

OVERVIEW OF RISK RECOGNITION POLICIES INTRODUCED TO THE LONG-TERM CARE WORKFORCE DURING THE FIRST YEAR OF COVID-19



Presentation Overview

1. Background & Methods
2. Compensating for Added Health Risks with a focus on Hazard Payment Policies
3. Protecting against Added Economic Risks with a focus on Single-Site Orders
4. Case Study – UK
5. Case Study – Québec, Canada
6. Discussion & Questions

OBJECTIVE

This presentation provides an overview of financial compensation introduced to the long-term care workforce to compensate and protect them for the risk they faced during the onset of the COVID-19 pandemic

We will consider two broad categories throughout the presentation:

- (1) Health risks** arising from direct contact with infected residents and co-workers
- (2) Economic risks** due to potential reduction in earnings among those affected by single-site work orders.

By documenting and comparing the strategies taken across multiple jurisdictions in the first six months of the COVID-19 pandemic, this presentation provides an opportunity for policy learning to address common challenges across long-term care sectors

BACKGROUND

- Long-term care workers, particularly personal support workers — who are also known as health care aides and nursing assistants — are among the lowest paid in the health and aging care sector
- Many have multiple employers or work more than full-time hours across several facilities to earn a living wage
- These precarious work arrangements experienced by many long-term care workers have led to the creation of a “shared” healthcare workforce with high rates of staff turnover within long-term and aging care sectors across the globe
- In the early months of the COVID-19 pandemic, the presence of this shared healthcare workforce among multiple long-term care homes was identified as a contributor to the spread of COVID-19



Methods

- We conducted an **environmental scan of publicly available policy documents and government news releases**, as well as orders, published between March 1, 2020 and March 31, 2021
- Our data collection included federal/national and sub-national governmental and long-term care associations' websites and focused on information related to the introduction of temporary wage supplements and single-site work orders
- The measures included in this study are limited to government and public health policies that directly or indirectly targeted the long-term care workforce
 - ***Specific organizational or corporate policy responses were not reviewed***
- The long-term care sectors are comparable across these jurisdictions



