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The Alberta Covid-19 Response: Critical Considerations for Healthcare Worker Single-Site Exclusion Policies and Wage Supplements

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Abstract

On April 20, 2020, Minister of Health for Alberta Tyler Shandro issued a single-site exclusion order and a wage supplement for health-care aids at long-term care centres in an effort to reduce the transmission of COVID-19 between and within high-risk populations. A medically secure long-term care environment involving Adequate staffing and diligent infection prevention measures in long-term care centres are necessary to maintain a medically secure environment. The presence of safe long-term care centres in turn can help alleviate the pressures of acute and intensive care units in-hospital, which have reached capacity as of December 2020. This paper argues that the April 20th order was an insufficient and inefficiently executed iteration of a policy initially intended to protect both the lives of residents and livelihoods of employees in long-term care throughout the pandemic. Instead, I propose that centralized regulation of all nursing support staff would have better addressed the financial and health concerns that this policy aimed to target. I will also point out systemic issues in Canadian long-term care provision that have been aggravated by COVID-19, as well as reiterate the need for general infection prevention measures outside of the long-term care setting.

Introduction

As Alberta's hospital surpassed intensive care unit (ICU) capacity by December 14, 2020, it is imperative to dissect how the provincial healthcare system could have better prepared for the "second wave" of COVID-19 positive cases and deaths as well as potentially accommodate any future health crises. Pandemic conditions demand a number of measures that Alberta Health Services have not had to enact before in care settings, including COVID-19-specific wings in acute-care and the use of adaptive procedures to integrate the best medical science available at the moment. Highly-skilled staff are necessary to account for the longer incubation period and unpredictable progression of the virus, as well as to accommodate the needs of patients who must isolate away from their familial support systems.

COVID-19 safety measures are paramount for long-term care residents, who are typically frail with chronic diseases and as a result, suffer from a reduced immune capacity. Long-term care residents require 24-hour functional support in facilities that need to be adequately staffed for personal care needs and to maintain infection prevention standards (Hsu et al. 2020). With COVID-19 deaths in Canada predominantly coming from long-term care centre outbreaks, ICU

beds may remain full as immunocompromised or recently positive patients that cannot return to their care centre if they survive. It is therefore essential to enact policy that prevents long-term care centre outbreaks to alleviate pressure on acute care departments.

The key to healthy long-term care centres and residents are skilled, healthy, and financially supported care workers. This paper will argue that Minister Shandro's April 20th health-care aid wage top-up and single-site exclusion order was an insufficient and inefficiently executed iteration of a policy initially intended to protect both the lives of residents and livelihoods of employees in long-term care throughout the pandemic. Instead, I propose that centralized regulation of all nursing support staff would have better addressed the financial and health concerns this policy aimed to target. I will also point out systemic issues in Canadian long-term care centres that have been aggravated by COVID-19, as well as reiterate the need for general infection prevention measures outside of the long-term care setting.

Background

COVID-19 outbreaks in long-term care centres present a significant Canadian problem. Long-term care residents account for 81 percent of all COVID-19 deaths in Canada; a stark outlier from other OECD countries, of whom average long-term care centre COVID-19 deaths at 38 percent. (CIHI 2020b) At the beginning of December, 64 to 70 percent of the reported COVID-19 deaths in Alberta came from long-term care centres (Lee 2020). 45 of these long-term care outbreaks occurred in the Calgary zone, while 47 are from the Edmonton Zone (Castillo 2020). The case fatality rate amongst residents in Canadian long term care centres is 20 percent, which is approximately 5 percent higher than the global case fatality rate in the same age group (Hsu et al. 2020).

While patient care and survival are certainly priorities, healthcare worker burnout is also a serious consideration. A BC survey reported that "41 percent [of healthcare workers] reported severe depression, 60 percent were emotionally exhausted, [and] 57 percent reported high levels of burnout" (Petryk 2020). A similar survey that documented the second wave of COVID-19 in Canada found that half of respondents scored within a positive range for post-traumatic stress disorder, 40 percent scored within the moderate to severe anxiety range, and a third were experiencing "feelings of high depersonalization . . . and low personal accomplishment" (Smart 2020). Nursing absenteeism is 6 percent higher in 2020 than in previous years, possibly due to high burnout and infection rates within the workforce (CIHI 2020a). In September, 10 percent of COVID-19 cases in Alberta were comprised of healthcare workers (CIHI 2020a). These findings indicate that COVID-19 is physically and psychologically taxing for front-line healthcare workers.

