Ministry of Health and Long-Term Care
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<tr>
<td>AFHTO</td>
<td>Association of Family Health Teams Ontario</td>
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<td>AOHC</td>
<td>Association of Ontario Health Centres</td>
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<tr>
<td>CAMH</td>
<td>Centre for Addiction and Mental Health</td>
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<td>CBSA</td>
<td>Canadian Border Services Agency</td>
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<td>CCIRH</td>
<td>Canadian Collaboration for Immigrant and Refugee Health</td>
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<td>CHC</td>
<td>Community Health Centre</td>
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<td>CMAH</td>
<td>Community Mental Health Association of Canada</td>
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<td>CRC</td>
<td>Canadian Red Cross</td>
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<td>DND</td>
<td>Department of National Defence</td>
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<td>EMAT</td>
<td>Emergency Medical Assistance Team</td>
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<td>FHT</td>
<td>Family Health Teams</td>
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<td>GAR</td>
<td>Government Assisted Refugee</td>
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<td>GOC</td>
<td>Government Operations Centre</td>
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<td>HPOC</td>
<td>Health Portfolio Operations Centre</td>
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<td>IFHP</td>
<td>Interim Federal Health Program</td>
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<td>ILS</td>
<td>Interim Lodging Site</td>
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<td>IME</td>
<td>Immigration Medical Examination</td>
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<td>IRCC</td>
<td>Immigration, Refugees and Citizenship Canada</td>
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<tr>
<td>LGBTQI</td>
<td>Lesbian, Gay, Bisexual, Trans, Queer, and Intersex</td>
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<td>LHIN</td>
<td>Local Health Integration Network</td>
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<td>MCIIT</td>
<td>Ministry of Citizenship, Immigration and International Trade</td>
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<td>MEOC</td>
<td>Ministry Emergency Operations Centre</td>
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<td>MOHLTC</td>
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<td>MOL</td>
<td>Ministry of Labour</td>
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<td>NACI</td>
<td>National Advisory Committee on Immunization</td>
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<td>NCC</td>
<td>National Coordination Cell</td>
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<td>NPAO</td>
<td>Nurse Practitioners’ Association of Ontario</td>
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<td>NPLC</td>
<td>Nurse Practitioner-Led Clinic</td>
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<td>OCFP</td>
<td>Ontario College of Family Physicians</td>
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<td>OHIP</td>
<td>Ontario Health Insurance Plan</td>
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<td>OMA</td>
<td>Ontario Medical Association</td>
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<td>OPI</td>
<td>Over the Phone Interpretation</td>
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<td>PEOC</td>
<td>Provincial Emergency Operations Centre</td>
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<td>PHAC</td>
<td>Public Health Agency of Canada</td>
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<td>PHO</td>
<td>Public Health Ontario</td>
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<td>PHU</td>
<td>Public Health Unit</td>
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<td>PPE</td>
<td>Personal Protective Equipment</td>
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<td>PSR</td>
<td>Privately Sponsored Refugee</td>
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<td>PTSD</td>
<td>Post-Traumatic Stress Disorder</td>
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<td>RAP</td>
<td>Resettlement Assistance Program</td>
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<td>RNAO</td>
<td>Registered Nurses’ Association of Ontario</td>
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<td>UNHCR</td>
<td>United Nations High Commissioner for Refugees</td>
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Background and Context

The Crisis in Syria

Since the outbreak of civil war in Syria in 2011, over 4 million Syrians have fled the country. Most have taken temporary shelter in refugee camps in neighbouring countries of Lebanon, Jordan, and Turkey. The United Nations High Commissioner for Refugees (UNHCR) has called situation in Syria the largest humanitarian emergency of our era.

The UNHCR has issued an urgent appeal to the international community for assistance in resettling vulnerable refugees who have been displaced from Syria.

Canada is among several countries around the world that is responding to this urgent situation by taking in refugees from Syria for permanent resettlement.

Canada’s Commitment

The Government of Canada has committed to resettling 25,000 government assisted refugees from Syria. Government Assisted Refugees (GARs) are refugees that have been registered and identified by the UNHCR and referred to Canada. The federal government funds a network of settlement agencies to provide assistance and income support to GARs. Beyond this commitment, additional refugees will be arriving that are privately sponsored. Privately sponsored refugees (PSRs) are identified and supported by private sponsors of organizations or groups of individuals for their first year in Canada (this support includes income support and practical assistance).

On November 24, 2015, the Government of Canada released its plan for welcoming Syrian refugees to Canada. Under this plan, the Government of Canada wishes to bring in 25,000 refugees (government assisted and privately sponsored) by the end of February 2016.

Ontario’s Responsibility

Ontario has a long and proud history of welcoming refugees and helping them settle and integrate in their new communities. In 2014, Ontario welcomed over 11,400 refugees to start a new life in our province.

Ontario will play a significant role in the resettlement of Syrian refugees.
Toronto’s Lester B. Pearson International Airport will be one of two entry points for refugees arriving in Canada. Montréal’s Pierre Elliot Trudeau International Airport will be the other point of entry. Refugees who arrive at either airport may be temporarily accommodated or settled in Ontario.

Temporary accommodation sites in Ontario and Québec will house refugees whose housing at their final destination community is not yet ready. These sites will provide important interim lodging for some refugees until they can be moved to a permanent host community.

As Canada’s largest province, Ontario will become home to a large proportion of the refugees. On September 12, 2015, the Government of Ontario announced funding to help bring 10,000 refugees to Ontario by the end of 2016, and it is possible that more than 10,000 may ultimately settle in Ontario. Cities and towns across the province will welcome Syrian refugees into their communities.

Ontario is committed to collaborating with the Government of Canada and other partners to support the permanent resettlement and integration of Syrian refugees in Canada.

Health System Considerations

The arrival of a large number of newcomers to Canada and Ontario requires consideration about potential impacts to the health system. Ontario’s health system will be engaged both in activities related to the initial arrival of refugees, and in their ongoing settlement as they begin their new lives. The health and well-being of the refugees, and of the Canadians who will be welcoming them into their communities, will be an important concern throughout the resettlement process.

This Health System Action Plan outlines the actions to be taken by Ontario’s health system to support the objectives of the resettlement effort. It outlines roles and responsibilities among the various partners who will be involved in this effort, and provides guidance to support seamless and coordinated operations.

This plan is based on the best available information and planning assumptions at time of publication. The planning activities for Syrian refugee resettlement remain fluid and dynamic, and it is likely that aspects of this plan will evolve as the process progresses. The health system will be kept up to date throughout the process. Some health stakeholders may be asked to contribute to certain response activities or the development of new solutions as the situation unfolds.

Even as the health system works together on addressing existing challenges, the successful resettlement of Syrian refugees in Ontario will require a truly coordinated effort among all health system partners. It will also require close collaboration across sectors with areas such as social services, education, housing and others that are all interdependent with health. Settlement services and other non-profit agencies play a
key role in connecting newcomers to Canada and have extensive programs designed for refugees. Effective information sharing and collaboration between health system partners and these agencies will be essential in supporting the health and well-being of refugees. Ontario has the ability to lead in this regard, and to play a key role in the overall humanitarian effort. Ontario’s health system is up to the task.

Considerations related to Other Refugees in Ontario

The health needs of the Syrian refugee population are significant. It is important that the health system provides this group of refugees with high quality care. However, this Health System Action Plan: Syrian Refugees does not suggest that Syrian refugees should be given preferential treatment over refugees from other countries. Ontario welcomes thousands of refugees from around the world each year, all of whom deserve to receive the best health care our system can provide. The need for this Health System Action Plan is due to the scale of the effort to resettle such a large number of refugees within a short period of time.

Relatedly, nothing in this plan suggests the provision of special treatment to Syrian refugees over and above the treatment provided to other Ontarians.
Overview and Scope of Plan

Purpose of Ontario’s Health System Action Plan for Syrian Refugees

This Health System Action Plan: Syrian Refugees has been developed to guide Ontario’s health system in supporting the arrival and integration of Syrian Refugees in Ontario. It includes information and guidance related both to government assisted and privately sponsored refugees.

This plan is intended for health system stakeholders across the province, and provides a high-level summary of:

- Overall goal and objectives related to the resettlement of Syrian refugees in Ontario and Canada, focusing on the role of the health system.
- Actions that will be required to support refugee health and well-being, and to mitigate any potential public health risks.
- Guidance to support action by health system partners, including roles and responsibilities.
- Areas where local and/or sector plans, protocols, or processes may need to be developed.

This document does not include:

- All health system plans that may be put in place for specific local areas, sectors, organizations, services, or facilities.

This plan provides a framework and summary of actions. It will be supported by a series of annexes with more detailed guidance on specific topics and related roles and responsibilities. Annexes will be shared with relevant partners, and will be updated if new information becomes available or the situation changes.

Please note this plan contains references to third party websites for information purposes only. The Government of Ontario does not exercise control over the content of these websites and is not able to confirm that all information available on these sites is accurate or current.
Canada’s National Strategic Plan for Syrian Refugee Resettlement

The Government of Canada is responsible for the development and implementation of the overall plan to bring Syrian refugees to Canada. It has outlined a five-phase process by which refugees will be identified, transported, and settled in Canada. The five phases are:

1. **Identifying Syrian refugees to come to Canada:**
   Canada will work with the UNHCR to identify people in Jordan and Lebanon, where they have an extensive list of registered refugees. Canada is implementing a similar process in Turkey, where refugees are registered with the state and not the UNHCR.

2. **Processing Syrian refugees overseas:**
   Interested refugees will be scheduled for processing in dedicated visa offices in Amman and Beirut. Visa processing capacity will also be enhanced in Turkey. Security and health screening is also conducted during this phase.

3. **Transportation to Canada:**
   Transportation via privately chartered aircraft, with military aircraft assisting if needed, will be organized to help bring refugees to Canada. Flights will be destined to either Montréal or Toronto.

4. **Welcoming in Canada:**
   Upon arrival in Canada, all refugees will be welcomed and Border Services Officers will oversee the process for admission of the refugees into Canada. This will include final verification of identity. All refugees will be screened for signs of illness when they arrive in Canada and treatment will be available if anyone is ill upon arrival.

5. **Settlement and community integration:**
   Syrian refugees will be transported to communities across Canada, where they will begin to build a new life for themselves and their family. They will be provided with immediate, essential services and long-term settlement support to ensure their successful settlement and integration into Canadian society.

The five phases involved in this operation involve many considerations that extend beyond health. Activities related to identity verification, security screening, immigration processing, transportation logistics, language services, and community integration are all key components of the plan being coordinated by the Government of Canada. While these aspects of the process are outside the scope of Ontario’s Health Action Plan: Syrian Refugees, they will impact this plan.
There are health considerations involved in each of the five phases of the overall resettlement initiative, but many of these are also outside the scope of Ontario’s health system. Health care activities involved in phases one, two, and three are being coordinated by the federal government. For example:

- Before refugees are approved for travel, medical personnel appointed and overseen by the federal government will complete an immigration medical examination (IME) for each individual. This examination will include screening for infectious and communicable diseases, including but not limited to tuberculosis for example.

- Before refugees board their flights, they will undergo a fit-to-fly assessment to ensure they are not ill at the time of boarding.

- In some cases, medical personnel may be assigned to accompany a flight to respond to any health concerns that may arise in transit. The Department of National Defence may provide military medical personnel for such flights.

Phases four and five of the resettlement initiative will require the active engagement of Ontario’s health system. For example:

- When refugees arrive at Lester B. Pearson International Airport, Ontario health personnel will be required to respond in the event of illness identified during flight or during border screening.

- Following refugees’ arrival, Ontario’s health system will play a significant role in supporting their needs as they integrate into communities throughout the province. Ongoing monitoring of system capacity and its ability to address refugees’ health needs as well as public health surveillance for infectious diseases, should they occur, will also be important to ensure that any health risks are mitigated.

**Coordination of Health-Related Actions**

The Government of Canada will coordinate all health screening and monitoring activities for refugees prior to their arrival in Canada. The Health Portfolio Operations Centre (HPOC), managed by the Public Health Agency of Canada (PHAC), will coordinate the health aspects of the federal response and liaise with provincial and territorial health ministries.

Ontario’s Ministry of Health and Long-Term Care (MOHLTC) will coordinate health system activities to support the arrival and resettlement of refugees in Ontario. The Ministry’s Emergency Operations Centre (MEOC) has been activated to provide a single point of contact and coordination for the provincial health system. The MEOC will collaborate and share information across levels of government as well as with system and local partners, including detailed guidance related to each component of this plan. Health system partners may direct questions to MEOC’s Health Care Provider Hotline at 1-866-212-2272 or emergencymanagement.moh@ontario.ca.
Local health planning and activities will be coordinated by Local Health Integration Networks (LHINs), in collaboration with other local health system partners.

### Coordination with Other Sectors

Supporting the ongoing health needs of the refugee population is just one aspect of a complex response involving many sectors. The education sector, social services sector, housing sector, and many others are also involved in the overall resettlement effort. Refugees' needs in these areas are interconnected, and the success of Ontario’s resettlement effort will depend on how well these sectors work together. Health system integration with other key sectors and partners will be essential.

Cross-sector coordination and integration will occur at many levels:

- A federal National Coordination Cell (NCC), supported by the federal Government Operations Centre (GOC) is providing overall operational coordination across federal departments and with partners internationally.

- Cabinet Office of Ontario is providing overall strategic coordination of the provincial resettlement effort. An Executive Lead has been appointed to oversee this effort and a Syrian Refugee Resettlement Team has been established. A Strategic Advisory Table has been established with cross-sector representation to ensure Ontario is meeting the needs of the refugee population in a coordinated manner.

- Local cross-sector coordination efforts will occur in municipalities that are identified as final destination communities for Syrian refugees. It is important that local health sector partners are well integrated in each community effort, in coordination with their respective Local Health Integration Network (LHIN).

- Settlement services and other non-profit agencies play a key role in connecting newcomers to Canada and have extensive programs designed for refugees. Effective information sharing and collaboration between health system partners and these agencies will be essential in supporting the health and well-being of refugees.

### Planning Assumptions and Considerations

The following planning assumptions and considerations have been identified to guide Ontario’s health system in planning to support Syrian refugees:

#### General Assumptions

- A total of 25,000 Syrian refugees will arrive in Canada by end of February 2016. Of these, 10,000 may arrive by December 31, 2015. The remaining 15,000 would arrive in January and February 2016. Both groups will contain a mix of government-assisted refugees (GARs) and privately sponsored refugees (PSRs).
• Up to two thirds of refugees could arrive at Lester B. Pearson International Airport.

• At least 10,000 of these refugees could ultimately settle in Ontario.

• Refugees will complete immigration processing before traveling to Canada. They will arrive in Canada with permanent residency status.

• The federal government will identify appropriate cities and communities for interim lodging and final destination of government assisted refugees, with appropriate input from Ontario.

• Planning and response will be carried out in consideration of cultural sensitivities, the dignity and privacy of the refugees and their family connections.

Health-Related Assumptions

• The overall health of the refugee population is assessed as generally good, but many individuals will have specific health needs related to having experienced war in their country, and/or the difficult living conditions of refugee camps. Health needs could be physical (e.g., injury, chronic illness, nutritional deficits) or mental (e.g. post-traumatic stress, depression, anxiety). There will be a significant proportion of children (potentially up to half), for which paediatric care will be required.

• There is currently no indication of any significant risk of infectious diseases among the refugee population writ large. However, continued monitoring will be important to mitigate potential health risks.

• As part of immigration process, refugees will undergo a full immigration medical examination overseas prior to departure. They will also undergo a fit-to-fly assessment prior to boarding flights to Canada. Once they land in Canada, refugees will be screened for symptoms and signs of infectious disease by Canadian Border Services in accordance with the Quarantine Act.

• Refugees will be given a paper copy of their immigration medical examination (IME) results prior to departure for Canada, and will bring it with them to Canada.

• Arriving Syrian refugees will receive type 1 health benefits covered under the Interim Federal Health Program (IFHP), which is valid for 12 months following arrival. Refugees who settle in Ontario will be eligible for Ontario Health Insurance Plan (OHIP) coverage upon arrival.
**Language Considerations**

Many of the arriving refugees will not yet be fluent in English or French. Arabic or Kurdish will likely be the first language of most individuals. Wherever possible, health system partners should offer language assistance services at points of contact with Syrian refugees. Options to consider include in-person or over the phone interpretation (OPI) services, translation of core written messages, bilingual staff and students, and partnering with local sponsorship or community organizations. Access Alliance Multicultural Health and Community Services is one example of an organization that provides interpretation services for health care providers.

**Cultural Considerations**

Cultural sensitivity and awareness is important to consider when delivering health services to refugees. Considerations may include practices that respect modesty, such as providing long gowns that cover the lower legs, or ensuring access to gender-matched health care providers and interpreters, as appropriate.

The Ministry of Health and Long-Term Care is working with partners and subject matter experts to identify and share resources to support health sector partners in delivering culturally sensitive care. This information will be shared as part of education and awareness activities conducted by the ministry and other partners.

**Considerations related to Lesbian, Gay, Bisexual, Trans, Queer, and Intersex (LGBTQI) Refugees**

Research shows that LGBTQI individuals often have unique health needs and may delay or avoid seeking health care or choose to withhold personal information from health care providers due to past negative experiences. LGBTQI refugees may have faced persecution in their home country based on homophobia, biphobia, or transphobia, and may not feel comfortable disclosing their sexual orientation or gender identity.

Providing upfront information about LGBTQI resources and services is important to support LGBTQI refugees when they arrive in Ontario. Health care providers are encouraged to identify local LGBTQI organizations in their area that can provide resources to patients. In smaller municipalities, if LGBTQI organizations are not located in close proximity, information may be provided for services in the next closest municipality where they are available. Online resources may also be provided.

In Ontario, Rainbow Health Ontario works to improve the health and well-being of LGBTQI people, and to increase access to competent and LGBTQI-friendly health care. Their website offers an array of LGBTQI health related information including fact sheets, academic research articles, and other health services and resources.
Key Websites

Government of Canada

- Welcome Refugees – Immigration, Refugees and Citizenship Canada
- Interim Federal Health Program

Government of Ontario

- Syrian Refugees: How You Can Help (ontario.ca/syrianrefugees)
- Ministry of Citizenship, Immigration and International Trade
- Syrian Refugees: Information for Health Sector Partners
Ontario Health System Action Plan: Syrian Refugees

Goal

Ontario’s health system must be prepared and ready to support the needs of arriving Syrian refugees. The goal of this plan is to wrap health services around refugees at each stage of their resettlement journey.

