CANADIAN HEALTH PROFESSIONALS SECRETARIAT

COVID-19—
NUPGE Components and CHPS Members Videoconference

November 19–20, 2020

The National Union of Public and General Employees (NUPGE) is a family of 11 Component and 3 affiliate unions. Taken together, we are one of the largest unions in Canada. Most of our 390,000 members work to deliver public services of every kind to the citizens of their home provinces. We also have a large and growing number of members who work for private businesses.

Larry Brown, President

Bert Blundon, Secretary-Treasurer

COVID-19—CHPS Members and NUPGE Components
November 19–20, 2020

PARTICIPANTS

BCGEU/NUPGE	Mahen Ramdharry
HSABC/NUPGE	Val Avery Jaime Matten Edith MacHattie
HSAA/NUPGE	Travis Asplund Darlene Fetaz
SGEU/NUPGE	Genny Goodyear
HSAS/NUPGE	Karen Wasylenko Angela Barsalou Natalie Horejda
MGEU/NUPGE	Shayne Orr
OPSEU/NUPGE	Sara Labelle Noemi Khondo Michèle Dawson Haber Sandi Blancher Marc Casey Kelsea Mahabir
MAHCP/NUPGE	Bob Moroz
NBU/NUPGE	Susie Proulx-Daigle Joyce Aucoin Leigh Sprague
NSGEU/NUPGE	Laura MacMillan Uta Berthold-Brush
PEI UPSE/NUPGE	Carolyn Knox
NAPE/NUPGE	Bonnie Tobin
AAHP/NUPGE	Virginia Whitten Pam Toope

Guest Speakers

Christine Nielsen, CEO, Canadian Society for Medical Laboratory Science (CSMLS)

Dr. Peter Smith, Scientific Co-Director and Senior Scientist, Institute for Work & Health

NUPGE

Larry Brown, NUPGE President
Bert Blundon, Secretary Treasurer
Len Bush, Managing Director (Office of the President)
Anil Naidoo, National Representative
Sandra Megeney, Administrative Representative

1. Welcome and Introductions

Participants from 10 NUPGE Components and 3 CHPS member unions joined the call. Anil Naidoo, CHPS co-Chair and a NUPGE National Representative, welcomed everyone and shared the Land Acknowledgement.

The purpose of today's meeting was to have a more focused meeting about the second wave of COVID-19 and discuss the impacts on health professionals. It was also to discuss some of the ongoing issues of importance to CHPS, (i.e., pharmacare, LTC, paid plasma etc.)

CHPS co-Chair, Val Avery, thanked NUPGE's President, Larry Brown, for his leadership, support, and his presentation at HSABC's Convention.

2. Welcome and Report from the National Union: Larry Brown, NUPGE President

Brother Brown outlined some of the second wave's key risks facing the country. He noted that there were crises in Manitoba, Alberta, and BC. The Ontario numbers were high but currently confined mostly to Toronto and region. The Atlantic provinces continue to do well with their Atlantic Bubble.

There has been real progress in procuring PPE, but distribution issues are still a concern. Brother Brown noted that HSABC President Val Avery has led the way in trying to press the federal government to admit that COVID-19 is an airborne infection and spread not only via droplets and contact.

There is tangible COVID fatigue in the country and among the membership. Still, there is hope in the vaccines, with Pfizer and Moderna reporting immunity ratings more than 90%.

Spring was a disaster for LTC, with a large number of staff and residents suffering infections and/or death. NUPGE has been working to have LTC covered under the *Canada Health Act*. Since the first wave and the tragedy in LTC, not much has changed. The Speech from the Throne sounded positive around pressing for national standards in LTC, but there still has not been any action. CCPA has released a report on what national standards should look like. It would be worthwhile for the government to look at this work and to move forward on this critical issue. NUPGE sent a letter to the Prime Minister on this issue last week.

Revera is an interesting case in LTC, since it is a for-profit company owned by the federal public sector pension plan. It has also had a lot of problems with COVID infections. The federal unions are really involved in fighting to try and get their pension plan to divest. The Public Service Alliance (PSAC) and the Professional Institute of Public Service (PIPSC)—Canada's 2-largest federal public service unions are pushing to have Revera changed from a for-profit home to a publicly owned and operated entity.

Another area of interest is gender-based violence and domestic violence. There is a national action campaign to ensure job protected leave for workers, workplace protection for workers experiencing DV, for initiating prevention programs, and signing onto the ILO Convention.

Other key fights include the call for national pharmacare. This is another commitment in the Throne Speech that NUPGE will be pressing for the government to honour. National child care is gaining momentum and discussion as parents try to deal with lack of child care during the pandemic. Finally, the Cambie case was a major victory for all public health care advocates. Justice John J. Steeves struck down the arguments made by Dr. Brian Day that health care should be open to more privatization.