On April 20, 2020, Minister Shandro announced a subsidy of $24.5 million to address enhanced infection control protocol in long-term care centres. $7.3 million was allocated for every month of the pandemic to top up the wage for healthcare workers by $2.00 (French 2020). This policy was intended to offset the financial strain caused by single-site exclusion orders, which mandated that healthcare workers limit their employment to one long-term care centre for the duration of the pandemic to limit the potential spread of the virus (McGowan 2020). In addition, the province simultaneously announced that it would fast-track the education of 1000 healthcare aides to assist with long term care staffing (French 2020). Although iterations of these policies have

been seen throughout Canada, Alberta chose not to centralize regulation for healthcare workers, which I will argue would have provided healthcare workers with greater stability and support.

The Alternative: Centralizing the Nursing and Support Staff Workforce

It is estimated that 30 percent of health-care aides in Alberta work in multiple long-term care centres. However, Minister Shandro's single-site order does not exclude healthcare aides from working outside of long-term care facilities, which 15 percent of aides reportedly do at an average of 18 hours a week (Duan et al. 2020). For example, a long-term care worker in Alberta could also work in acute care, homecare, or even a grocery store, which does little to suppress COVID-19 transmission but may be necessary for financial stability (AHS 2020a). This province's policy did not rule out additional sources for transmission outside of long-term care centres, and furthermore was only enacted after outbreaks had already begun (Holroyd-Leduc et al. 2020).

The single-site work order decreased work hours for health-care aides by an average of sixteen hours (Duan et al. 2020). To offset the financial impacts of reduced jobs, British Columbia and Alberta mandated that employers therefore increase employee hours (Possamai 2020). Even with surge hiring of health-care aides, long-term care organizations like the Brenda Stafford Foundation, which experienced a number of outbreaks in their Calgary homes, still reported that the overall decrease in staff makes it difficult to take back residents who were previously admitted to the ICU under the new isolation precautions (Castillo 2020). Nursing unions have also expressed concern that rapid nursing training, be it for recent graduates or from other departments, may diminish the quality of care required for highly unstable patients (Leung 2020).

The financial stability of the long-term care worker is essential to quality patient care, but the April 20 policy that aimed to increase wages for these workers did not sufficiently address the needs of health-care aides and licensed practical nurses. First, Minister Shandro's $2.00 top-up was significantly lower than other provinces' and thus should have better represented the average income that would have been lost working at multiple sites. Ontario's pay enhancement was $4.00, while Quebec chose to hire 10 000 additional personal support workers at a $26.00 hourly wage (Hsu et al. 2020). As Alberta's financial compensation is inadequate, nursing unions have expressed their concern that there is little financial incentive for nurses to stay working in precarious and taxing working conditions. Second, the wage top-ups were not implemented imminently and universally. On May 28, CUPE Alberta published that most of their long-term care workers had not received their wage supplement (Cooper 2020). By June 23, AUPE reported that a third of the 17 000 health-care workers they represented in private care facilities were still waiting for the top-up. The lack of clear direction from the Minister of Health resulted in some employers paying the top-up selectively, such as only for workers who were non-unionized or for only some, but not all, of the employee's hours (French 2020). It is also significant that the Alberta governments' wage supplement only applies to health-care aides who were contracted to long-term care sites, to the exclusion of other health-care support staff in Alberta Health Services (AHS), Covenant Health, Carewest or Capital Care (AHS 2020b).

Minister Shandro should have centralized all long-term care wages, both public and private, under a uniform wage grid. A model for this policy can be seen in BC's single-site transition framework (Possamai 2020). This framework managed provincial resources based on weekly

employee reports of worksite preferences and guaranteed full-time pay with benefits (Duan 2020). Therefore, long-term care workers are paid the same wages as unionized workers in public facilities (Holroyd-Leduc 2020). If seizing control of long-term care staffing is considered too interventionist for Alberta's government, it could have instead set firm deadlines and consequences for employers to reach deals with their staff, as was suggested by AUPE Vice-President Susan Slade (French 2020). A centralized approach to regulating and managing all health-care aides and supplemental workers would have likely simplified the lines of communication needed to ensure wage-top ups, and have protected long-term care residents from unregulated sources of virus transmission. It is also worth noting that deadlocked and ongoing negotiations between the UNA, AHS and the Alberta government about the elimination of nursing positions, rollbacks, and pay demands have all contributed to a strained relationship between nurses and the United Conservative Party. It therefore remains unclear whether the province's current relationship with nursing unions would affect how nursing unions would respond to a centralization of wages.