Objectives

To achieve the goal of this plan and to meet the health needs of Syrian refugees arriving in Ontario, three overall objectives will provide the framework for health system actions:

- **Understand**
  - Understand refugees’ health status to assess needs

- **Prepare**
  - Prepare the health system to support refugees’ health needs by providing necessary information, coordination, and outreach

- **Respond**
  - Respond to refugees’ health needs upon arrival in the settings and communities they inhabit

The ministry will provide further information on the evaluation of these objectives.

Guidance to Support Action

Ontario’s health system stakeholders will take specific actions to meet each of the above objectives.

The remainder of this document outlines the actions required, key partners involved, roles and responsibilities, and general guidance related to each action. More detailed information and guidance will be provided in a series of annexes to this plan. Annexes will be shared with relevant partners, and will be updated if new information becomes available or the situation changes.
1: Understand refugees’ health status to assess needs

Refugee health profiles

Key Partners:

- Immigration, Refugees and Citizenship Canada (IRCC)
- Public Health Agency of Canada (PHAC)
- Public Health Ontario (PHO)
- Subject matter experts

Summary:

A health profile describes the general health characteristics and concerns of a population. It does not provide information about individuals, but rather about health issues that are likely to affect individuals within the population group. Health profiles can be used by health care providers to identify potential concerns when assessing their patients.

IRCC has published a population profile for Syrian refugees that includes a health profile.

More Information:

- Population Profile: Syrian Refugees – IRCC

Examples of Syrian Refugee Health Needs

*Based on Lebanon and Jordan experience as cited by 2015 Handicap international report.*
Pre-arrival medical assessment information

Key Partners:

- Department of National Defence (DND)
- Immigration, Refugees and Citizenship Canada (IRCC)
- Public Health Agency of Canada (PHAC)

Summary:

Each Syrian refugee arriving in Canada will be provided with a paper record of their immigration medical examination (IME) completed by medical personnel overseen by the Government of Canada.

Individuals are not required to provide their immigration medical examination records to provincial agencies or to health care providers. However, they may do so upon request to support health service delivery.

The ministry will work with the federal government to develop a mechanism for receiving appropriate, aggregate information pertaining to the health status of arriving refugees that the ministry can share with relevant partners on a regular basis.

IRCC will report any case of a reportable disease identified during an IME to Public Health Ontario, who will notify the appropriate local public health unit, as per existing notification processes.

More Information:

- Immigration medical record report – sample available from MEOC
2: Prepare the health system to support refugees’ health needs

Ministry Emergency Operations Centre (MEOC)

Key Partners:

- Local Health Integration Networks (LHINs)
- Public Health Units (PHUs)
- Health Care Provider Associations, Colleges, and Unions
- Provincial Emergency Operations Centre (PEOC)
- Health Portfolio Operations Centre (HPOC)

Summary:

The Ministry Emergency Operations Centre (MEOC) has been activated. It provides a single point of contact and coordination for the provincial health system in support of the Syrian refugee resettlement effort in Ontario. The MEOC will collaborate and share information across levels of government and with local partners, including detailed guidance related each component of this plan.

The MEOC will institute a regular business cycle of teleconferences and situation reports with the following groups, and will adjust the timing based on the situation:

- LHINs
- PHUs
- Associations, colleges, unions and other health stakeholders

MEOC Health Care Provider Hotline:

- Phone: 1-866-212-2272
- Email: emergencymanagement.moh@ontario.ca

Local planning to meet health service demands

Key Partners:

- Local Health Integration Networks (LHINs)
- Public Health Units (PHUs)
- Emergency Medical Assistance Team (EMAT)
- Local health providers and additional partners
- Canadian Red Cross (CRC)
Summary:

Local Health Integration Networks (LHINs) are responsible for local planning and coordination of health services. A coordination table should be created and led by each LHIN to guide local activities. Tables should be inter-professional and include local health system leaders and representatives from primary care, including paediatrics, mental health, public health, dental, emergency services, and other key areas likely to be involved in supporting refugee health care. It should engage persons with experience in providing care to refugees.

All health sector partners potentially involved in providing care or services to refugees should:

- Anticipate services and supports provided by their organizations that may be accessed by or delivered to refugees
- Prepare to deliver those services and supports in consideration of refugee needs (including culture and language considerations).
- Connect with their local LHIN coordination table and stay up-to-date on ministry guidance provided.
- Register for the Interim Federal Health Program.

Providers that are located in close proximity to Resettlement Assistance Program (RAP) centres, Interim Lodging Sites (ILSs), or Toronto’s Lester B. Pearson International Airport may be required to undertake additional preparedness activities in coordination with local LHIN tables. Identified RAP centres in Ontario are located in Hamilton, Kitchener, London, Ottawa, Toronto, and Windsor. Identified ILSs in Ontario are military bases in Borden, Kingston, Meaford, Petawawa, and Trenton.

Primary care providers are often an individual’s initial point of contact to the health system. They will play a key role in developing and supporting local coordination plans for required health services. Upon arrival, refugees may require transitional care and should present to a primary care provider for initial medical assessment and/or referral to other health services.

A Refugee HealthLine, that will develop and maintain a registry of health care providers, will be used to connect refugees to health service providers for transitional care. All health care providers interested in participating can contact toll-free 1-866-286-4770 to add their name, practice, location, service and the number of prospective patients/clients they are able to take on.

A full overview of roles and responsibilities for local health system coordination will be provided in an annex to this plan.

More Information:

- Annex: Local Health System Coordination

**Refugee HealthLine:**

- 1-866-286-4770
Health insurance coverage

Key Partners:

- ServiceOntario
- Immigration, Refugees and Citizenship Canada (IRCC)
- Public Health Agency of Canada (PHAC)
- Ministry of Citizenship, Immigration, and International Trade (MCIIT)

Summary:

At the current time, Syrian refugees who arrive in Canada on or after November 4, 2015 will receive an Interim Federal Health Program (IFHP) certificate upon arrival. The IFHP certificate is valid for 12 months and includes basic coverage, supplemental coverage (e.g. vision and dental care), and prescription drug coverage. The IFHP is administered by Immigration, Refugees and Citizenship Canada. Additional information is available on IRCC’s website.

Health care providers who may be involved in managing the care of refugees should register for the IFHP. This may include physicians, nurse practitioners, dentists, optometrists, therapists, hospitals, paramedic services and others.

Refugees who are settling in Ontario will be eligible to apply for the Ontario Health Insurance Plan (OHIP) upon arrival. Convention refugees and protected persons are exempt from the usual 3-month waiting period. Individuals may apply for an OHIP card in person at a ServiceOntario Centre (see Health Insurance Coverage Annex for more information).

Refugees may initially utilize IFHP coverage when accessing primary health care services if they have not yet registered for OHIP. Once registered with OHIP, they will use OHIP for primary care services, but can continue to use IFHP coverage for supplementary benefits not covered by OHIP.

Some provincial health programs require OHIP coverage, and are not covered by IFHP, such as services provided by Community Care Access Centres.

Dental issues are a key health concern among the refugee population, particularly children. Partial dental coverage will be provided under the IFHP for the first 12 months following arrival. Local public health units, dental providers, and some Community Health Centres may also provide dental services under the Healthy Smiles Ontario program for low-income children beginning January 1, 2016.
More Information:
- Annex: Health Insurance Coverage
- Interim Federal Health Program (IFHP) certificate – sample available from MEOC
- **IFHP – Immigration, Refugees and Citizenship Canada**
- IFHP – Medavie Blue Cross (coverage provider)
- IFHP - Registration Information
- [Verify a patient’s IFHP coverage online](#) or call 1-888-614-1880
- ServiceOntario
- Healthy Smiles Ontario

Information and resources for health care providers to support refugee care

Key Partners:
- Association of Ontario Health Centres (AOHC)
- Ontario College of Family Physicians (OCFP)
- Registered Nurses’ Association of Ontario (RNAO)
- Public Health Ontario (PHO)
- Refugee Clinics
- Additional subject matter experts

Summary:
While several organizations and providers in Ontario have extensive experience providing services to refugee groups, some of the Syrian refugees may be resettled in communities that do not typically provide refugee-focused services.

The ministry is collaborating with key partners to develop education and awareness webinars and materials for the health sector to support refugee resettlement. These materials will help direct participants to existing resources to support local planning, address the care needs of the refugee population, and clarify health insurance benefits coverage.

Further details and scheduling of education and awareness webinars and materials by specific organizations (e.g. health care provider colleges and associations) will be provided when they are available.

Worker health and safety

Key Partners:
- Public Health Ontario (PHO)
- Ministry of Labour (MOL)
Summary:

There is currently no indication of any significant risk of infectious diseases among the Syrian refugee population. Health care workers who are providing services to refugees should be prepared to undertake routine practices and additional precautions for infection prevention and control (IPAC), appropriate to the scope of their duties. IPAC precautions include worker immunization, personal protective equipment (PPE), hand hygiene, and IPAC training.

The ministry has worked with Public Health Ontario to develop guidance for health worker safety based on the current risk situation. More information will be provided in an annex to this plan.

More Information:

- Annex: Worker Health and Safety and IPAC Practices in Clinical Care Settings
3: Respond to refugees’ health needs upon arrival

Arrival at the airport

Key Partners:
- Canadian Border Services Agency (CBSA)
- Public Health Agency of Canada (PHAC)
- Emergency Medical Assistance Team (EMAT)
- Peel Paramedic Services
- Toronto Paramedic Services
- Hospitals in the vicinity of the airport
- Public Health Units

Summary:
Lester B. Pearson International Airport in Toronto will be one of two points of entry to Canada for Syrian refugees. Appropriate health assessment and response capacity at the airport and local hospitals will be required to support each group of refugees as they arrive. The ministry will alert the health system of arriving flights with as much advance notice as possible.

The Canadian Border Services Agency (CBSA) will conduct routine processing, which includes screening for signs of illness. Individuals who may be ill will be referred to a Public Health Agency of Canada (PHAC) quarantine officer. Quarantine officers will assess whether there is a need to apply measures authorized under the Quarantine Act.

A small component of the Emergency Medical Assistance Team (EMAT) will initially be stationed at the airport to provide on-site medical care to any refugees who have urgent or sub-acute medical conditions upon arrival. Whether there is a need for EMAT to have a continued onsite presence will be determined based on experiences from the first few incoming flights.

Paramedics and ambulances will be staged at the airport to provide care and transport to hospital in the event that any individuals require more definitive medical care. Hospitals in the vicinity of the airport should ensure appropriate emergency department staffing levels and translation services at times of flight arrivals to meet potential needs.

Public health units will work with quarantine officers in the event that a case of a reportable infectious disease is suspected.

More Information:
- Annex: Airport Health Services
- Emergency Medical Assistance Team
Temporary accommodation sites

Key Partners:

- Emergency Medical Assistance Team (EMAT)
- Department of National Defence (DND)
- Public Health Agency of Canada (PHAC)
- Canadian Red Cross (CRC)
- Local Health Integration Networks (LHINs)
- Public Health Units (PHUs)

Summary:

Most of the arriving refugees will travel directly to their new home communities. In the event that government-assisted refugees’ permanent housing is not yet ready when they arrive in Canada, they will be housed temporarily in one of two types of sites.

Federal Resettlement Assistance Program (RAP) centres currently perform the function of providing temporary accommodation and transitional support to government-assisted refugees. There are six RAP centres identified in Ontario. They are located in Hamilton, Kitchener, London, Ottawa, Toronto, and Windsor. RAP centres will be the first choice for temporary accommodation. However, their capacity is limited and may be exceeded as refugees continue to arrive.

The federal government has identified six military bases that may provide additional temporary accommodation to refugees until housing at their final destination community is ready. These are referred to as Interim Lodging Sites (ILSs). Five of the six ILSs are located in Ontario: Borden, Meaford, Kingston, Petawawa, and Trenton. The sixth ILS is Valcartier in Québec. Kingston is expected to be the first ILS site to be activated.

Government-assisted refugees arriving at either Toronto’s Pearson International Airport or Montréal’s Trudeau International Airport may be temporarily housed at an ILS if required. Whether ILSs are used depends on many factors, including processing overseas, housing absorption, RAP capacity, and base readiness and capacity. If required, the Canadian Red Cross will perform overall site management at some or all ILSs.

A small component of the EMAT team may initially be deployed to the first ILS activated in Ontario. EMAT would provide onsite primary care to refugees, and would coordinate locally with the appropriate LHIN coordination table(s). EMAT would also work with local health care providers in the event that a refugee requires additional care outside of the ILS.

EMAT would likely provide onsite care to one ILS only. Therefore, should more than one ILS require onsite care, the ministry would likely work with the appropriate LHIN coordination table(s) to arrange onsite primary care using local providers. More information is provided in the Interim Lodging Sites annex to this plan.
Public health units may be asked to provide certain immunizations to refugees who are temporarily housed at ILSs to protect them before they move on to their final destination communities (See Immunization section of this plan for more information).

In addition to RAP centres and ILSs, other provincial and municipal properties may provide temporary accommodation in certain circumstances, if required.

More Information:

- Annex: Interim Lodging Sites

Health system information for refugees and sponsors

Key Partners:

- Public Health Ontario (PHO)
- Public Health Agency of Canada (PHAC)
- Ministry of Citizenship, Immigration, and International Trade (MCIIT)
- Health care providers

Summary:

Ontario has a long history of welcoming refugees. There are many existing resources and programs to support refugees and their sponsors to understand and access Ontario’s health system. Many of these resources are made available through resettlement agencies and sponsoring organizations.

The ministry has developed an information package for Syrian refugees to support their access to health services in Ontario. This information package includes instructions on how to register for the Ontario Health Insurance Plan (OHIP), how to locate appropriate health care providers, and other information.

The information package will be posted online and distributed to settlement and sponsorship agencies throughout the province.

More Information:

- Fact Sheet: Refugee Health Care Options in Ontario

Primary and community care

Key Partners:

- Association of Ontario Health Centres (AOHC)
- Ontario College of Family Physicians (OCFP)
- Registered Nurses’ Association of Ontario (RNAO)
- Nurse Practitioners’ Association of Ontario (NPAO)
- Ontario Medical Association (OMA)
- Association of Family Health Teams Ontario (AFHTO)
- Refugee health clinics
• Community Health Centres (CHCs)
• Family Health Teams (FHTs)
• Nurse Practitioner-Led Clinics (NPLCs)
• Midwifery Practices
• Private practices
• Walk-in clinics

**Summary:**

Primary care providers are often an individual’s initial point of contact to the health system. They will play a key role in supporting local coordination plans for required health services. Upon arrival, refugees may require transitional care and should present to a primary care provider for initial medical assessment and/or referral to other health services.

A Refugee HealthLine, that will develop and maintain a registry of health care providers, will be used to connect refugees to health service providers for transitional care. All health care providers interested in participating can contact toll-free **1-866-286-4770** to add their name, practice, location, service and the number of prospective patients/clients they are able to take on.

Refugee Health Clinics and Community Health Centres are experienced in providing care to refugee populations. They are a preferred option for providing transitional care and other services, where available. As a significant percentage of incoming refugees are expected to be children, access to paediatric care will also be necessary.

Once refugees have settled into their permanent accommodations, they will require regular health services. Having their health needs supported by the local health system will be an important component in their overall integration into Canadian society.

In addition to primary health care, newly arrived refugees are likely to require other supports and supplemental services. Dental and vision care needs may be identified as part of the transitional primary care assessment. Home and community care support services may also be required.

**Refugee HealthLine:**

- **1-866-286-4770**

**More Information:**

- Annex: Local Health System Coordination
- **Canadian Medical Association Journal: Evidence-based clinical guidelines for immigrants and refugees**
- **Canadian Medical Association Journal: Caring for a newly arrived Syrian refugee family**
- **The College of Family Physicians of Canada: Refugee Health Care**
- **Canadian Collaboration for Immigrant and Refugee Health (CCIRH): Migrant Health Knowledge Exchange Network**
**Immunization**

**Key Partners:**
- Public Health Units
- Health care providers

**Summary:**
Given the deterioration of the Syrian health system beginning in 2011, it is estimated that many of the arriving refugees – particularly children – are not up-to-date on their immunizations. Immunization is not part of the standard immigration medical examination that is conducted prior to refugees’ travel to Canada. Ontario Health care providers should conduct an assessment of immunization history and offer catch-up immunizations as required. Local public health units may advise health care providers regarding immunization, and may also be required to support the immunization of large groups of incoming refugees staying in Interim Lodging Sites (ILSs) or Refugee Assistance Program (RAP) centres across the province.

Some refugees may have documented immunization information as part of their health record provided by the United Nations Refugee Agency (UNHCR) or other records. Only documented evidence should be used to confirm immunization history. Individual recall of immunization or history of illness should not be considered reliable evidence of immunity. When an individual’s vaccine record is unreliable or unavailable, vaccines should be provided as if the individual were not yet immunized.

Catch-up immunization schedules for children and adults are provided in Ontario’s publicly funded immunization schedules, as well as by the National Advisory Committee on Immunization (NACI). If a number of vaccines are required, providers may need to prioritize which vaccines to give first. The immunization annex to this plan provides guidance on which vaccines should be given priority, depending on the client’s age.

The immunization annex to this plan also provides information on vaccine schedules and products that were commonly used in Syria prior to 2011. This may be helpful to interpret immunization records that may be available.

**More Information:**
- Annex: Immunization
- [Publicly Funded Immunization Schedules for Ontario](#)
- [Canadian Immunization Guide: Vaccination of Specific Populations](#)

**Mental health and addictions services**

**Key Partners:**
- Local Health Integration Networks (LHINs)
- Community Mental Health Association of Canada (CMAH)
- Mental health and addictions service providers
Summary:

Individuals who have experienced war and have been forced to leave their homes will understandably experience symptoms of distress. Many refugees have lost friends and family in the conflict. Many have experienced periods in refugee camps, trauma, violence, and may experience post-traumatic stress disorder (PTSD) and other issues. All of them have lost their homes, possessions, routines, and community supports. They may experience anxiety and uncertainty about their future once they arrive in Canada. Many are likely to require specific mental health supports as they move beyond events of the past and become accustomed to their new lives in Canada.