Bert Blundon, Secretary-Treasurer

Brother Blundon talked about the current COVID cases in the Atlantic provinces being linked to international travel. He also pointed out that low-wage earners are at higher risk to contract COVID-19. Brother Blundon pointed out that the LTC death statistics were startling and that LTC deaths were 4 times higher in private for-profit facilities than in public facilities. Finally, he touched on the issue of blood and plasma privatization and how that connected with the fight for treatments for COVID.

3. Opening Statement—Val Avery, CHPS co-chair and HSABC President

Sister Avery talked about COVID-19, poverty, and racial injustice, and made the links between infection and socio-economic struggles. While it is hard to get solid data in BC and other jurisdictions on this issue, clearly there is great inequality in who is exposed to COVID.

Mental health is also a great concern after 8 months of lockdowns, partial-lockdowns, and restrictions. Many have lost jobs, and families have been isolated and split. For health care workers, pre-COVID, there were already major problems with shortages, workload, and burnout. COVID has made preexisting serious problems into a crisis.

Unions are also fighting for presumptive coverage for mental health: for psychological injury because of trauma and what people are experiencing in the workplace. The impacts of COVID are not only physical.

It is critical that across Canada the issue of paid sick leave for workers is raised and addressed.

Review of Agenda—provided by Anil Naidoo

The agenda was reviewed and adopted by the group.

4. Key Issue Updates

The Cambie case was a major win! The decision was on September 10, 2020. And while the ruling is being appealed, Justice Steeves provided a very thorough ruling that will be hard to overturn on appeal.

With regard to our work against the expansion of for-profit paid plasma in Canada, it is unfortunate that Kat Lanteigne has left BloodWatch.org. At the same time, the CHC is down to one staff member; these are not good developments for our movement.

In Alberta, there is a Private Member's **Bill 204** that would reverse the ban against paying for plasma and blood.

In Ontario, the LTC commission is hearing presenters. Unfortunately, the same issues around residents and staff deaths and/or infections are replaying from the first wave in the second wave. There are still issues around inadequate care in LTC, with staffing deficits and PPE issues.

OPSEU expressed its concerns around **Bill 218** in Ontario. This bill would limit the negligent suits brought against LTC operators, requiring there to be verified proof of gross negligence.

On LTC, both NUPGE and the CLC have advocated for LTC to be brought under the *Canada Health Act*.

Related to PPE issues, the standards within the country have improved somewhat. There are more concerns about the quality of product, and there is still not enough recognition of the importance of N95 masks .

HSABC noted that they are seeing more friction between employees and supervisors due to COVID. This has led to an increase in grievance issues. We need to look at more resources and services to provide support, i.e., United Way in BC has a 211 call line to support people experiencing mental health issues.

The ongoing HHR shortage was a concern. COVID has intensified the situation beyond what it was pre-pandemic.

The opioid crisis was also brought up as an ongoing issue that had been overshadowed by COVID but was becoming more deadly.

With the lockdowns and impacts on health care, there is now a major surgical backlog; many provinces are allowing these surgeries to be outsourced and care provided by private for-profit clinics. This is a concerning trend.

Bill 175 in Ontario is a direct attack on homecare, seeking to remove public oversight of a system that has many private for-profit providers.

In Alberta, **Bill 30** is a direct attack on public health care, restructuring the pay and billing system, doubling private sector surgeries and undermining governance structures. In addition, lab privatization is moving forward unabated.

5. CHPS Constituents Reports—full reports are attached below:

<u>MAHCP</u>

There is an ongoing PPE battle, expired PPE is being issued, there are major outbreaks in personal care facilities, as well as acute care facilities. 2 health care workers have died, and our fight for proper PPE continues to try and stop more needless deaths and illness. Things are very bad in Manitoba now, our curve is out of control. We have outdated PPE found in storage and this negligence is putting our members at risk. Premier Pallister is being highly criticized for his handling of this crisis.

We also have rredeployment issues, staffing issues in LTC homes, anti-labour legislation and a large number of anti-maskers. We are issuing a number of grievances and will continue to work to protect workers.

<u>MGEU</u>

As noted, the PPE issue is huge with no real change as demand is increasing.

MGEU has began a mental health campaign which was planned before COVID but is now critical. We have had a major outbreak in our correctional facilities as well as in 30 personal care homes. There have been hundreds of school exposures. To date, 113 health care workers have tested positive and the entire province of Manitoba is in Code Red.