Acknowledging Systemic Issues in Long-Term Care

Nursing home care in Canada is not structured or staffed to maintain or improve the functional abilities of residents.
- The Royal Society of Canada Task Force on COVID-19

While stabilizing the wages of healthcare workers in long-term care through a centralized wage grid remains an ideal policy replacement, it is important to acknowledge the systemic conditions within Canada's long-term care health provision that COVID-19 has exacerbated. The physical layouts of many long-term care centres have shared dining, bathing and recreation areas which makes quarantining new or ill residents while providing quality care challenging. The province's September 3rd policy outlines a risk-based approach for quarantine requirements in long-term care, but outbreaks and poor mental health outcomes remained inevitable due to the physical conditions of the building (Castillo 2020).

With outbreaks of respiratory infections common in long-term care prior to the pandemic, the lack of proactive precautions implemented may also indicate a significant management gap in what should have been necessary infection transmission protocol (Holroyd-Leduc 2020). Greater preparedness in protocol can be exemplified by the Australian government's prioritization of the aged care sector, which addressed staff retention and surge staffing, gave direct access for these workers to the national PPE stockpile, and implemented dedicated rapid response teams for outbreaks imminently on March 11. Australia reported less than 1 percent of nursing homes had COVID-19 cases, with residents making up 17 percent of deaths (Estabrooks 2020).

The use of casual and agency workers employed in dining, laundry and environmental services in long-term care homes is a problem that is particularly relevant to COVID-19. Many of these workers are immigrant women from ethnic minorities, with limited formal training, high workloads, and in many cases lack an overhead body to represent their voice (Estabrooks 2020). This is especially concerning when a number of these workers are subjected to single-site exclusion orders but not necessarily the wage top-ups. Casual workers do not receive benefits; disadvantaging workers who need a stable income amidst a highly stressful work environment. From this report, patients also suffer from a greater use of casual employees because they are not able to build long-

term relationships with casual staff in a capacity necessary to combat loneliness or rebuild and maintain their skill sets (Possamai 2020).

An argument can also be made that an incentivization to private ownership in Alberta's long-term care infrastructure often disadvantages both patients and health-care workers. Out of Alberta's 176 long-term care homes, 46 percent are publicly owned, 25 percent are owned by private organizations, and 28 percent are owned by private not-for-profit organizations (CIHI 2020a). Canada's 2007 SARS Commission' published a report about how the deteriorating quality of long-term care conditions contributed to Canada's poor COVID-19 outcomes in these centres. This report cited that pre-pandemic conditions of these centres already saw "minimum standards of care; insufficient staffing, low-paid precarious employment, residents with complex medical needs, outdated and crowded facilities, and ownership models that often appear to prioritize profits over investing in staff, resources and facilities" (Possamai 2020). Pre-pandemic long-term care homes saw residents receive on average only 2.3 direct hours with care aides out of 24 hours (Estabrooks 2020). Canada also has fewer healthcare workers per 100 residents than the OECD average (CIHI 2020b). The report suggested systemic remedies that must be mandated on a provincial scale, including regular and proactive on-site inspections as well as regular and full-time staff. In comparison, nations with centralized organizations for long-term care provision such as Australia, Hungary, Austria and Slovenia reportedly had lower COVID-19 cases and deaths (CIHI 2020b). In August, a report by the Royal Society of Canada Task Force on COVID-19 criticized how a lack of integration across community, long-term care and acute care departments led to hospitals discharging patients who had tested positive for COVID-19 to care centres without adequate infection control measures (Estabrooks 2020). Centralized regulation could have eliminated this concern.

Long-term care centres also suffered from unclear PPE requirements, which resulted in some nurses refusing to work because the N95 masking requirements were initially unclear (Possamai 2020). Overall, slow implementation of infection control protocols, ineffective communication, understaffed departments and outdated long-term care settings may be several systemic reasons why Canadian long term care centres were quick to see outbreaks in March (Hsu et al. 2020).