A variety of mental health and addictions support services are available to refugees who need them. These include counselling and treatment, crisis intervention, and social rehabilitation services.

Due to cultural and language barriers, it is possible that discussions concerning mental health and mental illness may be interpreted or received differently by individuals. In order to provide the best possible care, providers should be sensitive to this.

Coordination of services is provided locally. Each Local Health Integration Network (LHIN) has a mental health lead who can help identify local mental health and addictions agencies and service providers.

Refugees and sponsors should be made aware of the supports available to them. They may be referred to the ConnexOntario Helplines below (which operates in 170 languages), or referred directly to an appropriate service provider. The Refugee HealthLine may also be used to connect to transitional care. Neither ConnexOntario nor the Refugee HealthLine are crisis lines, but can help connect refugees to services. Distress and Crisis Ontario also provides a listing of local crisis lines.

Coordination of appropriate language services will be particularly important for provision of mental health and addictions services.

More Information:

- [ConnexOntario](#) Mental Health Helpline: 1-866-531-2600
- [ConnexOntario](#) Drug and Alcohol Helpline: 1-800-565-8603
- [Distress and Crisis Ontario](#)
- [Centre for Addiction and Mental Health (CAMH): Refugee Mental Health ToolKit](#)
Infectious disease and health system surveillance

Key Partners:

- Health Care Providers
- Public Health Units
- Public Health Ontario (PHO)
- Public Health Agency of Canada (PHAC)

Summary:

The risk of infectious diseases spreading to the Canadian population as a result of the Syrian refugee operation is low. Refugees do not currently represent a threat to Ontario or Canada with respect to communicable diseases. However, refugees are a priority group for communicable disease prevention and control efforts because they are more vulnerable. This is particularly true in group accommodation settings.

Syrian refugees will arrive over the course of three months and will be housed in numerous communities across Canada. As such, the overall health system impacts of the resettlement effort are generally expected to be low. However, certain services may experience increased demands in some local areas. Clinics specializing in immigrant and refugee health, as well as primary care services in areas that receive a larger concentration of refugees, could be most impacted.

The ministry and Public Health Ontario are considering minor enhancements to routine surveillance processes to support the arrival of Syrian refugees. These activities would pertain only to surveillance of infectious diseases and health system impacts. It would not cover surveillance of chronic diseases, injury, or mental health issues at this time.

The refugees will arrive during influenza season, which is a period of natural surge in the health system. As such, it will be important for the ministry and health system partners to monitor the impact of the resettlement process on health care providers, and to be prepared to provide support if needed.

Additional information on surveillance will be made available in an annex to this plan.

More Information:

- Annex: Infectious Disease and Health System Surveillance
- Annex: Infectious Disease Case and Contact Management
Looking Ahead

In the months and years ahead, the Syrian refugees who settle in Ontario will build a new life for themselves and their families. They will become our neighbours, friends, colleagues, and community members. Their health and well-being will continue to be supported by our provincial health system, as it is for all Ontarians.

More Syrian refugees – in addition to the initial group of 25,000 – may continue to be resettled in Canada throughout 2016 and beyond. Ontario is committed to supporting this ongoing effort. We will continue to provide the necessary guidance and coordination that the health system needs to wrap health services around this population.

The actions that Ontario’s health system takes now will provide a solid start for refugees as they settle and integrate into Ontario’s communities. Our actions will also build a strong foundation for the health system to support future refugees that may arrive in Ontario.

When we look back, we will take pride in the work our health system did to support the arrival of Syrian refugees. We will know that we played a fundamental role in the overall humanitarian effort, and made a difference in the lives of thousands of new Ontarians.
Annexes

The following annexes to this plan will be made available through the Ministry of Health and Long-Term Care’s Emergency Operations Centre (MEOC).

MEOC Health Care Provider Hotline:
Phone: 1-866-212-2272
Email: emergencymanagement.moh@ontario.ca

- Airport Health Services
- Health Insurance Coverage
- Infectious Disease and Health System Surveillance
- Infectious Disease Case and Contact Management
- Interim Lodging Sites
- Immunization
- Local Health System Coordination
- Worker Health and Safety and IPAC Practices in Clinical Care Settings

The following resources are also available from the MEOC:

- Fact Sheet: Refugee Health Care Options in Ontario
- Interim Federal Health Plan Certificate - Sample
- Immigration Medical Examination Report - Sample
- Population Profile: Syrian Refugees (Immigration, Refugees and Citizenship Canada)
Ontario Health System Action Plan: Syrian Refugees  
Annex: Airport Health Services  
December 17, 2015

The planning activities for Syrian refugee resettlement remain fluid and dynamic and it is likely that aspects of this annex will evolve as the process progresses. Updated versions of the annex will be issued as required.

This annex builds on information provided in the Ontario Health System Action Plan: Syrian Refugees. It outlines more detailed information about the airport arrival response concept of operations for Syrian refugees who are resettling in Ontario.

Toronto Pearson International Airport and Montreal’s Trudeau International Airport have been identified as the two points of entry (POE) in Canada for Syrian refugees. Amman, Jordan will be the point of departure with a flight time of approximately 12 hours to Toronto. Airlift operations are expected to take place from early December 2015 through to the end of February 2016. It is expected that the highest volume of refugee arrivals will occur in January and February 2016. It is unknown how many flights will land at Pearson Airport. This Annex will focus on the concept of operations at Pearson International Airport. The diagram at the end of this annex provides an overview of the airport arrival concept of operations.

In-flight Medical Emergency
- If there is an acute medical emergency during the flight, the aircraft will be diverted according to normal protocols or will carry on to the scheduled point of entry with appropriate notification of ground resources, including emergency response personnel.
- There may be some medical issues on board, such as vomiting due to travel sickness, anxiety, etc. Should a passenger show severe symptoms of infectious disease they will be isolated as much as possible. For example, the last two rows of the plane may be left empty to provide an isolation space during the flight.
- The planning and coordination of in-flight medical care is the role of the federal government. It is not expected that provincial/local resources will be required during this phase of the response.

Terminal Health Screening and Care
Upon arrival, refugees will go through regular health and security screening processes. During screening, acute medical emergencies, communicable disease concerns or primary care needs may be identified. If identified, individuals will be directed to the appropriate level of care
required before continuing on to their final destination community or temporary accommodations.

**Acute Medical Emergencies**
- Any acute medical emergencies requiring immediate attention prior to point of entry processing (see below) will be transported to hospital by Peel Regional Paramedic Services (PRPS) paramedics and ambulances staged at the airport terminal.
  - Toronto Paramedic Services will provide support to PRPS as required.
- Once an individual has been treated and released from hospital, they will return to the point of entry to complete point-of-entry processing.

**Point of Entry Screening**
**Canada Border Services Agency Screening Officers**
- Canada Border Services Agency (CBSA) processing of Syrian refugees will begin at the point of entry upon disembarkation of the aircraft.
- After CBSA processing, individuals will be immediately directed to CBSA Screening Officers who will perform initial screening for signs and symptoms of communicable disease. They will refer to the Quarantine Officer, for further assessment, anyone who screens positive according to the screening algorithm, appears ill, or reports feeling ill. All other passengers will be processed following CBSA standard procedure.
- CBSA officers will issue Interim Federal Health Program (IFHP) Certificates, valid for 12 months, to refugees at the point of entry.

**Public Health Agency of Canada Quarantine Officers**
- Public Health Agency of Canada (PHAC) Quarantine Officers will be on site to assess passengers referred by Screening Officers. Quarantine Officers will assess these individuals and determine whether there is a need to apply measures authorized under the Quarantine Act.
- If an order is issued to report to public health:
  - Quarantine Officers will notify Public Health Ontario (PHO) and forward the assessment to PHO.
  - PHO will notify the impacted public health unit and the MOHLTC MEOC
  - Quarantine Officers will also send a notification of orders issued to Peel Region Public Health and Toronto Public Health for information purposes as per routine process.
- If an order is issued to report to hospital for medical assessment:
  - Quarantine Officers will notify the MOHLTC MEOC for appropriate follow-up.

**Primary Care in Terminal**
- Following CBSA processing and quarantine assessment, or at any point during processing, an individual experiencing an urgent or sub-acute medical complaint may present to a primary health care clinic set up by the Emergency Medical Assistance Team (EMAT) in the terminal. Here, individuals will be assessed by an interdisciplinary team consisting of medics, nurses, nurse practitioners, and/or physicians.
The purpose of the EMAT primary health care clinic is to prevent surge at surrounding hospital emergency departments and community paramedic services.

- PRPS paramedics and ambulances will be staged at the terminal to provide transport to hospital for those requiring more definitive medical care.
- Note: if transportation to hospital occurs before CBSA processing and quarantine assessment has been completed, an individual will return to the point of entry once they have been treated and released from hospital.

Welcome Centre

- Following CBSA processing and quarantine assessment, and barring any issues, refugees will proceed to a Welcome Centre, located in the vicinity of the POE. At the Welcome Centre, refugees will receive basic services, information and support.
- Privately Sponsored Refugees (PSRs) will be transported to a rendezvous site to meet their sponsors, and then move on to their new accommodations.
- Government Assisted Refugees (GARs) will be matched to their accommodation sites by Immigration, Refugees, and Citizenship Canada (IRCC) and transported to their accommodations.
Airport Arrival Concept of Operations Diagram

In-flight
Is there an acute medical emergency?

Yes
- Arrive at Pearson Airport
- CBSA Screening Officers perform initial screening for communicable disease. Is the individual suspected of having a communicable disease?
  - No
  - Primary care required
  - EMAT provides primary care at the Infield Terminal (IFT). Are there acute medical needs?
    - No
      - Primary care required
    - Yes
      - PRPS provides care and transport to hospital.

No
- Welcome Centre
  - Order issued to refugees
    - Report to hospital or
    - Report to local PHU
  - Inform Toronto PH and Peel Region PH
  - Notify PHO/MOHLTC
  - Inform local PHU
  - Interim Lodging Sites (ILS)
  - Destination communities

Provincial / Local key partners:
- Emergency Medical Assistance Team (EMAT)
- Peel Regional Paramedic Services (PRPS)
- Toronto Paramedic Services (TPS)
- Hospitals
- Public Health Units (PHUs)
- Ministry of Health and Long-Term Care (MOHLTC)
Ontario Health System Action Plan: Syrian Refugees

Annex: Health Insurance Coverage

December 17, 2015

The planning activities for Syrian refugee resettlement remain fluid and dynamic and it is likely that aspects of this annex will evolve as the process progresses. Updated versions of the annex will be issued as required.

This annex builds on information provided in the Ontario Health System Action Plan: Syrian Refugees. It outlines more detailed information about health insurance coverage for Syrian refugees who are resettling in Ontario.

Interim Federal Health Program

The federal Minister of Immigration, Refugees and Citizenship (IRCC) has designated the Syrian refugees eligible for Type 1 benefits under the Interim Federal Health Program (IFHP).

- At the current time, Syrian refugees who arrived in Canada, on or after November 4, 2015, both Government Assisted Refugees (GARs) and Privately Sponsored Refugees (PSRs) will receive Type 1 benefits. Type 1 benefits include Basic Coverage, Supplemental Coverage, and Prescription Drug Coverage.

Coverage will be for up to a year, starting immediately upon arrival at point of entry. Once a refugee is eligible for coverage under a provincial or territorial health plan, basic health care coverage under the IFHP will cease. However, the Supplemental and Prescription Drug Coverage will continue for up to one year.

Basic Coverage includes:
- in-patient and outpatient hospital services
- services of medical doctors, registered nurses and other health-care professionals licensed in Canada, including pre and postnatal care
- laboratory, diagnostic and ambulance services

Supplemental Coverage includes health-care benefits such as:
- limited dental and vision care
- home care and long-term care
- services by allied health-care practitioners including clinical psychologists, occupational therapists, speech language therapists and physiotherapists
• assistive devices, medical supplies and equipment (e.g. prosthetic equipment, mobility aids, hearing aids)

Prescription Drug Coverage includes:
• prescription medications and other products listed on provincial-territorial public drug plan formularies

Please see the Provider section of Medavie Blue Cross IFHP website for more information on coverage and benefit grids. Health providers are also able to verify a patient’s IFHP coverage. This includes accessing a secure section of the provider web portal or by calling Medavie Blue Cross at 1-888-614-1880 (08:30 to 16:30 in each Canadian zone) to verify a patient’s coverage.

Medavie Blue Cross maintains a list of registered providers on their website so that private sponsors, clients and others stakeholders can readily identify providers in their community.

Information is available on IRCC’s website for both beneficiaries and providers. In the case of health care providers, the website includes instructions on how to become registered with the program, how to determine eligibility and how to submit a claim.

Ontario Health Insurance Plan

Ontario Health Insurance Plan Eligibility for Refugees

Every resident of Ontario who meets the eligibility requirements as set out in Regulation 552 of the Health Insurance Act is entitled to Ontario Health Insurance Plan (OHIP) coverage.

Convention refugees/protected persons residing in Ontario are OHIP eligible and are exempt from the typical three-month waiting period.

Obtaining an Ontario Health Card

To obtain an Ontario health card, eligible residents over the age of 15 years and six months must apply in person at a ServiceOntario centre.

The requirements to complete the registration process at the ServiceOntario centre are as follows:

• Individuals are required to provide documents that confirm their OHIP-eligible immigration status, their residence in Ontario and their identity. The person’s photo and signature are also captured to appear on his/her Ontario health card when issued.
• Children under the age of 15 years and six months can be registered by their parents or legal guardians; a child is not required to present in person at a ServiceOntario centre.
It is anticipated that Syrian refugees will have a Permanent Resident document with coding indicating they are a Convention Refugee / Protected Person. This will enable them to be exempt from the three-month waiting period.

ServiceOntario staff are familiar with Convention Refugee / Protected Person coding, as well as the additional documents required to complete registration for OHIP coverage.

After an individual is successfully registered for OHIP, ServiceOntario will mail an Ontario health card. All OHIP registrants are provided with a transaction record at the time of registration. The transaction record can be used to indicate OHIP coverage when receiving insured health services until the Ontario health card arrives in the mail.

As stated above, all refugees from Syria will be eligible for immediate coverage under the IFHP, and providers can bill this program for health services until refugees are eligible for coverage under a provincial or territorial health plan.

Syrian refugees who will be residing in Ontario are eligible for OHIP. If OHIP-insured services are provided to a Syrian refugee prior to him / her registering for OHIP, these services will be eligible under OHIP. After registering for an Ontario health card, the patient will need to inform the provider of the patient’s OHIP number and version code to enable the provider to bill OHIP for the services.

In those cases where a Syrian refugee has not yet obtained their Ontario health card, the provider has the usual options in handling billing for these services, including holding the claim until the patient can provide their OHIP number.

To obtain further information on the billing of these services, providers may contact their local OHIP claims office or the Service Support Contact Centre at: 1 (800) 262-6524.
Health Insurance Coverage for the First Year: Diagram

- **IFHP**—Interim Federal Health Program. Coverage will be for up to 12 months, starting immediately upon arrival at point of entry. Once a refugee is eligible for coverage under a provincial or territorial health plan, basic health care coverage under the Interim Federal Health Program would cease. However, the Supplemental and Prescription Drug Coverage would continue for up to 12 months.

- **OHIP**—Ontario Health Insurance Plan. To obtain an Ontario health card, eligible residents must apply in person at a ServiceOntario centre. Convention refugees/protected persons have an OHIP-eligible status and are exempt from the 3-month waiting period.
The planning activities for Syrian refugee resettlement remain fluid and dynamic and it is likely that aspects of this annex will evolve as the process progresses. Updated versions of the annex will be issued as required.

This annex was developed in partnership with Public Health Ontario.

This annex builds on information provided in the Ontario Health System Action Plan: Syrian Refugees. It outlines more detailed information about surveillance for Syrian refugees who are resettling in Ontario.

Purpose
The purpose of this surveillance annex is to provide an overview of potential public health threats among refugees to Ontario and to summarize how surveillance of infectious disease routinely operates in Ontario. A variety of data sources will be highlighted that may be utilized to support situational awareness, public health action and policy development associated with the resettlement of Syrian refugees in Ontario. The information contained in this annex is subject to change as more information becomes available.

Scope
The following surveillance objectives and recommendations pertain to public health threats that may impact refugees, as well as the potential impact to our health system. Given the impact of displacement and ongoing insecurities experienced overseas, the scope of surveillance not only focuses on communicable disease in Ontario, but non-communicable diseases including mental health.

Surveillance objectives
1. To facilitate early recognition of public health threats in order to rapidly implement prevention and control measures, particularly in group accommodation settings;
2. To assess refugee impact on the health system, particularly during the influenza season;
3. To provide a general overview of the incidence of infectious diseases among Syrian
refugees in Ontario to inform future planning in Ontario and Canada, and other countries receiving Syrian refugees in the near future.

**Routine surveillance of infectious disease in Ontario**
In Ontario, the [Health Protection and Promotion Act](https://www.ontario.ca/laws/statutes/hppa) (HPPA) and its relevant regulations create a framework by which healthcare providers and laboratories, as well as other individuals (including school principals and superintendents of institutions), have a legal duty to report certain illnesses, known as Reportable Diseases, to public health authorities. The [Ontario Public Health Standards’ Infectious Disease Protocol, 2015](https://www.publichealthontario.ca/en/health-topics/communicable-diseases), incorporated under s.7 of the HPPA, provides direction on the public health management of reportable diseases in Ontario.

Public Health Units (PHUs) in Ontario are responsible for the management of reportable infectious diseases of public health importance with an aim to prevent further transmission. Their responsibilities include:

- case and contact management;
- identification, investigation and management of outbreaks, which includes complying with all active Enhanced Surveillance Directives (ESDs);
- tracking reportable diseases through the integrated Public Health Information System (iPHIS) or any other method specified by the ministry;
- reporting immunization coverage using Panorama or any other method specified by the ministry;
- interpretation, use, and communication of surveillance data to relevant audiences;
- notification of MOHLTC and Public Health Ontario (PHO) as specified in the Infectious Disease protocol.

PHO supports PHUs by providing scientific and technical advice for infectious disease surveillance, epidemiology, case and contact management, and outbreak management, and operates the Public Health Ontario Laboratory (PHOL).