COMPENSATING FOR ADDED HEALTH RISKS

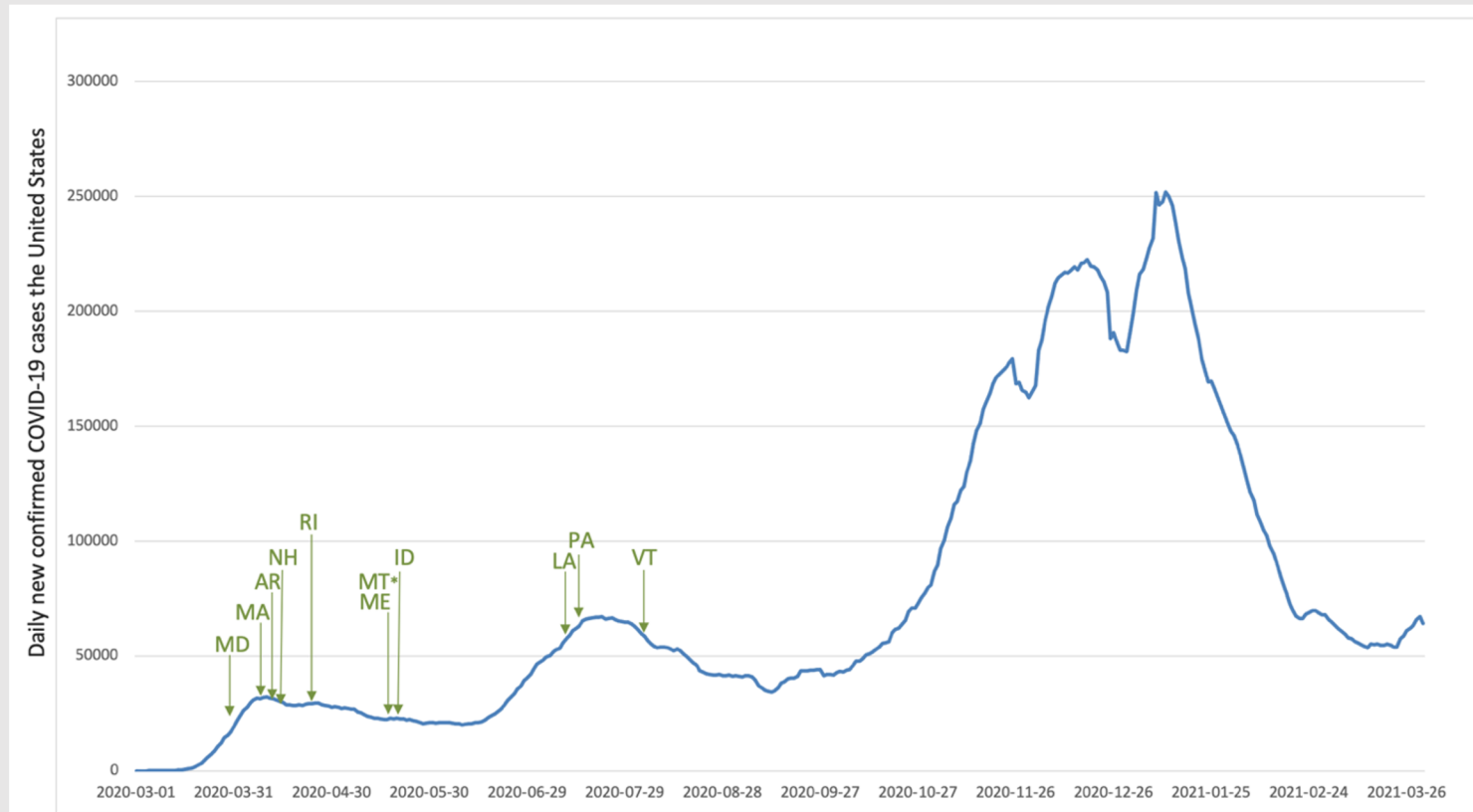
HAZARD PAY

- Hazard pay is defined as “additional pay for performing hazardous duty or work involving physical hardship” (1)
- By March 31st, 2021, 11 U.S. states, all thirteen Canadian provinces and territories, Scotland (U.K.), Wales (U.K.), and Australia introduced some form of hazard pay for the LTC workforce
- There was variability in the type of hazard pay introduced including
 - *Hourly top-up of a certain amount*
 - *A percentage increase*
 - *A one-time lump sum*

(1) <https://www.dol.gov/general/topic/wages/hazardpay>

HAZARD PAY in the United States

- Despite proposals to introduce a federal hazard pay program, by March 31, 2021, none had been passed into law
- \$1.9 trillion American Rescue Plan (ARP) Act funding package provided \$350 billion in state and local aid which could be used for hazard pay
- 11 states introduced state-level hazard pay programs which included LTC as an eligible workplace
 - MD=Maryland
 - MA=Massachusetts
 - AR=Arkansas
 - NH=New Hampshire
 - RI=Rhode Island
 - ME=Maine
 - MT=Montana
 - ID=Idaho
 - LA=Louisiana
 - PA=Pennsylvania
 - VT=Vermont



HAZARD PAY in CANADA

- On April 15, 2020, the Canadian Government announced it would provide up to \$2.3 billion to increase the wages of “low-income essential workers” across the country who have faced increased risks and to ensure continued operation of essential services
- Provinces and Territories determined the implementation details including eligible workers and amount of hazard pay. By July 2021, all provinces and territories had introduced some form of hazard pay
- 6 provinces (NB, NS, BC, ON, QU, SK) programs were limited to health and social care workers
- 6 provinces and territories (NL, PE, MB, YU, NWT, NU) programs were more general, using income thresholds to target low-income workers