<u>HSAS</u>

In SK there were 300 new cases on Saturday. The premier has mandated provincial masking. There are a maximum of 5 people allowed in a household and there are no visitors allowed into LTC homes. Staff are being redeployed and stress and mental health issues are on the rise. SK is also repurposing mask and PPE in general. There have been concerns that the repurposing is not being done based on science.

Health care workers are under enormous stress and there have been reports of verbal abuse towards workers.

<u>HSAA</u>

HSAA has 1000 fewer members from this time last year. To oppose Bill 32, we will be doing a member-to-member campaign.

Privatization continues, mostly in laundry and food services. Nurse layoffs stand at about 1600. HSAA is in collective bargaining right now. We are also in Phase 3 of the 'I Care Campaign'.

AB Health Services did not consider PPE for Home Care. It is very concerning that the client and family members do not have to wear PPE or physically distance. Currently, staff is at half capacity due to exposure. A big question is who will get the vaccine—AB was to receive 600,000—who will receive these?

BCGEU

In the BC gov - most employees continue to work from home. We are about to launch a campaign to bring privately-owned senior homes back into the public.

HSABC

For HSABC, we are seeing recruitment and retention as still a big issue. There are significant pay discrepancies an intense workload, which increase burn out rates. There is also the surgical back log. BC is taking some positive steps such as mandating mask wearing.

We are about to launch our 2-day virtual convention. There were a whole set of regional meetings, held virtually, in advance of our convention. In BC our numbers are increasing, waiting for new restrictions to be put in place at 3pm today

OPSEU

The budget held good news as health and long-term care special funds that were new this year are going to continue for the next 4 years. There are dangers as the Hospital Association projects a deficit in 2021.

On March 31st, the 2022 collective agreement expires. The Pharmacy Techs grievances have meant that they received 6% but had to go back to the arbitrator because the retirees were not included.

AAHP

Highlights of our report are that there is a new Premier. There is a provincial economic recovery team (12-person team) doing things without transparency. Collective Bargaining is ongoing and there is a Good Neighbour Agreement in place.

We are doing a campaign to raise public awareness about our membership. The campaign was launched in Feb 2020.

NBU

Collective bargaining has restarted, but virtually. The Nursing Home Act has strong opponents with CUPE planning on pursuing it all the way to Supreme Court.

There is a Joint job study and we have been able to win Supplemental Maternity Leave. Overall, numbers are rising, and Moncton just moved to Code Orange.

NSGEU

NS has had a mandatory masking since the end of July. There are currently 3 active cases. The premier officially proclaimed Allied Health Professionals' week.

There have been 63 deaths in province with 53 of those were in Northwood Facility. NSGEU has launched a 'Thank You Campaign' for its members. Pandemic pay is the employer's decision.

6. Medical Lab Tech. HHR Shortage—Call to Action

Speaker: Christine Nielsen, CEO, Canadian Society for Medical Laboratory Science (CSMLS)

Christine Nielsen shared her Power Point which will be included with this report.

Her presentation was well received and there is an opportunity to see if there are opportunities for collaboration or support.

Speaker: Dr. Peter Smith, Senior Scientist, Institute for Work and Health

Dr. Smith also shared his remarks for the group. The issues related to COVID-19 protections is clearly an issue for workers. It will be appended to this report.

7. Other Items

Sister Avery provided closing remarks for the meeting.

APPENDIX 1

Component Reports

November 19–20, 2020
11 am (EST)
Videoconference

Constituent Report

CHPS Organization: Health Sciences Association BC

1. **Number of health professionals that are members of constituent union:**

   Most HSABC members are covered by one of the following collective agreements:

   1. 17,000 health science professionals are covered by the Health Science Professionals collective agreement. HSA represents the vast majority of workers in the bargaining association that negotiates this agreement;

   2. 1,000 registered psychiatric nurses are covered by the Nurses' collective agreement;

   3. 1,000 health services & support workers are covered by the Community Health Services and Support collective agreement; and

   4. 1,100 community social service workers are covered by 1 of 3 collective agreements negotiated with the Community Social Services Employers' Association (CSSEA).

   5. An estimated 110 health science professionals are covered by collective agreements with private providers (primarily West Coast Medical Imaging)

2. **Have you noticed any changes or trends overall, and in specific disciplines?**

   Nothing to report.

3. **Comments on government or on the current political climate:**

General voting day in BC was on October 24, 2020. The results are a BC NDP majority government, with the provincial seat breakdown: BC NDP 57; BC Liberals 28; BC Greens 2.

This is the positive outcome that the labour movement, including HSA, was hoping for. The last term of a BC NDP minority government saw many positive initiatives, including reinvestment in public services, a poverty reduction plan for the province, strengthened employment standards, and needed labour code reforms. The BC NDP's election platform contained a number of new commitments, many targeted to enhance our public health system.