The data sources routinely and most commonly used to conduct infectious disease surveillance in Ontario include reportable disease notifications through iPHIS and data from PHOL; however, other sources are used where available depending on the disease under surveillance. Administrative data may also be used under certain circumstances. At the local level, surveillance varies by public health unit.

PHO will maintain the process for interjurisdictional notifications that is currently in place should landed refugees with a reportable disease migrate within Canada. As per the International Health Regulations, the MOHLTC will continue to ensure Ontario fulfills the surveillance and reporting requirements included within the regulations.

**Citizenship and Immigration Canada and the Health Screening Process**
As millions of Syrians continue to be displaced due to conflict in their home country, the Government of Canada will work with Canadians, including private sponsors, non-governmental organizations, provincial, territorial and municipal governments to welcome 25,000 Syrian refugees.
As part of the immigration process, a full immigration medical exam (IME) has been conducted for each person, including screening for some communicable diseases before arrival into Canada. As per the Quarantine Act, upon arrival, refugees will be screened for signs of illness when they arrive in Canada and treatment will be available if required.

The Emergency Medical Assistance Team (EMAT) will be onsite at the airport to support this process.

Please note, there are no changes to the reporting and notification process for incoming refugees to Canada who have been diagnosed with a reportable disease through the IME. These notices will be shared with public health units via PHO.

**Potential infectious disease threats to Ontario**

According to the Public Health Agency of Canada (PHAC), the risk of infectious diseases spreading within the Canadian population due to the Syrian refugee operation is generally quite low, although low immunization coverage is an issue in this group (PHAC, Infectious Disease Risks Associated with Transporting Refugees into Canada: Rapid risk assessment, November 17, 2015). Refugees do not currently represent a threat to Ontario/Canada with respect to communicable diseases, but they are a priority group for communicable disease prevention and control efforts because they are more vulnerable, particularly in group accommodation settings (ECDC, Communicable disease risks associated with the movement of refugees in Europe during the winter season; 10 November 2015). Based on the ECDC review and other rapid risk assessments, the potential infectious disease-related threats, their likelihood of occurring within this group of refugees, and public health impact in Ontario are listed in Table 1 below. The following list of health events is for information and planning purposes as they have been observed in a number of refugee populations.

**Table 1: Potential infectious disease threats by likelihood among refugees and impact to Ontario**

<table>
<thead>
<tr>
<th>Higher public health impact</th>
<th>Moderate likelihood of occurring</th>
<th>Low likelihood of occurring</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Measles</td>
<td>Active tuberculosis</td>
</tr>
<tr>
<td></td>
<td>Hepatitis A</td>
<td>Respiratory diseases (e.g., MERS)</td>
</tr>
<tr>
<td>Lower public Health Impact</td>
<td>Varicella</td>
<td>Rabies</td>
</tr>
<tr>
<td></td>
<td>Influenza</td>
<td>Cutaneous diphtheria</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bacterial meningitis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(meningococcal disease, <em>Haemophilus influenza</em> type b)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Invasive Group A Streptococcus</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rubella</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Polio</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pertussis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Malaria and other vector-borne diseases</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>Streptococcus pneumoniae</em></td>
</tr>
</tbody>
</table>
- Sexually transmitted infections
- Skin infections/ infestations (e.g., scabies, bed bugs, head lice, cutaneous leishmaniasis)
- Blood borne infections (hepatitis B, hepatitis C and HIV)
- Gastroenteritis
- Tetanus

Sources:

Surveillance Recommendations
The following data sources are recommended in order to meet the above mentioned surveillance objectives.

integrated Public Health Information System (iPHIS)
iPHIS is the database used by public health units to report information on cases of reportable diseases to PHO and the MOHLTC. PHO will be releasing an Enhanced Surveillance Directive (ESD) in order to increase awareness of the incoming Syrian refugee population and communicate data entry and other enhanced reporting requirements for PHUs so that cases or outbreaks of reportable diseases related to Syrian refugees can be easily identified and reported. This will allow for control and prevention methods to be rapidly implemented, particularly in group accommodation settings, and will also provide data to inform future planning within and outside Ontario.

Public Health Ontario Laboratory (PHOL)
PHOL tests primary clinical and environmental specimens that are submitted directly to PHOL by clinicians, health units, hospitals or community laboratories, as well as specimens and isolates that are sent for confirmatory or additional testing by other laboratories such as hospital or community laboratories. PHOL’s laboratory information system stores the results of all tests performed by PHOL, however, it does not capture results of testing performed by other laboratories. PHOL data is used as an early information source for some pathogens in clinical or environmental samples. No enhancements will be made to PHOL data to reflect the incoming Syrian refugee population.
**Acute Care Enhanced Surveillance (ACES)**

The primary goals of ACES are to monitor changes and trends in the incidence of endemic disease with a focus on respiratory and gastrointestinal illness, and to detect new or emerging infectious disease threats. Currently, the syndromic surveillance system monitors visits to Emergency Departments (ED) at more than 100 hospitals across Ontario (over 80% of all Ontario hospitals), covering 27 of Ontario’s 36 public health units. It captures data for approximately 12,000 visits and 3,000 admissions per day. Information from each ED visit across all sites is collected centrally within the system where it is then classified into syndromes based on the patient’s chief complaint or admission diagnosis.

ACES currently has available a number of syndromes that it monitors from ED room visits and hospital admissions that may see an impact from the incoming Syrian refugee population. These include communicable and chronic disease, injury, environmental health, substance misuse and mental health.

For more information regarding ACES, please visit: [http://www.kflaphi.ca/?page_id=59](http://www.kflaphi.ca/?page_id=59)

**Tracking of Immunizations Administered**

Immunization data will be reported to the MOHLTC. Further information will be communicated as to how this will be done.

**Surveillance and public health response for refugees while in Interim Lodging Sites**

Should an Interim Lodging Site (ILS) be activated to assist with the refugee response, surveillance within the site will occur. The purpose of this surveillance is to facilitate early recognition of outbreaks or diseases of public health concern and prompt implementation of prevention and control measures within the ILS. The MOHLTC and PHO are working in collaboration with PHAC and the Red Cross to develop and implement a surveillance strategy.

**Influenza surveillance**

As the incoming refugee population arrives in Canada during the influenza season, increased monitoring of the impact of influenza on the population and the health care system is encouraged. The following resources may be of assistance:

- PHO produces a weekly [Ontario Respiratory Pathogen Bulletin](http://www.kflaphi.ca/?page_id=59), which summarizes laboratory confirmed respiratory illnesses entered into iPHIS and from PHOL. It also summarizes transmission activity levels by public health unit and respiratory outbreaks in institutions;
- Critical Care Services Ontario produces a weekly Influenza Like Illness (ILI) report, accessible via the website, that summarizes by LHIN the number of patients in Critical Care Units in addition to the number of laboratory confirmed influenza from ILI patients;
- ACES developed an [ILI mapper](http://www.kflaphi.ca/?page_id=59), accessible via the website, that monitors syndromic surveillance of ILI in emergency room visits and hospital admissions across Ontario;
- From November to April, the Ministry of Health and Long-Term Care reviews a set of indicators on a weekly basis to assess how the province is progressing through the
influenza season. These indicators include data from syndromic and laboratory surveillance systems, as well as health system utilization data.

Global communicable disease monitoring
As per routine practice in Ontario, PHO and the MOHLTC encourage health system partners to monitor the following established information sources for situational awareness (please see Table 2).

Table 2: Recommended established information sources to monitor public health threats

<table>
<thead>
<tr>
<th>Source</th>
<th>Description</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Media Reports</td>
<td>• Public media reports from internet, television, print, etc.</td>
<td>• Provides situational awareness on local, provincial, national, and global issues, including countries from which refugees may be arriving.</td>
</tr>
<tr>
<td></td>
<td>• Reports can be local, provincial, national, and global.</td>
<td></td>
</tr>
<tr>
<td>ProMed</td>
<td>• Internet-based reporting system of information on communicable diseases and outbreaks and acute exposures to toxins that affect human health on a global scale.</td>
<td>• Provides situational awareness on global public health issues, including from countries from which refugees may be arriving.</td>
</tr>
<tr>
<td></td>
<td>• Reports are typically global.</td>
<td></td>
</tr>
<tr>
<td>CIDRAP news</td>
<td>• E-mail newsletter containing curated news scans on infectious disease topics impacting humans.</td>
<td>• Provides situational awareness on global public health issues, including from countries from which refugees may be arriving.</td>
</tr>
</tbody>
</table>

Communication of surveillance information for situational awareness and to inform public health action and decision making
A coordinated approach for communicating surveillance information will occur in order to ensure all stakeholders have the necessary information for situational awareness regarding any impacts to human health, increased burden to Ontario’s health care system or issues which would result in public health action.

Surveillance information will be communicated via the MEOC’s Situational Reports and other routine or enhanced data sharing mechanisms as appropriate.
The planning activities for Syrian refugee resettlement remain fluid and dynamic and it is likely that aspects of this annex will evolve as the process progresses. Updated versions of the annex will be issued as required.

This annex was developed in partnership with Public Health Ontario.

This annex builds on information provided in the Ontario Health System Action Plan: Syrian Refugees. It outlines more detailed information about public health management of infectious diseases for Syrian refugees who are resettling in Ontario.

This document contains information on the following:

- Routine case and contact management in Ontario;
- Routine surveillance for Syrian refugees;
- Recommendations regarding TB screening;
- Considerations for case and contact management in congregate living settings such as Interim Lodging Sites (ILSs);
- Table 1: Summary of case and contact management by disease/condition;
- Table 2: Diseases and conditions by likelihood of occurring and public health impact.

Routine case and contact management in Ontario

- In Ontario, infectious diseases that are deemed to be reportable under the Health Protection and Promotion Act (1990) are listed in Ontario Regulation 559/91.
- As outlined in the Health Protection and Promotion Act, 1990, health care professionals, health institutions and laboratories within Ontario have a duty to report to the local medical officer of health any individual who accesses care in Ontario who they know or believe has a reportable disease.
- Case and contact management is a core public health action to control and prevent infectious diseases and protect the health of the population.
Case management involves ensuring individuals diagnosed with reportable diseases are provided with the appropriate information about their disease, treatment, measures to prevent transmission to others and follow up. Interviews with cases can also assist with identifying outbreaks when common exposures are identified among the cases.

Contact management is appropriate for some reportable diseases and involves identifying individuals who may have been exposed to the reportable disease and providing follow up and interventions as appropriate. Follow-up and interventions may include counseling about signs and symptoms and what to do if these develop, laboratory testing for the disease, antibiotic prophylaxis and/or immunoprophylaxis (vaccination and/or immune globulin, as appropriate).

Local boards of health are responsible for ensuring appropriate case and contact management is completed. Local public health units complete case and contact management as outlined in the Ontario Public Health Standards, 2008 and Ontario protocols.

Information obtained from cases and some contact information is entered into the integrated Public Health Information System (iPHIS). Information about cases forms the basis of Ontario’s surveillance system that establishes the baseline rates for reportable diseases and assists in determining when an outbreak may be occurring because baseline rates are exceeded.

Health care professionals and public health units are required to work together to ensure the appropriate testing, treatment and follow up is complete for cases of reportable diseases in Ontario.

Routine surveillance for Syrian refugees
An Enhanced Surveillance Directive will provide public health units with information on how to identify reportable diseases occurring in Syrian refugees.

Recommendations regarding TB screening
Refugees from Syria do not require routine screening for latent tuberculosis (TB) by primary care providers just because of their refugee status. Syria, Lebanon, Jordan and Turkey are not considered high incidence countries for TB. In addition, as part of their Immigration Medical Examination by Citizenship and Immigration Canada, all Syrian refugees will have undergone an assessment for active TB, including a chest-X-ray for those 11 years of age and older.

However, as per usual care, clinicians should be advised to assess for signs and symptoms of pulmonary and extra pulmonary tuberculosis on history and physical exam and conduct the appropriate diagnostic tests should the history or physical exam suggest tuberculosis (including a chest X-ray and obtaining three sputum samples for smear and culture). (See Chapter 3, Canadian Tuberculosis Standards)
In addition, as per usual care, testing for latent TB would be indicated in Syrian refugees who have conditions that increase their risk of progression from latent to active TB as highlighted in Tables 1 and 2 of *Chapter 6 of the Canadian Tuberculosis Standards*, particularly if they are a candidate for treatment of latent tuberculosis. Additional information on the management of people new to Canada can be found in the *Chapter 13 of the Canadian Tuberculosis Standards*. Table 1 of Chapter 13 provides information on those at increased risk for TB exposure and/or latent TB infection, including the risk in immigrants from countries with high TB incidence.

**Rationale**

Since 2009, the World Health Organization (WHO) definition of a high incidence country for tuberculosis has been based on all forms of active TB, and not just smear positive active TB, as was done previously. Based on the current definition, the cut off for a high incidence country is 30 per 100,000 using a 3-year average. Guidelines only recommend routine screening in new immigrants from high incidence countries. (see *Chapter 13, Canadian Tuberculosis Standards* for additional details).

Based on 2014 WHO reports of new and relapsing active TB, the TB rates in Syria were 17/100,000 in 2014 with a decreasing trend. Rates in Turkey, Lebanon and Jordan were reported as 18/100,000, 16/100,000 and 5.5/100,000 respectively.

**References**

World Health Organization – Tuberculosis Country Profile

**Considerations for case and contact management in congregate living settings such as Interim Lodging Sites (ILSs)**

The management of cases and contacts in congregate living settings follows the general recommendations for case and contact management, as outlined in the *Routine case and contact management in Ontario* section above and in more detail in the associated protocols and reference documents. However, because of the nature of congregate living settings, which may involve communal sleeping arrangements, common meals in shared eating environments and shared washroom facilities, certain challenges may be encountered in case and contact management. This may include the following:

- difficulty isolating infectious cases;
- challenges with dedicating washroom facilities to cases with gastroenteric illness to prevent transmission;
- determining who should be considered contacts;
- larger numbers of contacts than usual;
- lack of immunization records should vaccination of contacts be required;
• potential need to immunize large numbers of people;
• logistical challenges such as laundry and showering facilities for managing scabies.

Although not a risk for communicable diseases, bed bug infestations are a possibility in a congregate living setting. Strategies should be instituted to detect bed bug infestations as early as possible (e.g. regular inspections of beds and bedding, early detection of bites by health care providers). Should bed bugs be detected, management of the living environment will require involvement of a pest management company and a coordinated effort to prevent introducing the bed bugs to other locations as people move from the congregate living setting.

Head lice may also be introduced into congregate living settings and require management to prevent further spread. Head lice do not pose a communicable disease risk.

Collaboration among local and provincial public health officials and health care providers working in the congregate living setting will assist with managing the public health challenges that may arise in congregate living settings.

The following outlines some general considerations regarding case and contact management in congregate living settings based on modes of transmission of different infectious diseases. Infectious disease-specific considerations can be found in Table 1. Table 2 provides an assessment of the likelihood of these diseases occurring and their potential public health impact should they occur.

1. Case management
   
   a. Airborne transmission

   Management of diseases spread by the airborne route (i.e. measles, tuberculosis, varicella) would require isolating the patient from others, which may not be possible in a congregate living setting. This would require the case to be removed from the congregate living setting to a location where isolation is possible.

   b. Gastrointestinal diseases and diseases spread by the fecal-oral route

   Management of cases of gastrointestinal infectious diseases (e.g. norovirus, rotavirus, salmonella, shigella, verotoxogenic E. coli) and other diseases spread by the fecal-oral route (e.g. hepatitis A, hepatitis E) to prevent transmission to others may require a number of measures. Such measures could include:

   • removing the individual from the congregate living setting;
   • isolating the case within the congregate living setting and dedicating washroom facilities for them;
   • providing enhanced access to hand hygiene for the case; or
   • enhanced environmental cleaning with a particular focus on cleaning of washrooms.
c. Droplet transmission

Cases of diseases spread by the droplet route (e.g., influenza, mumps, rubella, pertussis, meningococcal etc.) may be managed in a variety of ways depending on the disease and circumstances. Options include:

- removing the individual with the infection from the congregate living setting;
- isolating the individual within the congregate living setting;
- housing ill individuals with similar symptoms together in a separate location (cohorting);
- advising ill individuals to remain two metres away from others and/or advising ill individuals to wear a mask if close contact with others cannot be avoided;
- enhanced hand hygiene and environment cleaning would also be important for diseases such as influenza.

d. Direct Contact

Diseases such as scabies, impetigo and staphylococcal skin infections require immediate treatment and avoidance of direct contact with others until the case is no longer infectious. The bedding and clothing of people with scabies require laundering or removing from any body contact for at least three days. Cutaneous diphtheria requires isolation and treatment with antitoxin and antibiotics.

Bed bug bites should be considered in the differential diagnosis of people with skin lesions.

Head lice may also be a concern in congregate living settings.

2. Identification and Management of Contacts

a. Airborne transmission

Compared to the usual household, a larger number of contacts may be exposed to a person with an airborne infection in a congregate living setting. For diseases such as measles and varicella, where post-exposure prophylaxis (vaccination and/or immune globulin, as appropriate) is possible, rapid identification of exposed contacts would be required in order to provide post-exposure prophylaxis in a timely manner to those who are susceptible. For example, post-exposure prophylaxis for measles requires offering measles-containing vaccine within three days of exposure (if no contraindications to a live vaccine) or serum immune globulin within six days of exposure. Providing immunization to all susceptible individuals (with no contraindication to a live vaccine) in the congregate living setting, even if beyond the time frame for post-exposure prophylaxis, may prevent further transmission of the vaccine-preventable infection. Determining susceptibility in the contacts may be difficult due to the lack of immunization records. This could result in a large number of contacts requiring post-exposure prophylaxis.
Active tuberculosis (TB) among refugees is unlikely, as all refugees will have been screened for TB before arrival in Canada. The screening involves a chest X-ray for those 11 years of age and over. In the unlikely event of an active case of TB in a congregate living setting, the numbers of contacts requiring screening via tuberculin skin test may be larger than usual. In addition, some of the contacts may be skin test positive due to previous TB exposure or BCG vaccination, complicating the management of contacts and determining the extent of contact tracing to be conducted.

b. Gastrointestinal diseases and diseases spread by the fecal-oral route

One or more cases of gastrointestinal infection (especially due to highly infectious agents such as norovirus and rotavirus), or other diseases spread by the fecal-oral route (e.g. hepatitis A, hepatitis E) may indicate an outbreak. Outbreaks in congregate living settings may occur because of common meals or because of person-to-person transmission. Enhanced surveillance among exposed individuals would be required. Additional preventive measures included enhanced environmental cleaning, particularly of shared washrooms, and careful attention to hand hygiene.