- Alberta was late adopted of the federally funded hazard payment program, having introduced a lump sum top up in February of 2021

HAZARD PAY in AUSTRALIA

- The Workforce Retention Payment provided three payments of up to \$800AUD to direct care workers in LTC
- While a temporary measure, it was explicitly implemented to support workforce stabilization measures and ensure continuity of care



HAZARD PAY in the United Kingdom

- During the first year of the pandemic, hazard pay was only introduced in Wales and Scotland
- By the end of March 2021, a hazard pay not been implemented in Northern Ireland or England



**PROTECTING
AGAINST ADDED
ECONOMIC RISKS**

Why Protect Against Added Economic Risks?

- Some PSWs work for multiple employers or work more than full-time hours to earn a living wage
- These precarious work arrangements may have led to the creation of a “shared” workforce
- In the early months of the pandemic, this “shared” workforce was identified as a contributor to the spread of COVID-19

Single-Site Work Restrictions



Single-Site Protection

- There were **no measures** to restrict mobility of long-term care staff introduced in the US
- **Single-site orders were mandated or recommended in nearly all Canadian provinces and territories, the UK, and 4 Australian states**
- Because these restrictions may have contributed to income loss for the staff, a variety of financial measures were used to protect workers
- **There were broadly 2 categories of policy measures:**
 1. Allowing staff to work beyond full-time hours at a single-site
 2. Maintaining or increasing remuneration
- In some cases, these were designed to support staff retention as well as compensating for reduced income



COVID-19 action plan: long-term care homes

Read the COVID-19 action plan for long term care homes.

