcare worker who may need accommodation close to the hospital or to support healthcare workers in self isolation. Many hospitals have these arrangements already in place as part of their pandemic planning and we encourage you to continue making these arrangements locally.

### **Considerations**

In assessing these opportunities, we encourage hospital leaders to consider the following:

- Identifying properties located nearest to hospital sites.
- Arranging for a contract or rate arrangement that is fair and reasonable during a time of COVID-19.
- Ensuring appropriate infection control practices by the property.
- Ensuring access to food services and laundry facilities.
- Tracking accommodation expenses that are related to COVID-19 for future reconciliation.

## **Guidance: Hotels**

Hospitals may wish to enter into contractual arrangements with hotels to act as patient care centres that allow for the transfer of low acuity patients such as those designated as Alternate Level of Care (ALC). If hospitals determine this to be an appropriate capacity opportunity, hospitals are encouraged to enter a lease with a hotel to designate the hotel property as a hospital premises. This will enable hospitals to transfer patients to these settings and provide care in these settings using current hospital staff if available.

### **Considerations**

In assessing these opportunities, we encourage hospital leaders to consider the following:

#### ***1. Operational Model and Transfer of Patients***

Hospitals should consider if they are contracting with another care provider in which they are discharging the patient or if the hospital will remain the care

provider. If it is the latter, the hospital may wish to lease the hotel, thereby enabling the hotel to be designated a hospital premises under subsection 4(2) of the *Public Hospitals Act*.

## **2. Patient Appropriateness**

As always, hospitals should consider the clinical appropriateness of the patients who could be cared for in an alternate care facility. The province encourages hospitals to consider alternate health facilities for low acuity patients such as those designated as ALC.

## **3. Property Considerations**

Hospitals should consider the functionality of the setting including accessibility including access to elevators, floors and areas for which care teams can complete work like patient care centres. Hospitals may wish to also consider how the property may be conducive to isolation should a patient be diagnosed with COVID-19.

## **4. Staffing**

Hospitals should consider the care and contractual model that enables the best assignment of staff to care for patients including resourcing ancillary support services. This may require recruitment of additional staff, contracting staffing services or additional training of current staff and volunteers.

## **5. Equipment**

Hospitals should consider what type of equipment should be used. This may include but not be limited to the purchase of beds, call bells, AEDs and the assurance of all necessary medical supplies including personal protective equipment.

## **6. *Ancillary Support Services***

Hospitals should consider support services that will be required for patients including food services, environmental cleaning and infection control, security, and visitation policies.

## **7. *Insurance***

Hospitals should contact their insurer to ensure proper protections are in place to support patient care activity in an alternate health facility.

## **8. *Funding***

Working with OH Regions, hospitals should identify these opportunities and seek input from the regional offices on the opportunity. These expenses will qualify for reimbursement as part of the ministry's COVID-19 response. If hospitals require a cash advance to assist in COVID-19 response, the ministry is pleased to facilitate.

## **9. *Data and Reporting***

If alternate health facilities such as hotels are being used for patient care, hospitals should report these beds through the daily bed census reporting tool.

## **Guidance: Hotel Associations and Vendor Lists**

To assist hospitals in identifying hotels, hospitals may wish to reach out to the following associations.

### **Ontario Restaurant, Hotel and Motel Association (ORHMA)**

*Recommended contact for accommodation outside of the Greater Toronto Area, Ottawa, and Niagara Falls.*

Tony Elenis, President & CEO

Tel: 647-204-6633 (mobile)

[telenis@orhma.com](mailto:telenis@orhma.com)

[www.orhma.com](http://www.orhma.com)

### **Greater Toronto Hotel Association (GTHA)**

Terry Mundell, President

Tel: 416-301-3707 (mobile)

[tmundell@gtha.com](mailto:tmundell@gtha.com)

[www.gtha.com](http://www.gtha.com)

### **Ottawa Gatineau Hotel Association (OGHA)**

Steve Ball, President

Tel: 613-299-1404 (mobile)

[steveball@ogha.ca](mailto:steveball@ogha.ca)

[www.ogha.ca](http://www.ogha.ca)

### **Niagara Falls Canada Hotel Association (NFCHA)**

Doug Birrell, Executive Director

Tel: 905-322-1361 (office)

**[adb@overlookingthefalls.com](mailto:adb@overlookingthefalls.com)**

[www.niagarafallshotelassociation.ca](http://www.niagarafallshotelassociation.ca)



## Frequently Asked Questions: Hotels

### **1. *Is this province suggesting hotels must be used for patient care?***

No. Hospitals should work within their regions to identify the capacity opportunities that best suit their area. With that in mind, MOH and OH are encouraging regions and hospitals to first examine hospital capacity followed by long-term care and retirement home capacity ahead of hotel space.