In the event of a hepatitis A case in a congregate living setting, contacts who shared washrooms with the case would be offered post-exposure prophylaxis (vaccination and/or immune globulin as appropriate). If the case prepared food for others or if a food item was suspected as the potential source of hepatitis A, post-exposure prophylaxis would be offered to those who ate the implicated foods. Consideration would be given to whether all individuals in the congregate living setting should be vaccinated.

In the very unlikely event of a polio case, which would be considered a public health emergency, contact identification and management would be guided by an outbreak management team.

c. Droplet transmission

For vaccine-preventable infectious diseases such as mumps and rubella, post-exposure prophylaxis is not recommended. However, to prevent further spread in a congregate living setting, vaccinations would be offered to all those who are susceptible. Determining susceptibility in newly arrived refugees may be difficult due to the lack of immunization records. This could result in a large number of people being offered vaccination.

For pertussis, the focus of prevention efforts would be to protect infants less than 1 year of age since they are more likely to suffer complications from pertussis. The recommendations to provide antibiotic prophylaxis to persons in exposed household settings where there are high risk contacts (infants less than 1 year of age and pregnant women in their third trimester) will need to be adapted to the congregate
living setting. This may involve recommending antibiotic post-exposure prophylaxis for exposed high risk contacts or for exposed individuals who are in regular close contact with high risk contacts. In addition, to prevent further spread in a congregate living setting, pertussis vaccinations would be offered to all those who are not fully immunized. Due to the lack of immunization records, this could result in a large number of people being offered vaccination.

In the event of influenza detection in a congregate living setting, enhanced efforts would be made to offer and promote the influenza vaccine to those who had not already received this season’s vaccine. Enhanced environmental cleaning and hand washing would be promoted.

For invasive meningococcal disease, the recommendations for post-exposure prophylaxis (antibiotics and vaccination as appropriate) for household contacts and those who share saliva would be adapted to those living in a congregate setting. Those living in close proximity to the case may need to be considered similar to household contacts.

Similarly for invasive Group A streptococcus, the household recommendations would be adapted to those living in a congregate living setting with a focus on offering post-exposure (antibiotics) to those with more direct contact such as family members and those with exposure to saliva from the case or living in close proximity to a clinically severe case.

For any of the diseases discussed above, enhanced surveillance would be required to detect any further cases in the congregate living setting.

Since cutaneous diphtheria has been recently reported among refugees, information about this infection is included in the direct contact section below.

d. Direct Contact

No specific interventions are recommended for contacts of impetigo or staphylococcal skin infections apart from watching for the development of similar infections.

For scabies, concurrent application of a scabicide is required for all potentially exposed individual, with laundering of bedding and clothing or removing these from any body contact for at least three days. Shower facilities would be required for removal of the scabicide after overnight application.

For cutaneous diphtheria, individuals who are similar to household contacts or have had close contact require cultures from their nose and throat and antibiotic prophylaxis, unless the cutaneous diphtheria lesion in the case is found to be nontoxicigenic. Incompletely vaccinated contacts or those whose last diphtheria vaccination was more than 10 years ago should receive diphtheria-containing vaccine. Contacts will require careful monitoring and will be advised not to attend
school, and to avoid contact with children under 7 years of age or known unimmunized persons, and not to provide health care or handle food until treatment is complete and cultures from the nose and throat are negative. Vaccination should be offered to all individuals in the congregate living setting who have not completed their diphtheria vaccination series, recognizing difficulties of assessing immunization history when vaccination records are not available.

Enhanced surveillance would be required to detect any additional cases of these infections/infestations.

3. **Necessary resources for public health when completing case and contact management**
   - Coordination between ILS and public health unit
   - Language services
   - Access to medical care
   - Access to testing
   - Access to treatment
   - Laboratory processing and capacity
<table>
<thead>
<tr>
<th>Disease</th>
<th>Routine Case and Contact Management Resources and/or Guidance Documents</th>
<th>Special Considerations for Congregate Settings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed Bugs</td>
<td>CDC: Bed Bugs</td>
<td>Will require involvement of a pest control company and strategies to ensure bugs are not transported to other living environments as people move</td>
</tr>
<tr>
<td>Chlamydia*</td>
<td>Ontario Infectious Diseases Protocol: Appendix A and Appendix B</td>
<td>As per usual practice</td>
</tr>
<tr>
<td>Diphtheria*</td>
<td>Ontario Infectious Diseases Protocol: Appendix A and Appendix B</td>
<td>Obtain nasopharyngeal and throat swabs; Offer antibiotics; Update vaccination in close contacts (see Appendix A); Certain restrictions apply to close contacts (See Appendix A); Assess</td>
</tr>
<tr>
<td>Emerging Severe Respiratory Infections*</td>
<td>Ontario Infectious Diseases Protocol:</td>
<td></td>
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<tr>
<td></td>
<td><strong>SARS:</strong> Appendix A and Appendix B</td>
<td><strong>MERS-CoV:</strong> The MOHLTC’s website contains information including guidance for health care workers and health sector employers.</td>
</tr>
<tr>
<td>Typhoid Fever:</td>
<td>Ontaio Infectious Diseases Protocol: Appendix A and Appendix B</td>
<td>Fecal-oral; Food, water borne and person-to-person</td>
</tr>
<tr>
<td>Paratyphoid Fever:</td>
<td>Ontaio Infectious Diseases</td>
<td></td>
</tr>
</tbody>
</table>

Diphtheria immunization history and offer vaccination to all individuals who are not fully vaccinated.
### Ontario Infectious Diseases Protocols:

<table>
<thead>
<tr>
<th>Gastroenteritis – bacterial and viral</th>
<th>Protocol: Appendix A and Appendix B</th>
<th>those who shared implicated food</th>
<th>hours apart; Enhanced surveillance of close contacts and all individuals; Enhanced environmental cleaning and hand hygiene</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Salmonella</strong>: *</td>
<td></td>
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<tr>
<td><a href="#">Appendix A and Appendix B</a></td>
<td></td>
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<tr>
<td><strong>Shigella</strong>: *</td>
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<tr>
<td><a href="#">Appendix A and Appendix B</a></td>
<td></td>
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<tr>
<td><strong>Yersinia</strong>: *</td>
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<tr>
<td><a href="#">Appendix A and Appendix B</a></td>
<td></td>
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<tr>
<td><strong>Campylobacter</strong>: *</td>
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<tr>
<td><a href="#">Appendix A and Appendix B</a></td>
<td></td>
<td></td>
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<tr>
<td><strong>Verotoxigenic E. coli</strong>: *</td>
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<tr>
<td><a href="#">Appendix A and Appendix B</a></td>
<td></td>
<td></td>
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<tr>
<td><strong>Norovirus</strong>: *</td>
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<tr>
<td><a href="#">Appendix A and Appendix B</a></td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>Rotavirus</strong>: *</td>
<td></td>
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<tr>
<td><a href="#">Appendix A and Appendix B</a></td>
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</tbody>
</table>

Fecal-oral; Food, waterborne and person-to-person

Isolation or dedicated toilet facilities, enhanced hand hygiene and environmental cleaning.

Avoid food handling or caring for others

Close contacts at increased risk as well as those who shared washroom with case.

If food item is implicated as a source, increased risk for those who shared implicated food items.

Enhanced surveillance of close contacts and all individuals;

Enhanced environmental cleaning and hand hygiene.

For rotavirus, ensure vaccination of all eligible infants.
<table>
<thead>
<tr>
<th>Disease</th>
<th>Protocol</th>
<th>Transmission</th>
<th>Treatment and Management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gonorrhea</strong>*</td>
<td>Ontario Infectious Diseases Protocol: Appendix A and Appendix B</td>
<td>Sexually trans-mitted</td>
<td>Treatment and safer sex counselling As per usual practice</td>
</tr>
<tr>
<td><strong>Head Lice</strong></td>
<td><strong>CDC: Head Lice</strong></td>
<td>Infestation</td>
<td>Treatment with a pediculicide and nit removal; Launder clothing and bedding or bag for two weeks Secure contacts and others with head-to-head contact Check for lice in family contacts and head-to-head contacts and manage as cases if evidence of head lice found</td>
</tr>
<tr>
<td><strong>Hepatitis A</strong>*</td>
<td>Ontario Infectious Diseases Protocol: Appendix A and Appendix B</td>
<td>Fecal-oral; Food, water borne and person-to-person</td>
<td>Isolation or dedicated toilet facilities, hand hygiene, enhanced environmental cleaning Identify contacts who shared washroom facilities; If a food item is implicated, identify those who ate the food item Assess immunization history; Vaccinate and/or provide immune globulin as appropriate to exposed individuals as soon as possible Consider vaccination of all individuals depending on the</td>
</tr>
<tr>
<td>Disease</td>
<td>Protocol Details</td>
<td>Circumstances</td>
<td></td>
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<td>-------------------------------------------------------------------------------</td>
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<tr>
<td>Hepatitis B*</td>
<td>Ontario Infectious Diseases Protocol: Appendix A and Appendix B</td>
<td>As per usual practice; Screening and vaccination of household and sexual contacts</td>
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<tr>
<td></td>
<td>Blood-borne and sexually transmitted</td>
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<td></td>
<td>Safer sex and injection drug use counselling as appropriate;</td>
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<tr>
<td></td>
<td>Avoid sharing personal hygiene objects; Refer for clinical assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis C*</td>
<td>Ontario Infectious Diseases Protocol: Appendix A and Appendix B</td>
<td>As per usual practice</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Blood-borne</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Safer sex and injection drug use counselling as appropriate;</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Avoid sharing personal hygiene objects; Refer for clinical assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis E</td>
<td>CDC: Hepatitis E</td>
<td>Enhanced surveillance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fecal-oral</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Isolation or dedicated toilet facilities, hand hygiene, enhanced environmental cleaning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV*</td>
<td>Ontario Infectious</td>
<td>Safer sex and injection drug</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Blood-borne and</td>
<td>As per usual practice</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disease</td>
<td>Protocol:</td>
<td>Transmission</td>
<td>Use counselling as appropriate; Avoid sharing personal hygiene objects; Refer for clinical assessment</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>-----------------------------------------------</td>
<td>--------------</td>
<td>-----------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Influenza*</td>
<td>Ontario Infectious Diseases Protocol:</td>
<td>Droplet</td>
<td></td>
</tr>
<tr>
<td>Invasive Group A Streptococcal (IGAS) *</td>
<td>Ontario Infectious Diseases Protocol:</td>
<td>Droplet</td>
<td>Identify close contacts of clinically severe cases such as family members, those with saliva exposure and those living in close proximity</td>
</tr>
<tr>
<td>Leishmaniasis (Cutaneous and visceral)</td>
<td>WHO: Leishmaniasis</td>
<td>Vector-borne</td>
<td>No additional considerations required</td>
</tr>
<tr>
<td>Malaria* and</td>
<td>Ontario</td>
<td>Vector-borne</td>
<td>Treatment of</td>
</tr>
<tr>
<td>Disease</td>
<td>Protocol</td>
<td>Mode</td>
<td>Isolation/Prevention Measures</td>
</tr>
<tr>
<td>---------</td>
<td>-----------</td>
<td>------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>Malaria</td>
<td>Appendix A and Appendix B</td>
<td>Borne</td>
<td>Case as appropriate. Required for all residents and staff of congregate living centre while the case was infectious or for two hours after case left living environment. Assess immunization history and offer vaccination or immunoglobulin to exposed susceptible individuals as appropriate. Offer vaccination for all eligible, susceptible individuals to prevent further transmission.</td>
</tr>
<tr>
<td>Measles*</td>
<td>Ontario Infectious Diseases Protocol: Appendix A and Appendix B</td>
<td>Airborne</td>
<td>Isolation recommended. Identify susceptible susceptibles. Assess immunization history and offer vaccination or immunoglobulin to exposed susceptible individuals as appropriate. Offer vaccination for all eligible, susceptible individuals to prevent further transmission.</td>
</tr>
<tr>
<td>Meningococcal Disease (invasive)*</td>
<td>Ontario Infectious Diseases Protocol: Appendix A and Appendix B</td>
<td>Droplet</td>
<td>Case would be hospitalized. Identify close contacts such as family members, those with saliva exposure and those living in close proximity. Provide post-exposure prophylaxis (antibiotics and vaccination if a vaccine preventable serogroup).</td>
</tr>
<tr>
<td>Mumps*</td>
<td>Ontario Infectious</td>
<td>Droplet</td>
<td>Isolation or avoid close. Identify susceptibles. Assess immunization.</td>
</tr>
<tr>
<td>Diseases</td>
<td>Protocol: <strong>Appendix A and Appendix B</strong></td>
<td>contact including masking, hand hygiene, respiratory etiquette</td>
<td>in the congregate setting</td>
</tr>
<tr>
<td>-------------------</td>
<td>-----------------------------------------</td>
<td>---------------------------------------------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>Pertussis*</td>
<td><strong>Ontario Infectious Diseases Protocol: Appendix A and Appendix B</strong></td>
<td><strong>Droplet</strong></td>
<td>Isolation recommended</td>
</tr>
<tr>
<td>Poliomyelitis*</td>
<td><strong>Ontario Infectious Diseases Protocol: Appendix A and Appendix B</strong></td>
<td><strong>Fecal-oral</strong></td>
<td>Identification of a case of poliomyelitis is a public health emergency and requires immediate consultation and coordination between local and provincial public health officials.</td>
</tr>
<tr>
<td>Rabies*</td>
<td><strong>Ontario Infectious Diseases Protocol: Appendix A and Appendix B</strong></td>
<td>Animal bite; Direct contact with saliva or neurological fluid from infected person</td>
<td><strong>Hospitalization</strong></td>
</tr>
<tr>
<td>Disease</td>
<td>Protocol/Source</td>
<td>Mode of Transmission</td>
<td>Prevention/Control Measures</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>----------------------------------</td>
<td>----------------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Rubella</strong></td>
<td>Ontario Infectious Diseases Protocol: Appendix A and Appendix B</td>
<td>Droplet</td>
<td>Identify susceptible individuals in congregate settings; Assess immunization history and offer vaccination to all eligible, susceptible individuals to prevent further transmission.</td>
</tr>
<tr>
<td><strong>Scabies</strong></td>
<td>CDC: Scabies</td>
<td>Infestation Direct contact</td>
<td>Treat case with scabicide; Launder clothing and bedding or remove from body contact for at least three days; Avoid contact with others until treatment is complete; Identify those who had direct contact with case; Consultation may be required to determine extent of contact treatment.</td>
</tr>
<tr>
<td><strong>Schistosomiasis (Bilharzia)</strong></td>
<td>CDC: Schistosomiasis</td>
<td>Contact with infected water</td>
<td>No additional considerations required.</td>
</tr>
<tr>
<td><strong>Soil-Transmitted Helminths</strong></td>
<td>CDC: Ascariasis</td>
<td>Contact/Ingestion of contaminated soil</td>
<td>No additional considerations required.</td>
</tr>
<tr>
<td>Disease</td>
<td>CDC: Hookworm</td>
<td>Trichuriasis of contaminated soil</td>
<td>Syphilis*</td>
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<td>-----------</td>
</tr>
<tr>
<td>Tetanus*</td>
<td>Ontario Infectious Diseases Protocol: Appendix A and Appendix B</td>
<td>Direct contact with spores</td>
<td>No additional considerations required</td>
</tr>
<tr>
<td>Tuberculosis*</td>
<td>Ontario Infectious Diseases Protocol: Appendix A and Appendix B</td>
<td>Airborne</td>
<td>Isolation recommended</td>
</tr>
<tr>
<td>Varicella*</td>
<td>Ontario Infectious Diseases</td>
<td>Airborne and contact</td>
<td>Isolation recommended</td>
</tr>
</tbody>
</table>
**Protocol:**

*Appendix A and Appendix B*

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>while the case was infectious</td>
<td>vaccination and/or varicella zoster immune globulin to exposed susceptible individuals as soon as possible, as appropriate.</td>
<td>Offer vaccination for all eligible susceptible individuals to prevent further transmission</td>
</tr>
</tbody>
</table>

* Indicates a reportable disease in Ontario  
+ Reportable if occurs in an institutional setting
<table>
<thead>
<tr>
<th>Higher public health impact</th>
<th>Moderate likelihood of occurring</th>
<th>Low likelihood of occurring</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Measles</td>
<td>• Active tuberculosis</td>
</tr>
<tr>
<td></td>
<td>• Hepatitis A</td>
<td>• Respiratory diseases (e.g., MERS)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Rabies</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Cutaneous diphtheria</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Bacterial meningitis (invasive meningococcal disease, <em>Haemophilus influenza</em> type b)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Invasive Group A <em>Streptococcus</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Rubella</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Polio</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Pertussis</td>
</tr>
<tr>
<td>Lower public health impact</td>
<td>• Varicella</td>
<td>• Malaria and other vector borne diseases</td>
</tr>
<tr>
<td></td>
<td>• Influenza</td>
<td>• <em>Streptococcus</em> pneumoniae</td>
</tr>
<tr>
<td></td>
<td>• Sexually transmitted infections</td>
<td>• Tetanus</td>
</tr>
<tr>
<td></td>
<td>• Skin infections/ infestations (e.g., scabies, bed bugs, head lice), cutaneous leishmaniasis)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Blood borne infections (hepatitis B, hepatitis C and HIV)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Gastroenteritis</td>
<td></td>
</tr>
</tbody>
</table>
Ontario Health System Action Plan: Syrian Refugees

Annex: Interim Lodging Sites

December 17, 2015

The planning activities for Syrian refugee resettlement remain fluid and dynamic and it is likely that aspects of this annex will evolve as the process progresses. Updated versions of the annex will be issued as required.

This annex builds upon information provided in the Ontario Health System Action Plan: Syrian Refugees. It provides details information regarding Interim Lodging Sites (ILSs) including information on planning assumptions, proposed locations, local coordination, on-site primary care and off-site community surge/supports. Additional supplementary information related to ILSs is may be found in other relevant annexes (e.g. immunization, surveillance, etc.).