Version 1 — April 15, 2020

3. New emergency order to limit work sites for long-term care employees

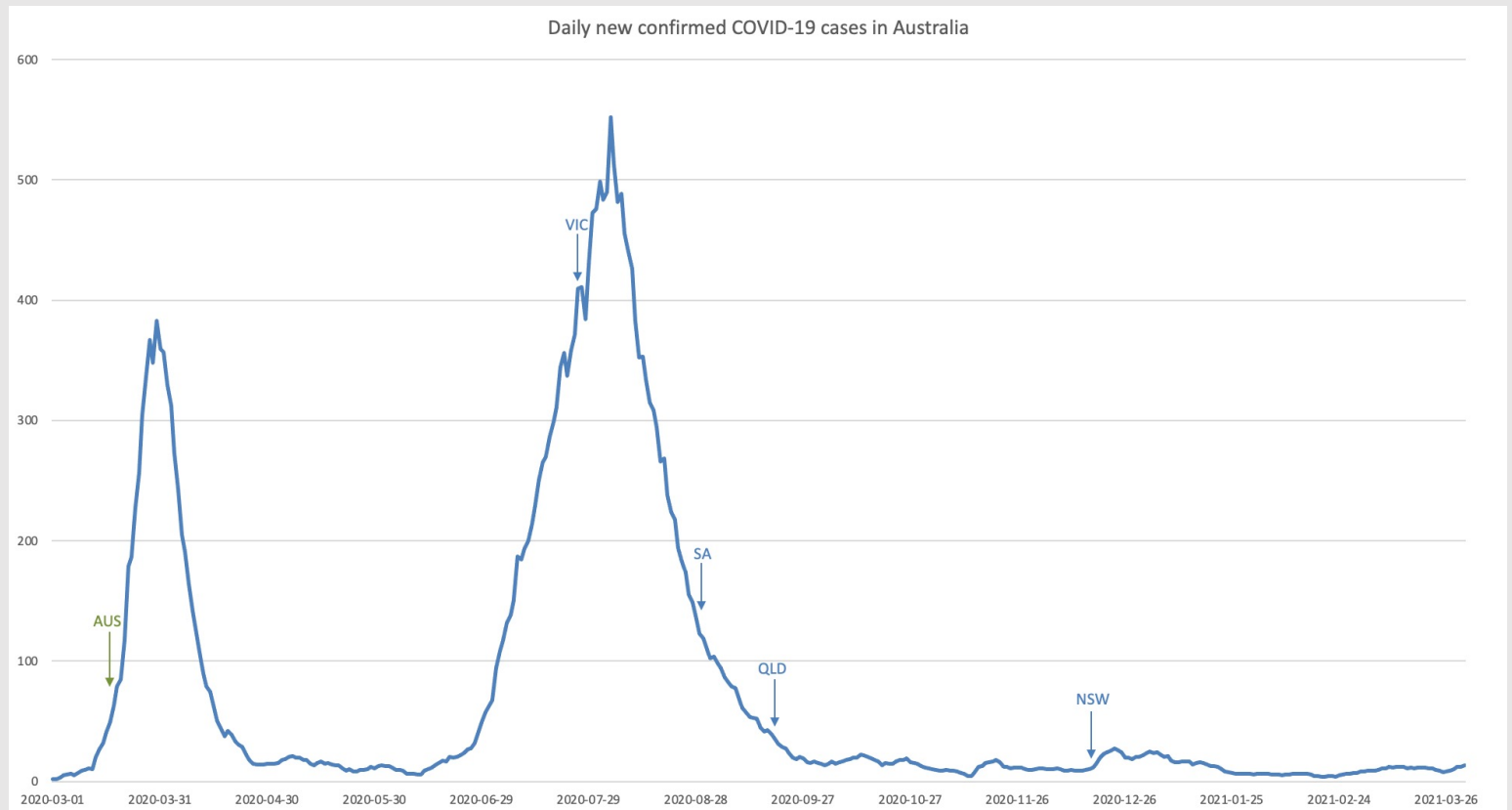
- Directing long-term care employers to ensure their employees including registered nurses, registered practical nurses, personal support workers, kitchen and cleaning staff only work in one long-term care home. This means that employees cannot work in multiple locations such as a retirement home, or other health care setting.
- Long-term care workers who must temporarily give up a job in another care setting as a result of this order are protected from losing that job because they are entitled to an unpaid leave of absence.
- Long-term care homes are encouraged to use emergency funds to bring part-time staff to full-time hours to meet staffing needs