### **2. *How is the province assisting hospitals in using hotels and alternate health facilities?***

The province has actioned two items to assist hospitals in pursuing this opportunity. The first is a blanket waiver under subsection 4(2) of the *Public Hospitals Act* to enable all hospitals to lease hotels if they so desire. The second is the issuance of this document to guide hospitals through a variety of factors they should consider.

### **3. *The blanket waiver under subsection 4(2) of the Public Hospitals Act has an end date of June 30, 2020. What if the only lease arrangement I can negotiate includes a date that is past June 30, 2020?***

The waiver is currently in place until June 30, 2020. Hospitals should ask all partners to be flexible, fair and as accommodating on setting lease terms during this state of emergency. As we work with Public Health Officials and hospitals leaders throughout the next few weeks, the ministry will revisit the terms of the waiver.

### **4. *What ancillary services might the province be coordinating that hospitals can access?***

The province will not be acting as supply chain for hospitals related to hotels. Hospitals know their local area and are aware of vendors who can assist them to support capacity growth including items such as food services, environmental services and infection control, security, equipment and staffing. Hospitals should also work with their shared services provider.

**5. *Should all hospitals be entering into hotel arrangements as a result of this information being shared?***

This is a guidance document. Hospitals should act as they see fit and in concert with the pandemic capacity plans being coordinated by Ontario Health's Regional Capacity Tables.

**6. *What is the role of Ontario Health compared to hospitals in addressing this opportunity?***

Ontario Health has established regional planning tables to ensure coordination of efforts to ensure appropriate capacity is available. Hospitals will be the entities by which hotels are contracted as service partners.

**7. *Is the hospital to notify Ontario Health of any hotel use?***

Yes. We are asking for Ontario Health Regional Leads to be notified so the use of hotels can be reported and tracked for both patient data and reimbursement purposes.

**8. *I do not have a need for hotels as a patient care centre but do for health care workers. Can I just use the local arrangements I already have in place?***

Yes.

**9. *How do we ensure the hospital will be paid for any expenses that are incurred for either housing healthcare workers or for the use of patient care?***

The ministry has committed to reimbursing hospitals for COVID-19 related expenses and is working with both Ontario Health and the Ontario Hospital Association to ensure the proper tracking of all expenses including those related to the use of hotels as housing and alternate health facilities.

***10. If my hospital needs a cash advance to support me securing a facility, can the ministry support us?***

Yes. The ministry is prepared to support cash advances as required. Please follow normal request protocols.

***11. Has the Ontario Hospital Association been consulted on this process and guidance document?***

Yes.

## **Section 2: Retirement Homes**

## Section 2: Retirement Homes

In response to questions about the temporary use of retirement home space to assist in hospital COVID-19 strategies, this document provides guidance on the use of retirement homes and outlines a few model's hospitals may wish to pursue.

### **General Guidance:**

#### Duration

It is anticipated that placement in a retirement home will last no more than six months, with the potential for up to another six months required to transition residents to an appropriate setting. Individuals on the long-term care wait list can expect to be placed for up to 12 months total in a retirement home prior to permanent placement in a long-term care home, depending on availability of long-term care beds.

#### Approved Retirement Homes

For all models, only retirement homes on the approved list provided by OH can be considered for these models. Retirement homes that indicate they have available space but do not appear on the approved inventory list must be first approved by OH before patients can be transferred or discharged to them. Ontario Health will be providing this list to hospitals in a timely manner.

As with all added capacity decisions we ask you notify your Ontario Health Regional Lead of any use of retirement homes. OH will in turn inform the Retirement Home Regulatory Authority (RHRA).

#### Long-Term Care Wait List

For all models, individuals on the long-term care wait list who are transferred to a retirement home will remain on the long-term care wait list. Placement into a retirement home is considered a temporary emergency placement. We appreciate this may be difficult for people who are looking for a permanent care setting, and our best efforts will be made to place them into a long-term care home as soon as an appropriate space is available following the crisis. The intent is not to move individuals a back to hospital following their stay, however this cannot be guaranteed.