Additional Measures

It is important to note this policy does not negate additional measures that I would have liked to see the provincial government enact throughout this pandemic. Current measures include restrictions on social gatherings, smaller building capacity limits, mask enforcement, and increased physical distancing. Calls for interprovincial travel bans have increased by January 2021, as variants of the coronavirus increase in prevalence (Fenton 2021). Perhaps mandatory quarantine requirements, such as those implemented in the Atlantic provinces, the territories, and Manitoba, could also decrease Alberta's positivity rate. What was heavily advocated for by the Alberta NDP and Alberta Teachers Association, but was ultimately turned down by the Alberta government, were policies of surge staffing in schools to account for the increased sanitization needs as well as smaller classes sizes in order to maintain physical distancing within the classroom (Kaufmann 2020). However, the UCP argued that this measure was unreasonably costly and reiterated that

parents could choose whether their children would attend in-person classes (Kaufmann 2020). Yet, the ability for parents to keep their children at home does not negate the need for greater safety measures within the classroom, especially when many parents cannot stay home. There is evidence that specific and mandatory measures that are targeted to the general public, like the implemented and rejected ones previously mentioned, contributes to fewer deaths and positive cases in long-term care centres. (CIHI 2020b)

Additional pandemic measures can be gleaned from other nations. The United Kingdom's NHS has a grading system in order to allocate healthcare staff to different departments according to their own health capacity, which keeps staff employed according to their own risk factors (NHS Confederation 2020). Alberta currently does not have the provisions to monitor the responsibilities of their healthcare workforce in the best interests of their health, which might be a welcome investment for maintaining a precariously positioned workforce. The NHS also allocates their doctors with a number of COVID-19 self-test kits for their own expedited monitoring (Rimmer 2020). Such measures to maintain healthcare worker wellness may make it easier to allocate additional dedicated healthcare aides for homecare, which could in turn incentivize families to bring their seniors home and temporarily reduce the capacity of long-term care centres. In addition, long-term care centres should be outfitted with dedicated contact tracing and point prevalence facility-wide asymptomatic testing to allow for 24-hour, or even rapid results (Lee 2020). In Alberta, asymptomatic testing was announced on April 17 for long-term care centres but was not enacted until a week later because of unclear logistical direction (Lee 2020). These measures offer opportunities for healthcare workers and employers to monitor and exercise greater control in mitigating the personal risks that healthcare workers must take when caring for vulnerable or COVID-positive patients. Of course, these measures also require dedicated compliance by the Alberta population.

In Alberta, it would have been particularly effective in COVID-19 messaging to eliminate the economy versus lockdown binary. A complete lockdown, as seen in Australia's four-month enforced restrictions, would have likely eliminated COVID-19 from economic decision-making. Now, the Australian economy is steadily improving as businesses re-open, and is strong enough to withstand sudden "snap lockdowns" if individual cases of the virus emerge. Key to these lockdowns are stringent enforcement practices and tangible metrics residents could aim for in their isolation practice (Bridges 2021). However, the government could still have assisted small businesses by providing direct interventions – such as paying for plexiglass installation, expanding city-wide internet bandwidth for online business, and incentivizing corporations to partner and assist with small businesses (eg. providing cars for delivery, etc.). In retrospect, this may have been preferrable to Alberta's extended 9-month gradual and lightly enforced restrictions of which continue to plague the economy (Lee 2020). This point returns us to the necessity of the provincial government in adequately compensating working Albertans financially and increasing accommodations to protect personal health – whether they are small business owners or healthcare aides.

Conclusion

A centralized regulation of nursing support staff could have resulted in an efficient implementation of protocols, more financially and mentally fit workers, and a reduction in virus transmission from stricter site limits. In conjunction with a reformed long-term care system and a general adherence to public health measures, it is possible that ICU beds would not currently be at capacity because preventative measures had been effective.

Today, overcrowding ICU beds increases the strain on triage nurses and physicians to decide if acute care or emergency patients – whether they are suffering from COVID-19 or a stroke deserve immediate treatment. The goal of centralizing healthcare worker pay on a uniform provincial grid would be to better equip nursing staff in controlling outbreaks within long-term care centres, ultimately diminishing the pressure of maintaining long-term care patients in acute care centres.

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