British Columbia, Canada

- In British Columbia, employees restricted to working at one facility by the single-site order would be paid the highest wage they received while working at multiple facilities
- Moreover, employees previously working at multiple sites could work the total combined hours at a single site up to a maximum of 1.3 Full-Time Equivalents (FTEs) or 48.75 hours per week
 - *This recognizes that many multi-site workers work more than full-time hours to earn a living wage*
- In addition to these measures, the British Columbia government introduced a centralized staffing approach which ensured long-term care staff were paid a “standardized wage” and were employed on a full-time basis

Single-Site Restrictions in Australia

- Although there was **no national single-site order in Australia**, several states introduced single-site orders after the first wave of the pandemic



Single-Site Restrictions in Australia

- **Guiding Principles** were developed to assist long-term care providers in limiting staff employment to a single-site with designated hotspots
 - *A key component of these principles was to ensure that no long-term care worker would be financially disadvantaged*
- Under a limited number of circumstances where extra hours are unavailable, **the primary employer would pay the employee their remaining total average take-home pay**
- Long-term care providers in designated COVID-19 hotspots could claim workforce costs **which included costs arising from implementing single-site work restrictions through the Support for Aged Care Workers in COVID-19 (SACWIC) grant**

Guiding Principles for residential aged care – keeping Victorian residents and workers safe

Date of document: 7 August 2020

The safety of residents and workers in residential aged care is the highest priority. These principles are designed to minimise the potential risk of workers unintentionally transmitting COVID-19 either by attending work while experiencing symptoms, or working across multiple sites and, by extension, reducing the overall risk of outbreak at any given site and also reducing the health risk for individual residents and workers in Victorian aged care homes, located in hotspots.

Development

The ‘Guiding Principles for residential aged care – keeping Victorian residents and workers safe’ were developed by industry leaders with input from Government, peak bodies and unions.

The Guiding Principles should be read in conjunction with the Department of Health’s Support for Aged Care Workers in COVID-19 [Grant Guidelines](#). The Grant Guidelines outlines the Australian Government’s provision of funding support to help employers and employees stop the spread of COVID-19.

Objectives

Risk Recognition Policies for the Long-Term Care Workforce During the First Year of the COVID-19 Pandemic: The United Kingdom

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The social care workforce as agents of change: translating systems to service delivery

- The UK social care system
 - *Mixed care economy*
 - *Personalisation & marketisation*
 - *Disconnected and fragmented care delivery models*
 - *Underfunded*
 - *Long-standing recruitment and retention challenges*
 - *Legacy of political neglect*
- Emotionally taxing work
- Working conditions
 - *Contract (in)security, wages,*
- The profile of the workforce
 - *Gender, age, ethnicity, nationality*
- Societal image and (under)value
- Relationship to the NHS

COVID19 policies & the social care workforce

- A complex assembly of policies.. For LTC many guidance were fragmented and came too late
- The government's COVID-19: adult social care action plan was published in April
 - *Almost a month after countrywide social distancing measures*
 - *In May, introduced a dedicated fund to fund to support infection control in care homes.*
- Challenges in accessing PPE and testing
- System fragmentations → difficult to co-ordinate support
- Attention, when arrived, was primarily on care homes

[Health Foundation](#), July 2020
[King's Fund](#), July 2020

Compensating for Added Health Risks: UK

Hazard pay not widely introduced

- In the first year, only Scotland and Wales
- One time payment for eligible workers
- A second payment in Wales