## **Guidance: Leasing/Licensing Model**

Hospitals may wish to enter into contractual arrangements with retirement homes to act as patient care centres that allow for the transfer of patients, for example those designated for Alternate Level of Care (ALC). If hospitals determine this to be an appropriate capacity opportunity, hospitals are encouraged to enter a lease or licensing agreement with a retirement home to designate the retirement home space as hospital premises. This will enable hospitals to transfer patients to retirement homes and provide care in these settings using staff that is employed or engaged by the hospital

Attached is a copy of the subsection 4(2) *Public Hospital Act* approval letter dated March 26, 2020, which authorizes hospitals to expand capacity by leasing or licencing additional premises.

### **Considerations**

In assessing this opportunity, we encourage hospitals leaders to consider the following:

#### **1. Care Provider**

Under this model, hospitals will remain the care provider responsible for the patient. The retirement home space will be designated as hospital premises under the *Public Hospitals Act*.

#### **2. Patient Appropriateness**

As always, hospitals should consider the clinical appropriateness of the patients who could be cared for in a retirement home setting.

#### **3. Property Considerations**

Hospitals should consider the functionality of the retirement home setting, as retirement homes vary. Consideration includes accessibility including access to elevators, floors and areas for which care teams can complete work like patient care centres. Hospitals may wish to also consider safety standards and protocols and how the property may be conducive to isolation should a patient be diagnosed with COVID-19.

#### **4. Risk Assessment**

Hospitals should undertake a point of care risk assessment to ensure safety precautions are in place. For example, environmental controls and appropriate use of personal protective equipment (PPE) to protect patients, residents and staff, and to prevent and stop the spread of infection.

#### **5. Staffing**

Hospitals should consider the care and contractual model that enables the best assignment of staff to care for patients including resourcing ancillary support services. This may require recruitment of additional staff, contracting staffing services or additional training of current staff and volunteers.

#### **6. Equipment**

Hospitals should consider what type of equipment should be used in a retirement home setting. This may include but not be limited to the purchasing of beds, lifts, and the assurance of all necessary medical supplies including PPE.

#### **7. Ancillary Support Services**

Hospitals should consider the retirement home's ability to provide support services that will be required for patients including food services, environmental cleaning and infection control, security, and visitation policies.

#### **8. Insurance**

Hospitals should contact their insurer to ensure proper protections are in place to support patient care activity in a retirement home location.

#### **9. Funding**

Working with OH Regions, hospitals should identify these opportunities and seek input from the regional offices on the opportunity. These expenses will qualify for

reimbursement as part of the government's COVID-19 response. If hospitals require a cash advance to assist in COVID-19 response, the Ministry of Health is pleased to facilitate.

## ***10. Data and Reporting***

If retirement home locations are being used for patient care, hospitals should report these beds through the daily bed census reporting tool.

### **Guidance: Other Models**

Hospitals can choose to contract with a retirement home to provide care to residents under one of three contract and care models, as part of their COVID-19 strategy.

Discharge from hospital and placement in retirement homes may be applicable to the following groups:

- Hospital ALC patients
  - On the long-term care (LTC) waitlist
  - Other hospital ALC patients

In addition, where beds are available in these models, the hospital can consider appropriate referrals from the community by LHINs (for example, for individuals in the community on the LTC waitlist who go into crisis) in order to moderate demand for new hospital admissions.

### **Eligibility:**

Eligibility will depend on the model of care. For all models, eligible individuals will:

- be assessed by a health care provider as deemed suitable for temporary residence in a retirement home, with available supports.
- Provide consent (or, where applicable, the individual's Patient/Substitute Decision Maker (SDM) will provide consent.
- not have a COVID-19 diagnosis.

Individuals placed in a retirement home under these models will not be asked to provide a co-pay during their stay in the retirement home.



Exclusion for all models, patients who have:

- COVID-19 diagnosis
- behaviour or mental health issues that cannot be managed in a retirement home setting
- bariatric issues
- swallowing issues

We advise hospitals to clearly communicate to patients that under this model they will be discharged from the hospital into a setting where they will receive appropriate care for their needs, given the COVID-19 crisis.

### Delivery Models

Hospitals can choose to use any of the following models, depending on the suitability to their needs:

#### **MODEL A – Accommodation and Care Services**

This model may be suitable for patients with a MAPLe score of 1, 2 or 3 or equivalent care needs

The retirement home provides accommodation, and all care and services. For example, bathing, dressing, medication administration, escort to meals and activities, transfer, up to 2-person lift, and incontinence management. These spaces would operate under the purview of the *Retirement Homes Act, 2010*.