Overview

Most arriving refugees in Canada will travel directly to their new home communities. Typically, Government Assisted Refugees (GARs) receive temporary accommodation support from Resettlement Assistance Program (RAP) centres located across Canada while their permanent accommodation is being identified. However, in the event RAP centre capacity is exceeded, the federal government has identified five military bases in Ontario (and others in Québec) that may provide additional temporary accommodation to refugees. These locations, known as Interim Lodging Sites (ILSs) will be activated on an as-needed basis and the intent is to use ILSs as only a 'destination of last resort' when no other options are available. It is anticipated that the typical length of stay for most refugees would be two weeks or less. However, longer stays are possible.

This annex identifies health planning considerations and arrangements to support delivery and access to health services for refugees located at ILSs.

General Planning Assumptions

Current federal government planning regarding ILSs indicate the following general planning assumptions:

- ILSs will be located within five hours driving time of two Points of Entry (POE): Toronto and Montreal
- Operational readiness and activation of each ILS will be progressive, based on projected
inflow of refugees that may require ILS services;

- The number and timing of refugees expected at each ILS is dynamic and dependent on many factors (i.e. overseas registration and matching)
- As much notice as possible will be provided to support partners in standing up ILSs.
- Refugees located in Ontario ILSs may arrive at either Pearson Airport or Trudeau Airport.
- Refugees will be arriving up to and including February 29, 2016. Refugees accommodated in ILSs may extend into the month of March;

### General ILS Concept and Locations

Upon arrival at the ILS, individuals will be greeted at a reception centre area where they will complete a registration process and be shown to their accommodations. ILSs in Ontario will be managed by the federal Immigration, Refugees and Citizenship Canada (IRCC). In support of IRCC, the Canadian Red Cross (CRC) will provide day-to-day site management and coordination of services, including general care and feeding.

Five potential ILSs have been identified at this time (see below). Whether ILSs are used is a federal decision, which depends on many factors, including processing overseas, housing absorption, RAP capacity, and base readiness and capacity. It is likely that demand for ILSs will increase overtime, with the peak period in January – early March, 2016.

Within Ontario, Kingston is expected to be the first activated ILS and Meaford the second activated ILS. All other ILS sites are on a contingency/as needed basis at this time and will be activated on an as-needed basis. Ontario ILSs may receive refugees from either Pearson or Trudeau Airports (and possibly both).

### Current ILS Planning*

<table>
<thead>
<tr>
<th>Priority</th>
<th>*Potential ILS</th>
<th>Capacity</th>
<th>POE Airport</th>
<th>LHIN</th>
<th>Public Health Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>CFB Kingston</td>
<td>690</td>
<td>Montreal</td>
<td>South East</td>
<td>KFL&amp;A Public Health</td>
</tr>
<tr>
<td>2</td>
<td>CFB Meaford</td>
<td>500</td>
<td>Toronto</td>
<td>South West</td>
<td>Grey-Bruce Health Unit</td>
</tr>
</tbody>
</table>

Contingency / as needed

- CFB Borden: 1500, POE Airport: Toronto, LHIN: North Simcoe Muskoka, Public Health Unit: Simcoe Muskoka District Health Unit
- CFB Trenton: 950, POE Airport: Toronto, LHIN: South East, Public Health Unit: Hastings Prince Edward Public Health
- CFB Petawawa: 200, POE Airport: Montreal, LHIN: Champlain, Public Health Unit: Renfrew County and District Health Unit

*Please note: all information in this table is based on current planning information and subject to change.
Local Coordination

Within each Local Health Integration Network (LHIN), a coordination table will be created and led by the LHIN to guide local planning and coordination activities. Tables will include local health system leaders/representatives, including: primary care, mental health, public health, dental, paramedic services, and other key partners likely to be involved with refugee health care. This may also include LHIN primary care leads and primary care networks as appropriate. In areas located in close proximity to ILSs, additional representation on these tables may need to be considered (e.g. Emergency Medical Assistance Team, Department of National Defense Liaison, etc.).

In addition, LHINs in close proximity to ILSs (e.g. hospitals, paramedics, public health units, etc.) should connect with local providers to discuss local arrangements to support ILS primary care and/or off-site surge as appropriate. Additional guidance on local coordination is available in the Local Health System Coordination Annex.

On-Site Primary Care Delivery

Refugees arriving at ILSs will have health needs, including primary care and other potential supports. Recognizing that refugees will be temporarily residing at ILSs en-route to their final destination communities, it is anticipated that the health focus will be on addressing immediate/urgent needs.

Given the unknown length of stay at ILSs, it is anticipated that every day a small proportion of refugees will need access to medical services, including dental and tertiary care. While some services will need to be made available onsite, it is anticipated that access to specialized services, including obstetrics, will be provided in local communities.

Note: Immunization delivery for individuals in ILSs is still under development – see Annex: Immunization.

Initial ILS Activation – EMAT Staffing Model

A small component of the Emergency Medical Assistance Team (EMAT)\(^1\) may initially be deployed to the first ILS activated in Ontario. Under the proposed model, if EMAT is deployed, EMAT will provide onsite primary care to refugees and will coordinate locally with the appropriate LHIN coordination table(s). EMAT will also work with local health care providers in the event that a refugee requires additional care outside of the ILS.

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\(^1\) The Emergency Medical Assistance Team (EMAT) is a mobile non-surgical field unit that provides support to Ontario’s health system in times of crisis. It is modular and scalable, able to provide support ranging from key staff providing basic medical screening to, full deployment. It is a program funded under the by MOHLTC and operated by the Sunnybrook Centre for Pre-hospital Medicine.
Proposed EMAT Clinic Model
The following is the proposed EMAT Clinical Model if EMAT is deployed to support onsite primary care at ILSs.

- Based on current planning assumptions for the first activated ILS, EMAT will hold a scheduled daily primary health clinic. Optimally, this would be scheduled for an operational period of 8 hours and would be staffed in the following way:
  - 1 nurse practitioner
  - 1 nurse
  - 1 security officer
  - 1 logistics support
  - 1 cleaner
  - 1 translator
  
  Note: subject to change/modification/scale depending on circumstances and site.

- If physician, or nurse practitioner, resources are not available for onsite service, they will be available by phone for orders, delegation, etc. to support nurses and paramedics

- EMAT will attempt to provide pediatric support where available

- If there are scheduling challenges due to staff availability, a risk-based analysis will lead the planning to optimize resources and patient safety. Some examples include shortening clinic hours, prioritizing patients, and/or asking staff to support more than one site through mobilization.

- Off hours health support will be available through 9-1-1, Telehealth, hospitals, and local primary care support where available.

- Environmental services and Infection Prevention and Control resources will be provided as needed.

- Diagnostic imaging, negative pressure, and serology are not included (Point of Care testing will be available).

Additional ILS Activations – Local Staffing Model
If EMAT is deployed, EMAT would likely provide onsite care to one ILS only. Should onsite care be required at more than one ILS, the ministry will work with the appropriate LHIN coordination table(s) to arrange onsite care using local health care providers.

A variety of options may exist to support local delivery of on-site primary care services. In some circumstances, it may be possible for EMAT personal to assist with the initial setup of a primary care clinic, followed by a handover to local providers after a short period of time.

ILS Health Equipment and Supplies
The Public Health Agency of Canada (PHAC) will deploy National Emergency Stockpile System (NESS) ‘mini-clinics’ to each ILS prior to activation. Consisting primarily of equipment and supplies NESS mini-clinics are designed as a portable, modular, and flexible medical emergency response resource. Each module is comprised of equipment necessary to provide assessment and care similar to that of a walk-in clinic.
Additional health-related equipment and supplies (e.g. access to pharmaceuticals, etc.) will be worked out operationally for each site.

**Community Surge and Supports**

Health providers located in close proximity to ILSs should be prepared to provide services to refugees, including preparing for potential surge/referrals from the on-site primary care clinic. This may include public health units, hospitals, paramedic services, dental providers, etc.

Please see the Local Health System Coordination Annex for a full overview of local coordination, roles and responsibilities, including ILS-related activities identified for hospitals, paramedic services and public health units.

Please see Annex: Immunization for additional guidance as it relates to ILSs

Please see Annex: Infectious Disease and Health System Surveillance for additional guidance as it relates to ILSs

Please see Annex: Infectious Disease Case and Contact Management for additional guidance as it relates to ILSs
Ontario Health System Action Plan: Syrian Refugees

Annex: Immunization

December 17, 2015

The planning activities for Syrian refugee resettlement remain fluid and dynamic and it is likely that aspects of this annex will evolve as the process progresses. Updated versions of the annex will be issued as required.

This annex was developed in partnership with Public Health Ontario.

At a Glance

This document provides an overview of which vaccines should be provided to Syrian refugees to ensure they are immunized according to the Publicly Funded Immunization Schedules for Ontario. Syrian refugees may require a number of vaccines over time to reach this standard. Immunizations should be offered as soon as possible.

As a general rule, the Publicly Funded Immunization Schedules for Ontario should be followed, specifically the Routine Schedule, or Catch-up Schedules 1 to 3 and the High Risk Schedules, based on age and risk factors.

This document should be read in full; however, as a quick reference for providers, this “At a Glance” section outlines the vaccines recommended for unimmunized individuals during the first visit:

Table 1: Recommended immunizations during the first visit for unimmunized individuals

Note: Subsequent doses are not considered in this table and should be administered according to the Publicly Funded Immunization Schedules for Ontario (see Routine Schedule or Catch-up Schedule 1 to 3).

<table>
<thead>
<tr>
<th>Age at first visit</th>
<th>DTaP-IPV-Hib</th>
<th>DTaP-IPV</th>
<th>Tdap-IPV</th>
<th>Pneu-C-13</th>
<th>Rot-1</th>
<th>Men-C-C</th>
<th>Men-C-ACYW</th>
<th>MMR</th>
<th>Var</th>
<th>MMRV</th>
<th>QIV</th>
<th>LAIV</th>
<th>TIV</th>
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<td>8 to 20 weeks</td>
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<td></td>
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<tr>
<td>21 weeks to 5 months</td>
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<td>6 to 11 months</td>
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<tr>
<td>Age Group</td>
<td>1 year</td>
<td>2 years</td>
<td>3 years</td>
<td>4 years</td>
<td>5 years</td>
<td>6 years</td>
<td>7 to 11 years</td>
<td>12 years</td>
<td>13 to 16 years</td>
<td>17 years</td>
<td>18 years</td>
<td>19 to 29 years</td>
<td>30 years and older</td>
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</table>

△: 1) MMRV can be considered rather than MMR and varicella vaccine in order to decrease the number of injections among children 1-3 years. Monovalent varicella (Var) is usually given at the 2nd visit in the Ontario catch-up schedule for these ages. If MMRV is given at the first visit, then Var is not required at the 2nd visit.
2) Either QIV or LAIV can be offered.
- Hepatitis B and HPV vaccines are routinely available through school based immunization programs. Hepatitis B vaccine may also be accessed through Ontario’s High Risk Vaccine Program.
- For individuals temporarily residing in Interim Lodging Sites or a similar accommodation setting (e.g. Resettlement Assistance Program (RAP) centre), based on the clinical judgement of the health care provider:
- Individuals 9 months to 55 years of age may receive Men-C-ACYW, even if Men-C-C is outlined in the routine schedule

**Planning Assumptions**
- Confirming or updating immunizations is not part of the immigration medical exam (IME).
- The Syrian Refugee Resettlement Immunization Program will provide both Privately Sponsored and Government Assisted refugees with access to vaccines that will protect both refugees and the Canadian public.
- According to WHO and UNICEF estimates, immunization coverage in Syria was above 80% until around 2011/2012. This includes coverage for Bacillus Calmette–Guérin (BCG), DTP (Diphtheria, Tetanus, Pertussis), polio (as oral polio vaccine [OPV]), measles, hepatitis B, and *Haemophilus Influenzae* type b.

[www.who.int/immunization/monitoring_surveillance/data/syr.pdf](http://www.who.int/immunization/monitoring_surveillance/data/syr.pdf)
However, since 2011, Syria’s health system has become overstretched, with only 42% of hospitals reported as fully functioning. Conflict has become the top cause of death, about half the country no longer has regular access to clean water and vaccination rates have dropped below 50% in some areas of the country.

While children under the age of 5 years are at greatest risk of vaccine preventable diseases (VPDs), all susceptible individuals are at risk of contracting and potentially spreading diseases.

While it is expected that some children may have been immunized against certain VPDs, it cannot be assumed that all refugees are completely immunized according to the Publicly Funded Immunization Schedules for Ontario.

Persons newly arrived in Canada lacking adequate documentation of immunization should be considered unimmunized and started on an immunization schedule appropriate for their age and risk factors.

Routine and “Catch-up” immunization schedules for children and adults are provided in the Publicly Funded Immunization Schedules for Ontario, as well as from the National Advisory Committee on Immunization (NACI).

Refugee families and their health care providers need easy-to-follow instructions for future immunizations.

Providers should familiarize themselves with foundational immunization guidelines including pre-vaccination counselling, identifying contraindications, vaccine preparation and administration, infection prevention and control practices, and counselling on possible adverse events following immunization. A synopsis of this information can be found in the Canadian Immunization Guide, Part 1; Key Immunization Information.

Bringing Syrian Refugees Up-to-Date with their Immunizations
(adapted from Immunizations: Bringing Newcomer Children Up-to-date. The Canadian Pediatric Society)

Step 1: Which immunizations has this individual received?

Evaluation of Immunization Status

Refugees may lack immunizations and/or immunization records. Only written evidence/documentation should be used to confirm previous immunizations. Individual recall of immunizations or history of illness may not be reliable and should not be used. Vaccination should only be considered valid if there is written documentation of administration of vaccine at ages and intervals comparable with the Ontario schedule. These records need to be reviewed carefully to determine which vaccines have been received as well as the timing of their receipt. This is done in order to determine which vaccines are needed. Although the potency of vaccines administered in other countries can generally be assumed to be adequate, immunization schedules vary throughout the world (see Appendix A: World Health Organization (WHO) Expanded Program of Immunization (EPI) Plus schedule in Table 2).
Routine serologic testing to determine immunity of children and adults without immunization records is not recommended. Children and adults lacking adequate documentation of immunization should be considered unimmunized and started on an immunization schedule appropriate for their age and risk factors.

**Step 2: Which immunizations does this individual need?**

Children and adults need to be assessed to determine whether they are fully immunized in accordance with the Publicly Funded Immunization Schedules for Ontario. Children and adults lacking adequate documentation of immunization should be considered unimmunized and started on an immunization schedule appropriate for their age and risk factors.

**Notable differences** between the Ontario schedule and the World Health Organization’s (WHO’s Expanded Program of Immunization [EPI]) Plus schedule include:

- **Bacillus Calmette-Guérin (BCG) vaccine** for protection against tuberculosis (TB) is recommended at birth in the WHO schedule. This vaccine is not routinely given in Ontario, except to children living in very specific geographic areas (e.g., some Aboriginal communities).

- **Measles vaccine** is often given as a single, monovalent vaccine (i.e., no mumps and rubella components) in the WHO schedule and is administered at 9 to 12 months of age. In Ontario, the first dose of a combination measles, mumps, rubella (MMR) vaccine is given at 12 months of age and a dose of varicella vaccine is routinely given at 15 months age. A booster dose of measles, mumps, rubella and varicella (MMRV) vaccine is given between 4-6 years of age, preferably before school entry. **Children require 2 doses of measles-containing vaccine after 12 months of age, regardless of receipt of doses administered before the age of 12 months.**

- **Oral polio vaccine** is used in many countries, while inactivated poliovirus (IPV) vaccine is used in Ontario.

- **Rotavirus, meningococcal, Haemophilus influenzae type b, pneumococcal, mumps, human papillomavirus, hepatitis B, and varicella vaccines** are not routinely given by public health systems in many developing countries, but may be available for those able to pay for them. In Ontario, all these vaccines are routinely given.

**Step 3: Creating an appropriate immunization schedule**

a) **Assessment of immunizations that are needed for unimmunized refugees:**

As the arrival of Syrian refugees coincides with influenza season in Ontario, for many age groups up to 6 routine immunizations may be indicated at the first visit and can be given safely and effectively. Although multiple injections can safely and effectively be given in one visit, we have assumed that either refugees or health care workers would prefer to provide a maximum of 4 injections at a single visit. If this is not the case, additional injections can be given, as there is no upper limit for the number of vaccines that can be administered at one visit. Providers may need to prioritize which vaccines to give first, if a number of vaccines are required. It is recommended that measles-containing and polio-
containing vaccines be given as a priority. Meningococcal vaccine (Men-C-ACYW) is recommended as a priority for children and adolescents 9 months of age and less than 19 years of age, who are in Interim Lodging Sites. The High Risk Vaccines Programs table in the Publicly Funded Immunization Schedules for Ontario provides information on hepatitis b vaccine high risk program.

Following the first visit, the health care provider should plan for subsequent doses as part of an on-going catch-up schedule (see Routine Schedule or Catch-up Schedules 1 to 3 under the Publicly Funded Immunization Schedules for Ontario).

Information on contraindications and precautions can be found in the Canadian Immunization Guide.

b) Assessment of immunizations that are needed for individuals who have received previous immunizations:

The age at immunization, the number of doses, and the intervals between doses should be carefully reviewed and compared with the Publicly Funded Immunization Schedules for Ontario to determine the need for additional doses of vaccines. Table 1 in this document can be used to develop catch-up schedules for individuals who have started but have not completed their immunizations.

For complex cases, consider contacting your local Public Health Unit. An immunization expert can you help determine which schedule to follow to ensure the individual is immunized appropriately.

c) Assessment of immunizations that are needed based on underlying medical conditions or risk factors:

Individuals with an underlying medical condition or risk factor that puts them at higher risk of certain infections may require other immunizations. The High Risk Vaccines Programs table in the Publicly Funded Immunization Schedules for Ontario provides information on high risk vaccine programs.

Step 4: Follow up

- Provide families with easy-to-follow instructions for their future vaccinations, including dates and locations where the vaccinations can be administered.
- Remind them to bring their yellow Ontario Immunization Card with them to all appointments.
- Try to minimize the number of appointments, and ease the process of ‘catching up’ as much as possible for refugee families with transportation and language difficulties.
Where Refugees Can Access Immunizations

At this time, it is anticipated that Syrian refugees will access vaccines once they are settled in Ontario. Many will be with private sponsors, while others may be accommodated through the Resettlement Assistance Program (RAP) Centres. Immunizations can be provided by primary care providers as well as public health units when required.