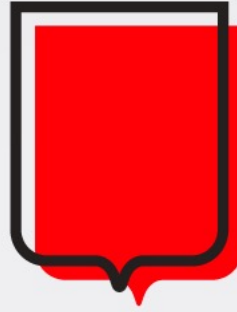
Pay raises

- Scotland

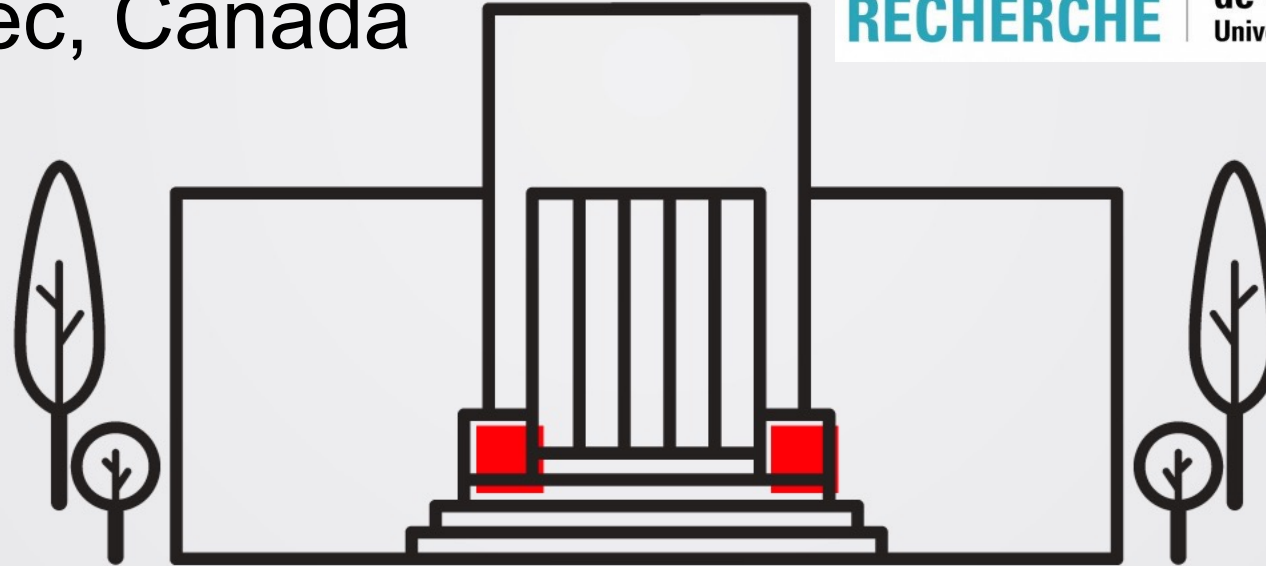
Single site restrictions : UK

- Recommended (not mandated) in all four nations
- DHSC announced the Adult Social Care Infection Control Fund (May 2020)
 - *Recommended restricting LTC staff to one facility*
- In Sept 2020 – the Winter Plan
 - *“limit all staff movement between settings unless absolutely necessary”*
 - *Met with resistance*
- Public Consultation – Nov 2020
 - *Did not put forward restricting staff to one site*
- March 21 Guidelines
 - *“Restricting workforce movement between care homes and other care settings”*
- England & Scotland
 - *Guidance on the financial compensation*

COVID-19 hazard pay & retention policies in long term care facilities: A case study of Quebec, Canada



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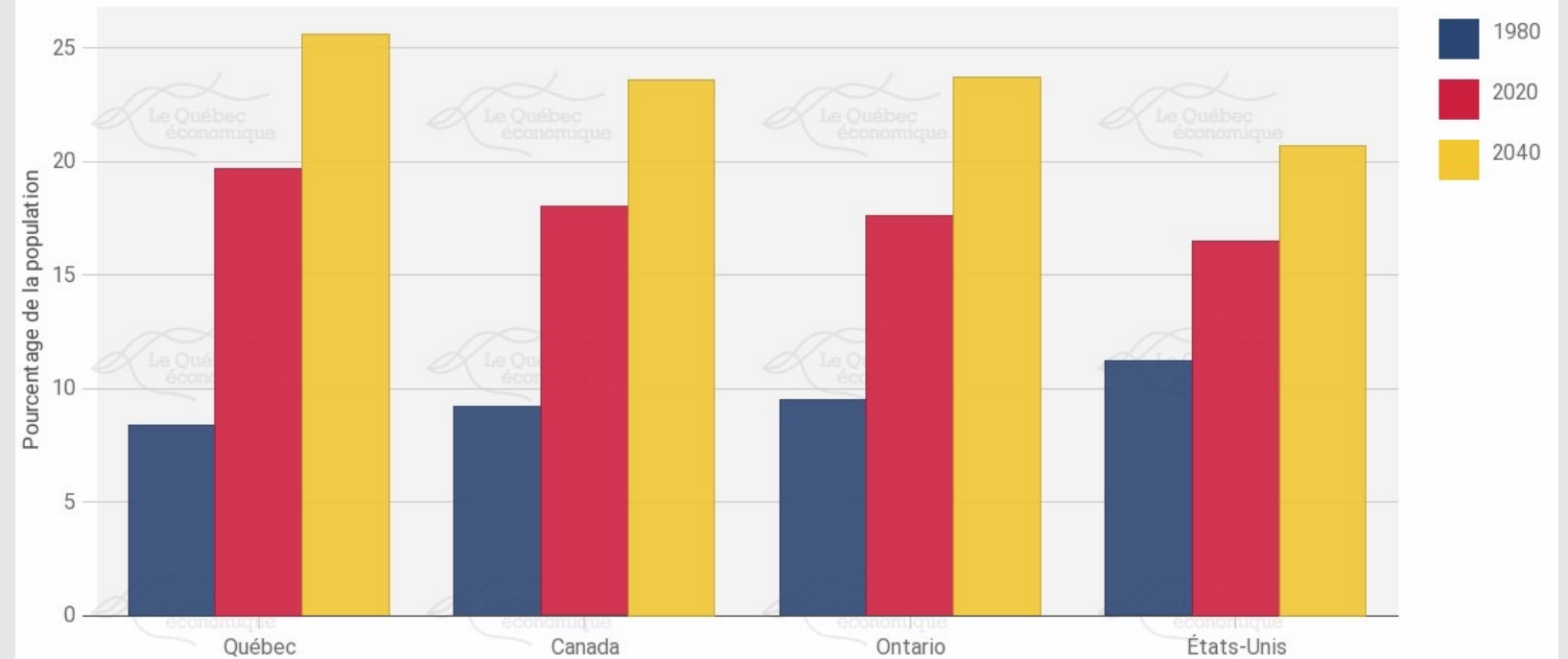