Supplies required to care for the resident are provided by the retirement home.

#### **MODEL B – Accommodation Only**

This model may be suitable for patients with a MAPLe score of 4 or 5 or equivalent care needs.

In this model hospitals contract with a retirement home to provide accommodation and facility services only. The hospital works with the LHIN to coordinate home and community care services to provide care for the individual in the Retirement Home.

These spaces would operate under neither the *Public Hospitals Act* nor the *Retirement Homes Act*

Examples of retirement home – accommodation and facility services:

- Housekeeping
- Meals
- Laundry
- Safety/security
- Maintenance
- Recreational activities

Examples of LHIN coordinated Home and Community Care:

- Personal support services and nursing services
- Other professional services, such as physiotherapy and occupational therapy
- Care supplies and PPE

Where possible, there should be a minimum number of suites in this model to ensure that care staff can provide dedicated care to the highest number of residents while working in only one setting, respecting the proper use of scarce health care resources.

### **Model C – Accommodation and Care Services for High Acuity Residents**

This model is suitable for patients with a MAPLe score of 4 or 5, or equivalent care needs.

The retirement home provides accommodations and all the care services outlined in Model A, plus the hospital works with the LHIN to coordinate the provision of any *additional* home and community care services to fill any remaining care needs.

The per diem paid to retirement homes would be the same as Model A (costs for additional home and community care services will be provided by the LHIN).

## Considerations for All Models

In assessing Models A-C, we encourage hospitals leaders to consider the following:

### **1. Care Provider**

Hospitals will be discharging patients into another care setting and should ensure individuals will continue to have access to a primary care provider.

### **2. Patient Appropriateness**

As always, hospitals should consider the clinical appropriateness of the patients who could be cared for in a retirement home setting. The province encourages hospitals to consider retirement home locations for those designated as ALC and others who can be safely cared for in this environment.

### **3. Property Considerations**

Prior to discharging patients, hospitals should consider the functionality of the retirement home setting, as retirement homes vary. Considerations include accessibility access to elevators, floors and areas for which care teams can complete work - like patient care centres. Hospitals will also want to consider safety standards and protocols and may wish to also consider how the property may be conducive to isolation should a patient be diagnosed with COVID-19.

### **4. Risk Assessment**

Hospitals should undertake a point of care risk assessment to ensure safety precautions are in place. For example, environmental and appropriate use of PPE to protect patients, residents and staff, and to prevent and stop the spread of infection.

### **5. Services**

Prior to discharge, hospitals should consider whether the services available through the retirement home can be provided by the LHIN to meet the needs of the patient.

## 6. *Equipment*

Hospitals should consider what type of equipment is required to provide care in a retirement home setting. This may include, but not be limited to, the purchasing of beds and lifts. It may also require the assurance of all necessary medical supplies, including PPE.

## 7. *Ancillary Support Services*

Hospitals should consider the retirement home’s ability to provide the support services required for residents including food services, environmental cleaning and infection control, security, and visitation policies.

## 8. *Funding*

Working with OH Regions, hospitals should identify these opportunities and seek input from the regional offices on the opportunity. These expenses will qualify for reimbursement as part of the government’s COVID-19 response. If hospitals require a cash advance to assist in COVID-19 response, the Ministry of Health is pleased to facilitate.

## 9. *Data and Reporting*

If retirement home locations are being used for resident are under any model, hospitals should report these beds through the daily bed census reporting tool.

### **Provincial Rate Sheet for Hospital Use of Retirement Homes**

The Ontario government has committed to reimburse hospitals for COVID-19 related expenses. Hospitals will be compensated at the rates indicated below.

All Options	Cost
Start-Up Costs - Furniture (e.g., bed, hospital bed) - Equipment (e.g., lift) - Transportation	<ul style="list-style-type: none"> <li>• Up to \$10,000 per room</li> <li>• Hospitals are encouraged to source this equipment from existing stockpiles.</li> </ul>

For all models, retirement home costs will be compensated for the total amount, based on the contracted number of spaces regardless of occupancy. Given the uncertainty around the length of time these arrangements may be required, it is suggested hospitals do not contract for an initial period of longer than six months, with an option to extend the contract if required.

These rates have been negotiated with the Ontario Retirement Communities Association (ORCA).