In situations where a large number of refugees may be sharing accommodations and there is a higher risk of disease transmission and potential outbreak, (e.g., Interim Lodging Site [ILS]), immunizations may be provided in these settings. Immunization delivery for individuals in ILSs is still under development.

Tracking of Immunizations Administered

Immunization data will be reported to the ministry. Further information will be communicated as to how this will be done.

Appendix A: World Health Organization (WHO) Expanded Program of Immunization (EPI) Plus schedule

Childhood immunization schedules differ considerably according to the country of origin. Refugee children may have been immunized according to the World Health Organization (WHO) Expanded Program of Immunization (EPI) Plus schedule (see Table 2). It is estimated that 90% of refugee children from Syria were vaccinated against polio as of August 31, 2015, but it is unknown if they have received other immunizations (Public Health Agency of Canada). Although immunization rates in Syria have dropped as a result of the current conflict, it is estimated that the rates in refugee centres in the Middle East are between 72% and 92%.

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Birth</th>
<th>6 weeks</th>
<th>10 weeks</th>
<th>14 weeks</th>
<th>9 to 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCG</td>
<td>●</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DPT</td>
<td></td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
</tr>
<tr>
<td>OPV</td>
<td>[●]</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
</tr>
<tr>
<td>Measles</td>
<td></td>
<td>●</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HB&lt;sup&gt;†&lt;/sup&gt;</td>
<td></td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
</tr>
<tr>
<td>Yellow Fever (YF)</td>
<td></td>
<td>●</td>
<td></td>
<td></td>
<td>●</td>
</tr>
</tbody>
</table>

*YF and HB added in 1994 for endemic countries
[ ] added during epidemics
† alternative schedules for HBV include: at 6 weeks; 10 weeks and 14 weeks OR at birth, 6 weeks and 9 to 12 months.

BCG Bacillus Calmette-Guérin vaccine; DPT diphtheria-pertussis-tetanus vaccine; OPV Oral polio vaccine; HBV hepatitis B vaccine

Source: Adapted from the WHO’s Expanded Program of Immunization (EPI) Plus* schedules.

The age at immunization (e.g., 9 months of age for immunization against measles in some countries), the number of doses, and the intervals between doses should be carefully reviewed and compared with the Publicly Funded Immunization Schedules for Ontario to determine the need for additional doses of vaccines.
The EPI Plus schedule is followed by many developing countries when vaccine supplies are available. Also, there are country-specific immunization protocols which vary based on local epidemiology and policies. Vaccination information for the Syrian Arab Republic can be found online.

The product types and/or names may differ from vaccines used in Canada. The U.S. Centers for Disease Control and Prevention (CDC) has a useful resource for interpreting vaccine components and identifying products by their trade name.

### Additional Resources
- Public Health Agency of Canada: National Advisory Committee on Immunization (NACI) Guidelines
- World Health Organization: Immunization, vaccines and biologicals
- The Canadian Pediatric Society: Immunizations: Bringing Newcomer Children Up-to-date
- Public Health Agency of Canada: The Canadian Immunization Guide
- Public Health Agency of Canada: A parent’s guide to vaccination
Ontario Health System Action Plan: Syrian Refugees
Annex: Local Health System Coordination
December 17, 2015

The planning activities for Syrian refugee resettlement remain fluid and dynamic and it is likely that aspects of this annex will evolve as the process progresses. Updated versions of the annex will be issued as required.

This annex builds on information provided in the Ontario Health System Action Plan: Syrian Refugees. It outlines more detailed information about Local Health System Coordination for Syrian refugees who are resettling in Ontario.

Refugees typically face greater settlement and integration challenges than other newcomers. Many have experienced prolonged periods in refugee camps, trauma, violence, and have had limited access to health care and education. As part of the immigration process, refugees undergo an immigration medical exam (IME) at their point of departure and are assessed by Quarantine Officers at an airport upon arrival into Canada.

Once refugees arrive at privately sponsored host destinations, communities with Resettlement Assistance Programs (RAPs), or Interim Lodging Sites (ILSs), they may require transitional care, which includes an initial medical assessment and/or referral to other health services. Once settled into their final accommodations, refugees will require ongoing permanent care. The initial entrance into the local health system will be a critical step in their overall integration into Canadian society.

This annex will identify:

- Anticipated local health and service needs of Syrian refugees in Ontario;
- Roles and responsibilities of local health care providers, health system partners, and health care services;
- How the newly developed Refugee HealthLine will help identify health care providers able to accommodate refugee patients and connect refugees with transitional care.

Refugee Health Needs and Service Requirements
The overall health and well-being of Syrian refugees has suffered and deteriorated as a result of the conflict and difficult living conditions in refugee camps. The health issues faced by incoming refugees will be reflective of the hardships endured (e.g. physical and psychosocial traumas, oral health). Chronic diseases such as cardiovascular diseases, hypertension,
and diabetes may have been exacerbated due to limited access to health care during their journey out of Syria.

Please refer to the Immigration, Refugees and Citizenship Canada’s (IRCC) Population Profile: Syrian Refugees for more detailed information on the health status of refugees.

Local Health and Service Needs
It is expected that refugees arriving in host communities may require a variety of health care and health services from local providers, including:

- Initial primary care assessments/transitional care
- Referral to specialists (e.g. maternity care, pediatrics, women’s health, reproductive health services)
- Psychosocial support, counselling, and mental health services
- Immunization
- Communicable disease prevention and treatment
- Acute care/hospital services
- Paramedic services
- Public health supports
- Chronic disease management (e.g. cardiac, respiratory, diabetes)
- Access to pharmaceutical medications
- Community care and support services
- Assistive devices
- Dental and vision care

Roles and Responsibilities for Local Health Care Coordination and Providers

Local Health Integration Networks (LHINs)
Within each Local Health Integration Network (LHIN), a coordination table will be created and led by the LHIN to guide local planning and coordination activities. Tables will include local health system leaders/representatives, including: primary care, mental health, public health, dental, paramedic services, and other key partners likely to be involved with refugee health care.

In areas located in close proximity to RAP centres, ILSs or Toronto Pearson International Airport (official Point of Entry), additional representation on these tables may need to be considered (e.g. RAP representatives, Department of National Defense Liaison, Emergency Medical Assistance Team).

LHINs will play a central role in coordinating the local health system response to address refugees’ immediate health care needs and ongoing care in support of their resettlement in Ontario. As the central coordinating body, a LHIN’s role includes the following specific activities:
Assemble a LHIN coordination table to support planning and response activities, including local health system sector leaders/representatives from primary care, mental health, public health, dental, paramedic services, and other key partners likely to be involved with refugee health care.

Conduct a health system capacity assessment of local health services, based on anticipated health needs.

Determine health care provider availability to support local surge capacity (e.g. acute, primary).

Establish a two-way communication process between LHINs and local health service providers to share information and provide updates on key refugee health issues (e.g. awareness of benefits coverage, refugee health needs, linguistic / cultural considerations).

Provide updates and flag issues to the Ministry Emergency Operations Centre (MEOC) as required.

Support local partner awareness and understanding of refugee health needs and care considerations by sharing information on available refugee-centred resources, education and awareness activities.

Develop a coordination strategy that addresses local health supports and activities for refugees at different phases of their journey (as applicable):

- **Point of Entry Arrival** - Local system surge capacity (e.g. hospitals, paramedics, public health) around airports where refugees land. The provincial Emergency Medical Assistance Team (EMAT) will provide initial onsite medical support for urgent refugee health needs that arise within the airport in collaboration with partners.

- **Temporary Accommodations** - Local system surge support (e.g. hospitals, paramedics, public health, and referral services) around RAP centres and potential ILSs while permanent lodgings are identified. The provincial EMAT may also provide initial onsite medical support at ILSs, augmented by or handed over to local partners if/as required.

- **Permanent/Longer-Term Accommodations** - Local system readiness to provide health supports for refugees arriving in their final destinations, including initial primary care assessments, ongoing primary care supports, and additional health services required (e.g. mental health, specialty referrals).

Ensure that local health sector coordination is well-integrated and represented at municipal/community cross-sector coordination tables.

**Public Health Units (PHUs)**

Local public health units (PHUs) will assist in providing community supports to refugee populations at different phases of their journey. Specific responsibilities include:

- Participating on LHIN coordination tables.
- Facilitating immunization for refugee populations based on ministry guidance and local planning.
Management of reportable infectious diseases of public health importance as outlined in the Infectious Disease and Health System Surveillance Annex.

Facilitating public health dentistry programs.

Providing information and education about healthy lifestyles and communicable disease prevention including education in sexually transmitted infections and reproductive health.

Maintaining staff awareness and understanding of refugee health needs and care considerations through refugee-centred education and awareness activities.

Providing healthy growth and development supports including parenting education, health education for all age groups and selected screening services.

Other potential activities coordinated at provincial and/or local levels.

**Primary Care Providers**

Primary care providers, including those identified through the Refugee HealthLine (1-866-286-4770), are the initial point of contact to the health care system and will play a key role in supporting local coordination plans for required health services. Upon arrival, refugees may require *transitional care* which includes initial medical assessment(s) and/or referral to other health services. Once settled into their final accommodations, refugees will require ongoing permanent care. The entrance into the local health system will be a critical step in their overall integration into Canadian society.

Primary care providers and inter-professional health care teams may include:

- Refugee Health Clinics,
- Community Health Centres (CHCs),
- Family Health Teams (FHTs),
- Nurse Practitioner-Led Clinics (NPLCs),
- Midwifery Practices,
- Physician practices, and
- Walk-in clinics.

Key responsibilities of all primary care providers involved in refugee care should include:

- Providing primary care services to refugee populations, including: initial health assessments; required immunizations; referrals to other health services, specialists, and diagnostics; and/or ongoing primary care support.
- Communicating availability to provide transitional health care and services to refugee patients to the Refugee HealthLine (1-866-286-4770).
- Maintaining staff awareness and understanding of refugee health needs and care considerations through refugee-centred education and awareness activities.
- Understanding refugee health benefits and billing processes (e.g. Ontario Health Insurance Plan (OHIP) and Interim Federal Health Program (IFHP), and registering for IFHP as applicable.
- Other potential primary care activities as communicated by local coordination tables.
- Other potential activities coordinated at provincial and/or local levels.
Refugee health clinics and CHCs are experienced in providing care to refugee populations and should be a primary option where available.

**Refugee HealthLine (1-866-286-4770)**

The Refugee HealthLine will play a key role in connecting refugee patients with various types of health providers, and will be developing and maintaining a registry of providers able to accommodate refugee patients. Providers interested in participating can contact 1-866-286-4770 to add their name, practice, location, service and the number of prospective patients they are able to take on.

Key responsibilities of the Refugee HealthLine include:

- Establish and maintain a mechanism to accept calls from various types of providers able to take on new patients.
- Develop and maintain a registry of health care providers able to accommodate refugee patients.
- Connect refugees, Resettlement Assistance Programs, sponsors, and settlement agencies to the closest, most appropriate health care providers capable of taking on refugee patients for transitional care (if available).
- Maintain staff awareness and understanding of refugee health needs and care considerations through refugee-centred education and awareness activities.
- Understanding refugee health benefits and billing processes (e.g. Ontario Health Insurance Plan (OHIP) and Interim Federal Health Program (IFHP)).
- Connect refugees to Telehealth when required for the provision of health advice and general health information.
- Identify and flag significant issues/trends to the MOHLTC’s MEOC.
- Other potential activities coordinated at provincial and/or local levels.

Please see the Refugee HealthLine Model section of this Annex for a detailed overview of this process.

**Community Care Access Centres (CCACs) and Community Support Services Agencies (CSS)**

It is anticipated that following initial primary care visits, refugees may require various home and community care support services. Community Care Access Centres (CCACs) and Community Support Services (CSS) agencies may see an increase in service volumes. CCACs, in their system navigation role, may also anticipate an increase in the volume of requests relating to accessing appropriate community resources. CCACs and CSS agencies should anticipate these needs and be prepared to provide such supports. Key responsibilities include:

- Connecting with local LHIN coordination tables and staying up to date on guidance provided.
- Identifying potential issues to the corresponding LHIN.
- Maintaining staff awareness and understanding of refugee health needs and care considerations through refugee-centred education and awareness activities.
• Understanding refugee health benefits and billing processes (e.g. OHIP and IFHP), and registering for IFHP as applicable.
• Other potential activities coordinated at provincial and/or local levels.

Hospitals
Hospitals throughout Ontario should expect to provide care for refugee populations. Hospitals located near RAP centres should be prepared for potential surge from newly settled refugees in their communities. In addition, hospitals located near federally-identified ILSs (exact sites to be determined) will need to be prepared to provide potential surge supports and acute care for any health issues that cannot be managed by the health team onsite at an ILS.

Key responsibilities for all hospitals in Ontario that may be expected to provide support to refugees include:

• Connecting with local LHIN coordination tables, and staying up-to-date on guidance provided by these tables.
• Maintaining staff awareness and understanding of refugee health needs and care considerations through refugee-centred education and awareness activities.
• Understanding refugee health benefits and billing processes (e.g. OHIP and IFHP), and registering for IFHP as applicable.
• Flagging issues to local LHINs.
• Other potential activities coordinated at provincial and/or local levels.

In addition, key responsibilities of hospitals located in close proximity to ILSs will also include:

• Connecting with local LHIN coordination tables to discuss local arrangements for surge supports at RAP centres and for on-site primary care at ILS sites.
• Participating in ILS-specific planning processes with EMAT and/or other ILS on-site care providers.
• Providing services to ILS residents requiring immediate acute/specialty services not available at ILS sites.

In addition, key responsibilities of hospitals located in close proximity to the Toronto Pearson International Airport Point of Entry that may provide services to ILS residents will also include:

• Liaise with the Greater Toronto Airport Authority to be aware of flight schedules.
• Ensure appropriate Emergency Department staffing levels and translation services.
• Coordinate with the EMAT and paramedic team(s) onsite.

Paramedic Services
Key responsibilities for all paramedic services in Ontario that may be expected to provide support to refugees include:

• Connecting with local LHIN coordination tables, and staying up to date on guidance provided and flagging issues
Maintaining staff awareness and an understanding of refugee health needs and care considerations through refugee-centred education and awareness activities.

Other potential activities coordinated at provincial and/or local levels.

In addition, paramedic services located near RAP centres and ILSs (sites to be confirmed) should be prepared for potentially increased call volumes and transport requirements and link with the EMAT (if deployed) and/or other team providing care onsite.

Please note: specific arrangements have been made with Peel Paramedic Services and Toronto Paramedic Services concerning Point of Entry Toronto Pearson International Airport planning. The specific roles and responsibilities of these agencies are detailed in the Airport Health Services Annex.

**Mental Health and Addictions Service Providers**

Refugees may require culturally, linguistically, and age appropriate mental health and addictions services, as some have experienced or witnessed extreme events, causing emotional and psychological suffering affecting not only themselves, but also their families. It is possible that they may not report their personal or family distress, or it may only come to light once the settlement process is complete.

Community based mental health and addictions services include:

- Abuse services, including family violence, child witness, and transitional support
- Case management / supportive counseling and services
- Counselling and treatment
- Crisis intervention
- Early psychosis intervention
- Short term crisis support beds
- Social rehabilitation / recreation

For mental health and addictions service providers in Ontario that may be expected to provide support to refugees, key responsibilities include:

- Communicating availability to accept new mental health and addictions clients to Refugee HealthLine 1-866-286-4770.
- Maintaining staff awareness and understanding of refugee health needs and care considerations through refugee-centred education and awareness activities.
- Understanding refugee health benefits and billing processes (e.g. OHIP and IFHP), and registering for IFHP as applicable.
- Other potential mental health services discussed at local coordination tables.
- Flagging issues to local LHINs.
- Other potential activities coordinated at provincial and/or local levels.

**Supplementary Health Services Providers**

It is anticipated that many refugees will require referral and access to supplementary health services (e.g. dental, vision, hearing).
Dental and Vision Care
LHIN coordination tables will include representation from dental practitioners from private and public health practices that can connect refugees to dental care. The Ontario Dental Association may be able to assist in identifying local representatives.

Local public health units will be able to provide information to the LHIN coordination tables about dental care from public health programs. For example, there is portable equipment, mobile and fixed clinics across the province that could support services to clients both in the interim lodging sites and in communities.

Vision care may also be required and may be identified as part of the initial transitional Primary Care assessment.

Dentists and optometrists that are able to accommodate refugee patients for transitional care and services can communicate their availability to the Refugee HealthLine (1-866-286-4770).

Some supplemental services not covered by OHIP will continue to be covered by the IFHP according to their coverage.

Assistive Devices
The Assistive Devices Program (ADP) provides Ontario residents who have long-term physical disabilities with support and funding to access personalized assistive devices appropriate for basic needs. It covers over 8,000 separate pieces of equipment or supplies (e.g. prostheses, wheelchairs/mobility aids and specialized seating systems, respiratory equipment).

Eligibility includes any Ontario resident who has a valid OHIP card issued in their name and has a physical disability of six months or longer.

Initial access is often through a medical specialist or general practitioner who provides a diagnosis and a vendor who sells the equipment or supplies to the client.

For refugees, ADP will pay 75% of the cost of the equipment and the IFHP will pay the remainder.

Access to Pharmaceutical Medications
Some supplemental services not covered by OHIP will continue to be covered by the IFHP according to its coverage policies. See the Health Benefits Annex for more information.

Key responsibilities of pharmacists/providers that may be involved in supporting refugee populations include:

- Providing relevant services to refugee populations in coordination with local/other partners and coordination tables.
- Maintaining staff awareness and understanding of refugee health needs and care considerations through refugee-centred education and awareness activities.
- Understanding refugee health benefits and billing processes (e.g. OHIP and IFHP), and registering for IFHP as applicable.
- Other potential activities coordinated at provincial and/or local levels.
Other Health Providers
Key responsibilities of other health service providers that may be involved in supporting refugee populations include:

- Providing relevant services to refugee populations in coordination with local/other partners and coordination bodies.
- Communicating availability to accept new patients to the Refugee HealthLine (1-866-286-4770), as applicable.
- Maintaining staff awareness and understanding of refugee health needs and care considerations through refugee-centred education and awareness activities.
- Understanding refugee health benefits and billing processes (e.g. OHIP and IFHP), and registering for IFHP as applicable.
- Other potential activities coordinated at provincial and/or local levels.