Quebec

- 8.6 million people (2021)
- 1.7 million sq. km
- Aging population: 19,7% are 65+ (2020)
- Universal public health insurance covers health care provided in LTC and covers partially accommodation costs

Publié sur Le Québec économique (<https://qe.cirano.qc.ca>)

Part des 65 ans et plus dans la population

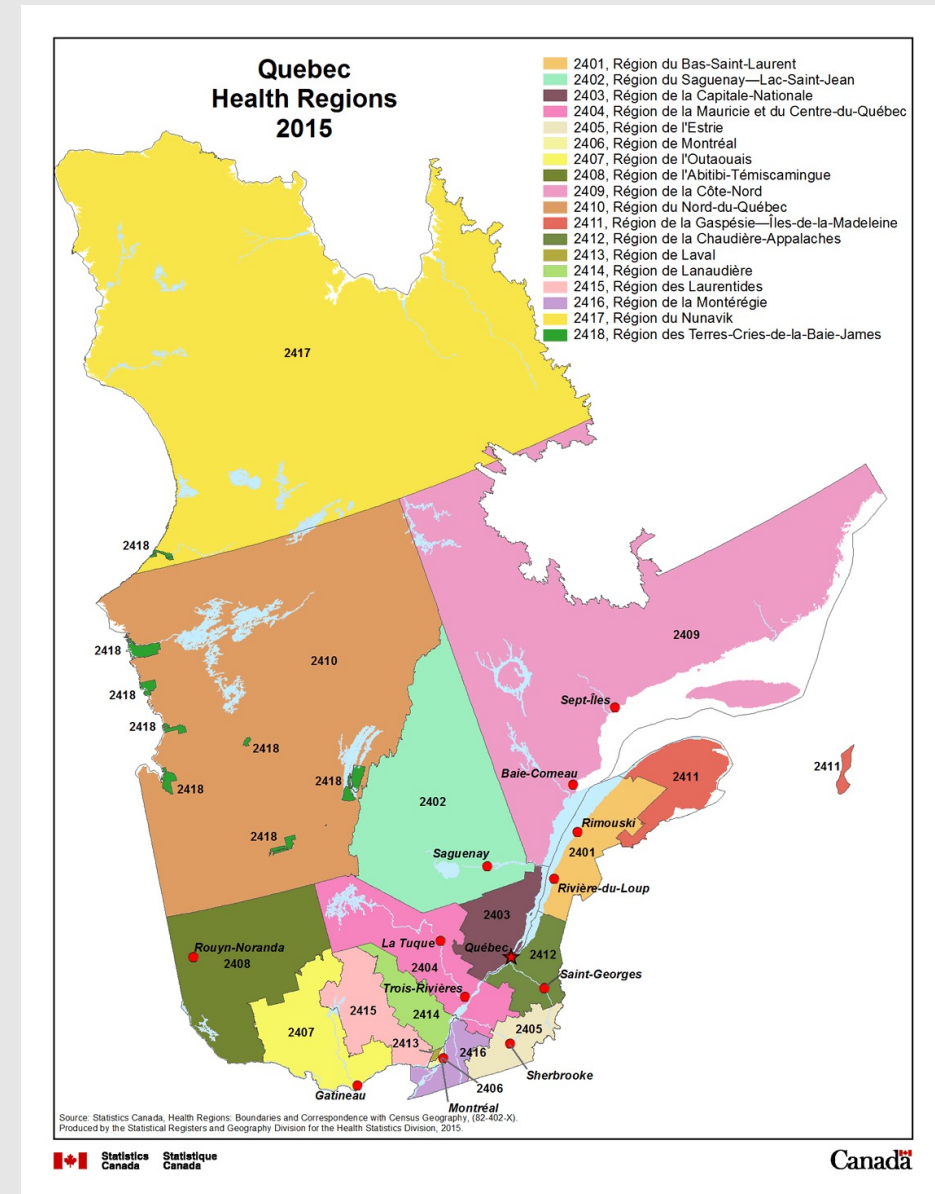


Mis à jour le 1 février 2021

Permalien : <http://qceco.ca/n/3850>

Governance

- Centralized system with 18 socio-sanitary regions:
 - Work conditions negotiated between unions and the provincial government
 - Government allocates funds directly to 22 health care organizations called CIUSSS/CISSS (depending on university affiliation) under which long term care facilities operate;
 - LTC facilities did not have CEOs or boards



Long Term Care in Quebec

417 Long term care facilities called CHSLD

- 315 public facilities (CHSLD publics)
- 59 private operating under similar conditions defined in an agreement with the government (*privés conventionnés*)
- 43 are private unfunded (*non-conventionnés*)
- 40,400 beds in CHSDLs of which 30,345 are in public facilities, 6,411 in private under agreement

A CIRANO report documented that in 2018-19, CHSLDs met **71% of basic care needs** of residents

Long Term Care in Quebec

- Precarious conditions:
 - 1/3 are full time employees
 - 36% stay in their position for 5+ years
- Low pay:
 - Personal Support Worker (PSW) hourly wage:
 - \$20.55 to \$22.35 in public facilities and
 - \$13 in private facilities (around minimum wage)
- High burden
 - Ratios of # residents/nurse & # residents/PSW are increasing
- Late Spring 2020: government realizes that the LTC sector is understaffed by about 10,000 PSW and decides to provide a paid 12-week training program

Workforce COVID-19 Bonus &

Top up	Who	Settings
8%	Staff working directly with COVID-19 infected patients	EDs, ICU, CHSLDs, clinics, paramedics
4%	All staff (lab technicians, cleaning staff, etc.)	All public facilities
8%	Nurses	Private facilities
4%	Other employees	Private facilities
\$4/hr	PSW	All
\$100/week	Full time healthcare providers	Hot zones (COVID-19 outbreaks – mostly CHSLDs)

Announced in April and June 2020, all were retroactive to March 13, 2020, ending with the lifting of the state of sanitary emergency, **still not lifted**

Workforce Mobility

- No single site order has been implemented in Quebec
 - Shortage of staff already present before the pandemic in LTC facilities
 - Single-site order didn't seem feasible to apply in the context
 - CISSS and CIUSSS were encouraged by the MSSS stabilize employment and offer full time positions to part-time staff.
- Mobility needs to be authorized by management and is only in exceptional cases to avoid services interruption.

Stabilizing the healthcare workforce

Creation of an exception register for labor mobility (announced November 24, 2020)

- Examine staff stability in residential facilities;
- Measure movements between facilities involving a change between hot and cold zones;
- Make managers accountable in limiting staff mobility and in ensuring infection prevention and control standards are met (CEO approval required for hot -> cold change)
- Applies to private and public (*conventionnés* & *n-conventionnés*) facilities
- Reduction in staff mobility from 25% to 5% between early 2020 and early 2021

Stabilizing the healthcare workforce

- Training of 10,000 PSW to fill the human resource gap in CHSLDs
 - Started Summer 2020
 - Salary raised to \$26/hour for new PSW
 - During training, scholarship of \$ 760/week are available.
\$21/hour to follow 3-month training (375 hours)

Completion of the certificate of professional studies, will provide a salary of \$49,000/year (\$256/hours) for full-time employment in a CHSLD.