Model	Patients	Cost
MODEL A – Accommodation and Care/Services	MAPLe score of 1, 2 or 3	<ul style="list-style-type: none"> <li>• \$250.00 per diem per patient for a private room</li> <li>• \$215.00 per diem per patient for a double occupancy room</li> </ul> Cost does not include equipment (e.g., furniture, lifts)
MODEL B – Accommodation Only	MAPLe score of 4 or 5	<ul style="list-style-type: none"> <li>• \$150.00 per diem per patient for a private room</li> <li>• \$110.00 per diem per patient for a double occupancy room</li> </ul> Costs do not include equipment, supplies or PPE
MODEL C – Accommodation and Care/Services (plus outside services)	MAPLe score of 4 or 5	<ul style="list-style-type: none"> <li>• \$250.00 per diem per patient for a private room</li> <li>• \$215.00 per diem per patient for a double occupancy room</li> </ul>

\* The cost of care coordination and care services provided through the LHINs has not been included in these costs. LHINs will be compensated by the Ontario government separately for these services.

## Frequently Asked Questions – Retirement Homes

### **1. Is this province suggesting retirement homes must be used for patient care?**

No, hospitals should work within their regions to identify the capacity opportunities that best suit their area. The government encourages hospitals to first examine hospital capacity, followed by long term care, ahead of retirement home capacity.

### **2. How is the province assisting hospitals in using retirement home locations?**

The province has actioned two items to assist hospitals in pursuing this opportunity.

The first is a blanket approval under the subsection 4(2) of the *Public Hospital's Act* (PHA) to enable hospitals to lease or licence retirement home space to operate as hospital premises.

The second is the issuance of this document and rate sheet to guide hospitals through a variety of factors they should consider.

### **3. The blanket waiver of the PHA s. 4(2) has an end date of June 30, 2020. What if the only lease arrangement I can negotiate includes an end date that extends past June 30, 2020?**

The approval is currently in place until June 30, 2020. Hospitals should ask all partners to be flexible, fair and as accommodating on setting lease or licensing terms during this state of emergency. As we work with Public Health Officials and hospitals leaders throughout the next few weeks, the Ministry of Health will revisit the terms of the blanket s. 4(2) PHA approval waiver.

**4. What ancillary services might the province be coordinating that hospitals can access?**

The province is not acting as supply chain for hospitals related to retirement homes. Hospitals know their local area and are aware of vendors who can assist them to support capacity growth, including items such as furniture, equipment and staffing. Hospitals should also work with their shared services provider.

**5. Should all hospitals enter into retirement home arrangements as a result of this information being shared?**

This is a guidance document. Hospitals should act as they see fit and in concert with the pandemic capacity plans coordinated by Ontario Health's Regional Capacity Tables.

**6. What is the role of Ontario Health compared to hospitals in addressing this opportunity?**

Ontario Health has established regional planning tables in order to coordinate efforts to ensure appropriate capacity is available. Hospitals will be the entities by which retirement homes are contracted as service partners.

**7. Is the hospital to notify Ontario Health of any retirement home use?**

Yes, we are asking for Ontario Health Regional Leads to be notified so the use of retirement homes can be reported and tracked for both patient /resident data and reimbursement purposes.

**8. How do we ensure the hospital will be paid for any expenses incurred for the use of retirement homes as part of their COVID-19 strategy?**

The Ministry of Health has committed to reimbursing hospitals for COVID-19 related expenses and is working with both Ontario Health and the Ontario Hospital Association to ensure the proper tracking of all expenses, including those related to the use of retirement home locations.

**9. If my hospital needs a cash advance to support me securing a facility, can the Ministry of Health support us?**

Yes, the government is prepared to support cash advances as required. Please follow normal request protocols.

**10. What happens if a patient is on the LTC wait list and a spot becomes available while they are in a retirement home on an emergency placement?**

To minimize disruptions, residents will remain in the retirement home as an emergency placement during the COVID crises. Best efforts will be made to place individuals into a long-term care home as soon as one becomes available following the crisis response period.

**11. What happens to residents at the end of the emergency placement (i.e., when the COVID-19 crisis is over)? Will they go back to the hospital?**

The LHIN care coordinator will work to coordinate placement of residents from retirement homes into long-term care homes. The intent is for residents not to move back to hospital following their stay. However, this cannot be guaranteed as it will depend on availability of a long-term care bed, or other suitable placement. We anticipate it may take up to six months to transition people out of retirement homes following the conclusion of the COVID response period.