Additional System Partners

ServiceOntario
Refugees arriving in Ontario with appropriate documentation will have OHIP eligible immigration status and are exempt from the standard 3-month waiting period. ServiceOntario will play a key role in providing refugees with OHIP cards.

Key responsibilities of ServiceOntario locations include:

- Providing relevant services to refugee populations (i.e. registration for OHIP and issuance of cards) in coordination with local/other partners.
- Maintaining staff awareness and understanding of refugee OHIP registration needs through refugee-centred education and awareness activities.
- Other potential activities coordinated at provincial and/or local levels.

Note: please see the Health Benefits Annex for information on obtaining benefits and processes for refugee registration for OHIP cards.

Laboratories
It is anticipated that there may be an increased demand for laboratory services and tests following initial primary care assessments of refugees – particularly around RAP centres. Laboratories in Ontario that may be expected to provide such support should have plans in place and do so in coordination with local partners, as applicable. The Ontario Association of Medical Laboratories may be able to assist with the identification of local representatives.

Other Partners
Other non-health partners that support the delivery of health services should have plans in place to support refugee health and do so in coordination with local partners, as applicable.
Refugee HealthLine Model

The Ministry has developed the temporary Refugee HealthLine to connect refugees to health care providers for transitional health care and services.

All providers/organizations/practicesclinics that deliver services under the Interim Federal Health Program (IFHP) and/or Ontario Health Insurance Plan (OHIP) are eligible to volunteer. Some examples include:

- Primary care providers (e.g. refugee health clinics, Community Health Centres, Family Health Teams, Nurse Practitioner-Led Clinics, midwifery practices, physician practices, walk-in clinics);
- Specialists (e.g. maternity care, pediatrics, women’s health, reproductive health services);
- Community care and support services;
- Allied health-care practitioners including clinical psychologists, occupational therapists, speech language therapists and physiotherapists;
- Mental health service providers;
- Dentists;
- Optometrists;

A Refugee HealthLine model has been developed to connect refugees to providers. This model includes a 4 phase process:

1. **Call Out** - The MOHLTC and partners (e.g. associations, local tables) will facilitate a centralized ‘call out’ for health care providers able to accommodate refugee patients. This will direct providers to a single point of contact to register and collect this information (Refugee HealthLine 1-866-286-4770).

2. **Identify Providers** – The Refugee HealthLine will capture and maintain aggregate data on provider availability to accommodate refugee patients.

3. **Communicate How to Find a Provider** – MOHLTC and other partners will communicate to refugees, Resettlement Assistance Programs, sponsors, and settlement agencies how to find a health care provider, sharing information on a single point of contact (Refugee HealthLine) to call for this information. This information may also be posted centrally on a government website. Other partners (e.g. associations/colleges) can also direct their membership to this central number and website.

4. **Maintain Over Time** – The Refugee HealthLine will maintain this system over time, including identification of new providers and removal of providers from the list that no longer have capacity.
Ontario Health System Action Plan: Syrian Refugees

Annex: Worker Health and Safety and IPAC Practices in Clinical Care Settings

December 17, 2015

The planning activities for Syrian refugee resettlement remain fluid and dynamic, and it is likely that aspects of this annex will evolve as the process progresses. Updated versions of the annex will be issued as required.

This annex was developed in partnership with Public Health Ontario.

This annex builds on information provided in the Ontario Health System Action Plan: Syrian Refugees. It outlines general Infection Prevention and Control (IPAC) guidance for a broad range of health workers who will be screening, triaging, assessing, transporting and providing care (e.g. physicians, nurses, dentists, dental assistants, paramedics, diagnostic imaging technicians, phlebotomists) for Syrian refugees who are resettling in Ontario.

A. Worker Immunization

Immunization is the first line of defence, followed by the completion of a Point of Care Risk Assessment (PCRA). To protect the health of workers and those with whom they are in contact, it is important that they be protected from and immune to measles, mumps, rubella, pertussis, varicella, hepatitis B and receive influenza vaccine annually. Workers should know their immunization status and ensure their immunizations are up to date. Immunizations appropriate for workers include:

- annual influenza vaccine
- measles, mumps, rubella (MMR) vaccine (two doses) or serologic documentation of immunity
- varicella vaccine (two doses) or serologic documentation of immunity
- hepatitis B vaccine (complete series) and serologic confirmation of immunity for workers who may be exposed to blood, body fluids or contaminated sharps in their work
- tetanus/diphtheria vaccine (every 10 years and primary series if no previous immunization)
- acellular pertussis vaccine (one dose Tdap).
- Polio (primary series if no previous immunization)
B. Tuberculin Skin Test (TST)¹
A TST using the two-step skin test is recommended for all workers before they begin to work or supply services in health care settings. The TST may be done by the employer or by the worker’s personal physician. A single-step TST is sufficient if:

- there is documentation of a prior two-step test, OR
- there is documentation of a negative TST within the last 12 months, OR
- there are two or more documented negative TST results at any time but the most recent was >12 months ago.

C. Personal Protective Equipment (PPE) and Hand Hygiene
Education and training in the care, use and limitations of PPE before the first use (and at regular intervals thereafter) must be provided to all workers who have the potential to be exposed to blood, body fluids secretions, excretions, mucous membranes and non-intact skin. Refer to training resources and if appropriate, in-time training and education should be available. See section E for more information on IPAC training.

The PPE shall also be properly used and maintained, a proper fit, inspected for damage or deterioration and stored in a convenient, clean and sanitary location when not in use.
PUTTING ON PPE

1. Perform Hand Hygiene

2. Put on Gown
   - Tie neck and waist ties securely

3. Put on Mask/N95 Respirator
   - Place mask over nose and under chin
   - Secure ties, loops or straps
   - Mould metal piece to your nose bridge
   - For respirators, perform a seal-check

4. Put on Protective Eyewear
   - Put on eye protection and adjust to fit
   - Face shield should fit over brow

5. Put on Gloves
   - Put on gloves, taking care not to tear or puncture glove
   - If a gown is worn, the glove fits over the gown’s cuff
**TAKE OFF PPE**

1. **Remove Gloves**
   - Remove gloves using a glove-to-glove/skin-to-skin technique
   - Grasp outside edge near the wrist and peel away, rolling the glove inside-out
   - Reach under the second glove and peel away
   - Discard immediately into waste receptacle

2. **Remove Gown**
   - Remove gown in a manner that prevents contamination of clothing or skin
   - Starting at the neck ties, the outer, ‘contaminated’, side of the gown is pulled forward and turned inward, rolled off the arms into a bundle, then discarded immediately in a manner that minimizes air disturbance

3. **Perform Hand Hygiene**

4. **Remove Eye Protection**
   - Arms of goggles and headband of face shields are considered to be ‘clean’ and may be touched with the hands
   - The front of goggles/face shield is considered to be contaminated
   - Remove eye protection by handling ear loops, sides or back only
   - Discard into waste receptacle or into appropriate container to be sent for reprocessing
   - Personally-owned eyewear may be cleaned by the individual after each use

5. **Remove Mask/N95 Respirator**
   - Ties/ear loops/straps are considered ‘clean’ and may be touched with hands
   - The front of the mask/respirator is considered to be contaminated
   - Untie bottom tie then top tie, or grasp straps or ear loops
   - Pull forward off the head, bending forward to allow mask/respirator to fall away from the face
   - Discard immediately into waste receptacle

6. **Perform Hand Hygiene**
D. Respiratory Protection Program, Fit Testing and Seal-Checking\textsuperscript{1,2}

Workers who will be screening, triaging, assessing, transporting and providing care may be required to wear an N95 respirator when there are concerns regarding potential airborne transmissible infections. When workers are required to wear respirators, the employer should implement and maintain a respiratory protection program. The program could include:

- training on how to put on and take off an N95 respirator
- a health screening to ensure the worker is able to wear and use an N95 respirator
- N95 respirator fit-testing using accepted protocols (for example, the CSA Standard Z94.4-11) to ensure the respirator fits is used and maintained properly and provides an effective seal with the face of the wearer
- educating the worker on how to check the seal of the respirator with the face prior to use (facial hair, eye protection, or other PPE must not interfere with the seal).

E. Infection Prevention and Control (IPAC) Training\textsuperscript{1}

Appropriate IPAC training should be provided to all workers who will be screening, triaging, assessing, transporting and providing care. Training should emphasize:

- the risks associated with infectious diseases, including acute respiratory infection and gastroenteritis
- the importance of appropriate immunization
- hand hygiene, including the use of alcohol-based hand rubs and hand washing
- principles and components of Routine Practices as well as additional transmission-based precautions (Additional Precautions)
- assessment of the risk of infection transmission and the appropriate selection and use of PPE, including safe application (donning), removal (doffing) and disposal
- reprocessing of reusable medical equipment (if necessary)
- appropriate cleaning and/or disinfection of surfaces or items where health care is provided.

Training resources and Programs:

I. IPAC Core competencies Online Learning Course
   http://www.publichealhtontario.ca/en/LearningAndDevelopment/OnlineLearning/InfectiousDiseases/IPACCore/Pages/default.aspx

II. Videos for:
   a. Putting on Personal Protective Equipment
   b. Removing Personal Protective Equipment

III. Just Clean Your Hands Videos
    http://www.publichealhtontario.ca/en/BrowseByTopic/InfectiousDiseases/JustCleanYourHands/Pages/JCYH-videos.aspx
IV. Safe Medication Practices

F. Additional Precautions
Additional Precautions refer to IPAC interventions (e.g., barrier equipment, accommodation, additional environmental controls) to be used in addition to Routine Practices to protect workers and persons and interrupt transmission of certain infectious diseases that are suspected or identified in a person.

Additional Precautions are based on the mode of transmission (e.g., direct or indirect contact, airborne or droplet). There are three categories of Additional Precautions: Contact Precautions, Droplet Precautions and Airborne Precautions. Each of these is based on the modes of transmission as outlined in the diagrams below:

- **Contact Transmission**: from Hands (Direct) or Objects (Indirect)
- **Droplet Transmission (up to 2 metres)**: from Coughing or Sneezing
- **Airborne Transmission (> 2 metres)**
- **Vehicle Transmission**
- **Vector-borne Transmission**
The following table provides guidance regarding additional precautions:

G. Communication
Consider early communication with regulatory Colleges and professional associations (e.g. College of Physicians and Surgeons of Ontario, Royal College of Dental Surgeons of Ontario, College of Family Physicians of Canada, College of Midwives of Ontario, College of Nurses of Ontario, Ontario Medical Association, Registered Nurses’ Association of Ontario).

There needs to be an internal and external communications plan that will address communicable disease issues within each workplace area.

H. Phases of Processing of Syrian Refugees and Associated IPAC Screening.
The phases are:

1. **Arrival at the airport**
   a. Quarantine Assessments
      i. Point-of-care risk assessment
A point-of-care risk assessment must be applied before every interaction with the person. Workers must screen the person to determine whether the person has a communicable disease and to assess the risk of exposure to blood, body fluids, secretions, excretions, mucous membranes and non-intact skin and identify the strategies that will decrease exposure risk and prevent the transmission of microorganisms.

Where there is a risk of transmission of infection based on the risk assessment, interventions and controls can be put into place to reduce one’s risk of acquiring or transmitting infection. While hand hygiene is always required, the risk assessment will indicate when Additional Precautions are to be used (see Section F).
ii. Hand Hygiene

What to use to clean your hands?

- Alcohol-based hand rub (ABHR) when hands are not visibly soiled.
- Plain liquid soap when hands are visibly soiled.

Hand Hygiene Technique

- When using an ABHR, apply sufficient product such that it will remain in contact with the hands for a minimum of 15 seconds before the product becomes dry (usually one to two full pumps).
- When using soap and water, a minimum of 15 seconds of mechanical lathering is required before rinsing.
- Clean hands with either soap and water or ABHR but not both at the same time, as it is irritating to the skin.

Hand hygiene should be practiced according to the 4 moments for hand hygiene, as describes in Ontario’s [Just Clean Your Hands](#) program.

iii. Alcohol-based hand rub (ABHR) dispensers

Install ABHR dispensers at the point-of-care. Point-of-care products should be accessible for use without leaving the person.
ABHR should also be provided and accessible in waiting area(s) to reduce the risks of transmission of communicable disease(s).

iv. Personal protective equipment

Personal protective equipment (PPE) is worn as part of Routine Practices to prevent transmission of microorganisms. The selection of PPE is based on the nature of the interaction between the worker and the person and/or the likely mode(s) of transmission of communicable diseases, according to the risk assessment. PPE includes gloves, gown and facial protection. PPE must be convenient and accessible to workers near where it might be needed.

v. Respiratory etiquette

Workers should adhere to practices that help prevent the spread of microorganisms that cause respiratory infections. These personal practices include:

- avoidance measures that minimize contact with droplets when coughing or sneezing, such as:
  - turning the head away from others
  - maintaining a two-metre separation from others
  - covering the nose and mouth with tissue
  - immediate disposal of tissues into waste after use
  - immediate hand hygiene after disposal of tissues.

If tissues are not available, other avoidance measures (e.g., sneeze into sleeve) may be used.

b. Immediate Urgent Care

Information on symptoms of acute respiratory infection (ARI), such as cough and fever, or other symptoms of communicable disease such as vomiting, diarrhea or rash should be assessed at triage. Additional screening may be added based on specific population risks that may be identified through surveillance. Communication of communicable disease risk prior to transport of those with a suspect communicable disease will be important for the receiving urgent care site and for transport workers.
2. Interim lodging sites (ILSs)

Prior to occupancy, please refer to the PIDAC’s *Infection Prevention and Control for Clinical Office Practice* document

a. Primary Care and Other “Transitional Care”
   i. Refer to the practices listed under 1. a.

   ii. Supplies (disposable ideally)†

   Single-use is preferred. Reusable medical equipment should be cleaned and disinfected or sterilized as appropriate for the equipment. If single-use supplies are not available and equipment reprocessing is required, it should be performed in a segregated area away from persons and clean areas. There must be a clearly designated individual who is responsible for reprocessing.

   iii. Access to hand hygiene sinks†

   Hand hygiene should be practiced according to the 4 moments for hand hygiene, as described in Ontario’s *Just Clean Your Hands* program. Alcohol based hand rub (ABHR) should be used as the preferred agent for cleaning when hands are not visibly soiled. Locate ABHR dispensers at point-of-care, i.e., within arm’s length of the person. Soap and water must be used for cleaning when hands are visibly soiled.

   If running water is not available, moistened towelettes should be used to remove visible soil, followed by alcohol-based hand rub. Hand washing sinks should be dedicated to that purpose and not used for any other purpose, such as equipment cleaning or disposal of waste fluids.

   iv. Placement of individuals requiring isolation for suspect or confirmed communicable disease(s)

   There needs to be consideration for a separate area designated for accommodation of individuals where Additional Precautions are required. This could be for an individual or for more than one individual if an outbreak is identified/reported. A designated washroom with a defined cleaning schedule should be put in place. The local public health unit will be involved, will provide guidance if/when this occurs and will collaborate with provincial and federal agencies as appropriate. For example, where ILSs are federal military bases, issues would be managed under federal authority.
v. Environmental cleaning (containment/outbreak, clinic areas)\(^1\)

Daily cleaning and disinfecting of surfaces, equipment and items using an approved surface cleaner and a hospital-grade, low-level disinfectant is necessary. Surfaces need to be cleaned and disinfected immediately when they are visibly soiled with blood or other body fluids, excretions or secretions (e.g., examination tables, floors, toilets). Medical equipment that only comes into contact with a person’s intact skin and is used between persons requires cleaning and low-level disinfection after each use (e.g. stethoscope, BP cuff). Other items that come in contact with a person should be replaced or discarded between uses (e.g., examination table paper coverings, stirrup covers).

Waste from the clinical exam setting can be divided into two categories: biomedical and general. Management of contaminated infectious waste shall follow provincial regulations and local bylaws and address issues such as the collection, storage, transport, handling and disposal of contaminated waste, including sharps and biomedical waste.

When handling waste, segregate at the point of use into either a plastic bag or a rigid container (lid). Do not double-bag waste unless the first bag becomes stretched or damaged, or when waste has spilled on the exterior. Close waste bags when three-quarters full and tie in a manner that prevents contents from escaping. Remove waste to central holding areas at frequent intervals. Waste shall be placed in appropriate containers that are available at the point-of-care use and stored in a designated enclosed room with access limited to authorized workers.

vi. Handling of sharps\(^2\)

Safety-engineered needles must be used according to the Needle Safety Regulation (O. Reg 474/07). Sharps should be discarded into a puncture-resistant, tamper-resistant, leak-proof container that has a clearly identifiable biological hazard label and is designed so that used sharps can be dropped in with one hand. A sharps container should be easily accessible in every “point of use” area (e.g., individual exam area) and mounted out of reach of children. It should not be filled with disinfectant, or overfilled with sharps. Sharps containers should be sealed and replaced when the contents reach the fill line marked on the container or when three-quarters full. Used sharps are considered biomedical waste.
vii. Medication, supply storage area (refrigeration for vaccines)\(^1\)

In the medication room/area there should be facilities for hand hygiene and a puncture-resistant sharps container that is accessible at point of use. There is a dedicated medication/vaccine refrigerator. Food/specimens should not be stored in the medication refrigerator. If vaccines are stored in this medication refrigerator, the temperatures is checked twice daily and recorded. There is an alarm on the medication/vaccine refrigerator to warn when the temperature falls outside the recommended range. Safety-engineered needles must be used according to the Needle Safety Regulation (O. Reg 474/07).

viii. Linen\(^2\)

Linen that is soiled with blood, body fluids, secretions or excretions should be handled using the same precautions, regardless of whether the person is on Additional Precautions.

Workers need to be aware of sharps when placing soiled linen in bags; workers are at risk from contaminated sharps, instruments or broken glass that may be contained with linen in the laundry bags. Workers should be trained in procedures for safe handling of soiled linen and should be offered immunization against hepatitis B.

Soiled laundry should be placed in soiled linen hampers. Appropriate PPE should be used based upon risk assessment (e.g., if there is risk of scabies, linen should be handled with gloves).

3. Integration Into the Ontario Healthcare System

   a. Determine whether there are special considerations when health care institutions – local primary care offices, hospitals, dental offices, etc. – are experiencing surge

      i. Communication and documentation of vaccination, screening and results.

References