- *8,500 new PSW trained are currently working in LTC facilities in Quebec*

Lessons learned & strategies implemented

- Need for an on-site manager accountable for the facility (added)
 - *Allow informal caregivers to provide care*
 - *New measures regarding placement agencies (announced March 30, 2021):*
 - New measures to strengthen prevention and control of infections: minimum duration of a placement at 14 days + no part-time multi-site placement allowed
 - Ceiling hourly rates
 - Employees are given priority for schedules over placement agency staff
 - Agencies' staff must wait 90 days before being placed in their previous workplace
 - Fines between \$1,000 and \$6,000 /day/staff for agencies not respecting any of the above
 - *Pay increases have been offered or are being negotiated*
 - New funding for private facilities to offer wages similar to those of public facilities

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10. Devenez préposé en CHSLD. <https://www.quebec.ca/education/devenir-prepose-chsld>
11. La mobilité du personnel en CHSLD passe de 25 % à 5 % en quelques mois. <https://ici.radio-canada.ca/nouvelle/1773124/mobilite-personnel-chsld-dube-zone-chaude-infirmieres>

Funding of LTC facilities

- Government funds beds for facilities and residents pay a co-pay based on their income.
- Maximum of resident's contribution for public and private (*CHSLD conventionnés*):
 - Individual room: \$1,966.20
 - 2-bed room: \$1,642.50
 - 3-bed or more room: \$1,223.70
- These amounts are indexed on January 1 of each year.
- About 22% of rooms are shared rooms
- Private unfunded CHSLD (non-conventionnés) set the monthly rent themselves

COVID-19 and types of LTC facilities in Montréal

Bilan des décès dans les CHSLD depuis un an, région de Montréal ¹

(En proportion du nombre de résidants)

	Proportion de cas	Taux de décès
CHSLD publics	48,6 %	17,4 %
CHSLD privés conventionnés	45,5 %	17,6 %
CHSLD privés non conventionnés	61,2 %	21,6 %
Total	49,2 %	17,9 %

1- Par région de Montréal, on entend Laval, Montréal et Montérégie. Les taux de la 2e vague et du total pourraient être légèrement surestimés parce le dénominateur (le nombre de lits) ne tient pas compte des résidants décédés qui ont été remplacés. En revanche, les lits ne sont jamais occupés À 100%, ce qui pourrait sous-estimer les taux.

Source : La Presse, à partir de données du MSSS



L'écart entre les vagues, région de Montréal ¹

(En proportion du nombre de résidants)

	Taux de décès, première vague	Taux de décès, deuxième vague	Total
CHSLD publics	12,9 %	4,5 %	17,4%
CHSLD privés conventionnés	12,9 %	4,7 %	17,6%
CHSLD privés non conventionnés	14,0 %	7,6 %	21,6%
Total	13,0 %	4,9 %	17,9%

1- Par région de Montréal, on entend Laval, Montréal et Montérégie. Les taux de la 2e vague et du total pourraient être légèrement surestimés parce que le dénominateur (le nombre de lits) ne tient pas compte des résidants décédés qui ont été remplacés. En revanche, les lits ne sont jamais 100% occupés, ce qui pourrait sous-estimer les taux.

Source : La Presse, à partir de données du MSSS



COVID-19: Government's preparation

- Government's expectation was that hospitals would be hard hit and implemented a strategy to free up hospital beds (10,000)
 - *Cancelling of non-essential surgeries*
 - *Transferring ALC patients to CHSLDs*
 - *PROBLEM: LTC facilities were already highly understaffed.*
- In October 2020, 88% of deaths were in seniors' facilities:
 - 66% in CHSLD
 - 17% in Private residences for seniors (RPA)
 - 5% in intermediate resources (RI)

Conclusion

- While **economic measures are insufficient on their own** to support long-term care workers, they are one of the tools available to governments to recognize their essential work and to improve retention in the short-term
- Notably, however, many of the bonuses and top-ups implemented to recognize the health and economic risks of low-income essential workers and the long-term care workforce in the early stage of the pandemic were **temporary and initially introduced for a limited time**, despite the continued health risks faced by the direct care workforce throughout 2020 and into 2021



Conclusion

While these measures compensate the long-term care workforce for the risks they faced during the early stages of the COVID-19 pandemic, it is important to consider the **structural issues that existed pre-pandemic** that have led to these financial incentives being introduced in the first place.

The **undervaluing** of the long-term care workforce, particularly personal support workers, is something governments should be forced to address given their **essential role** in maintaining the **safety, dignity and well-being of long-term care residents**.

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We have many more references – please reach out if you are interested in something in particular!

GET IN TOUCH!!



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