The Premier's handling of the pandemic, alongside Provincial Health Officer Dr. Bonnie Henry and Health Minister Adrian Dix, has been widely lauded and many claim their electoral victory was largely due to this issue. With the second wave of COVID hitting the province, we will continue to work to keep the government focused on the needs of health care workers who are once again are the first line of defense against this virus.

HSA will continue to lobby the government on the critical shortages of health science professionals facing the province. While the government made some progress on this issue—including new training spaces for some professions—there is much more work to do to avert the looming crisis.

4. Collective bargaining update:

Ratified the HSPBA collective agreement in January 2019.
Members at a small private imaging facility just ratified a three year agreement.

5. Significant grievances, arbitration, or legal decisions:

After almost ten years, the BC Supreme Court ruling on the Cambie case was delivered on September 10, 2020. Justice Steeves' ruling was unequivocal in its support for public health care. This decision ensures that access to health care will continue to be based on need and not on ability to pay.

Just days following the ruling, Dr. Brian Day—CEO of Cambie Surgeries—filed an appeal. HSA will continue to work through the BC Health Coalition, who have official intervenor status in the case, to rebuke Dr. Day's appeal.

Following the court ruling, HSA president Val Avery and HEU president Barb Nederpel co-authored an opinion piece on what's next:
https://thetyee.ca/Opinion/2020/09/22/Public-Health-Care-Just-Won-Big-BC/

6. Can you share examples where the pandemic exposed deficiencies in our health care system and what responses are being implemented or may be needed?

The pandemic has shone a bright light on the real legacy of the BC Liberal government's 16 years in power. Underfunding, understaffing, privatization, and refusal to create needed training opportunities in the sector have left our public health care system vulnerable. The BC NDP government has moved quickly to start filling to gaps—including massive investment in seniors care to enhance staffing levels, wages and care hours; infrastructure investment in hospitals in every corner of the province; opening new training seats in a variety of health professions; and reversing the trend of privatization. Despite these efforts, our public health care system and the critical professionals that are its backbone are struggling to support British Columbians through this pandemic.

HSA continues to advocate for better retention and recruitment of HSP, as well as continued innovation in our public system ahead of private solutions, such as increased OR time in hospitals, increased diagnostic capacity, and better wait list management to streamline access to specialists. We have seen some movement in all of these areas.

7. Updates on COVID-19:

- **COVID OH&S update (PPE, screening, infection prevention, etc.)**

Covid-19 has impacted our workers in every corner of the province. The use and access to PPE continues to be an area of concern, with specific issues involving N95 respirators. There have been reports of members being harassed for requesting the respirators, also cases of restricted access to respirators and medical masks.
Recent Ministry of Health policy has clarified the use of masks by all parties in health care settings including workers, patients, and visitors.

- **COVID HHR update (workload, burnout, training, staffing levels, etc.)**

Government, employers, and the union agree there are severe shortages in a number of critical professions (see Q. 11) All of these shortages were evident prior to COVID, but cancelled surgeries during the initial presentation of COVID have led to extreme backlogs and a huge effort to catch up, meaning these professionals are needed in greater numbers than before. Add to these challenges new government initiatives such as Hospital at Home and the expansion of multidisciplinary primary care teams, and the problem becomes even more evident. For example, many of the postings for a position do not

attract a net new professional into the system, but rather just move someone within the system around, creating a difficult to fill vacancy elsewhere.
These shortages contribute to extreme workload issues and burnout (not just COVID related). These shortages and workload issues create an environment in the workplace that is full of stress and is intimidating to students in these professions who rotate through the hospitals (thus creating another challenging in recruiting graduates to the public sector).
Anecdotally, our Labour Relations staff have seen a significant increase in discipline-related files over the past few months, and are working hard to support and represent our members.

- **COVID backlog—how is the surgical backlog being addressed?**

During the first wave of COVID all elective surgeries were cancelled, creating the largest backlog of surgeries in BC's history. Since the summer, surgeries have resumed and an aggressive strategy to work down the backlog is in place, including increased capacity in the public system. To date, under wave two of the virus, no blanket cancellations have happened and hospitals are better prepared with surge capacity for COVID outbreaks.

- **COVID in general (any other COVID-related issues to report?)**

In September the government announced a $1.6 billion investment in the health care system to ready it for wave two of the pandemic. This included increased access to flu vaccines, increased testing and tracing programs, the hiring of more health care professionals specifically in long-term and seniors care, the Hospital-at-Home program to support COVID out-patients, and other initiatives.
Within this new funding, HSA continues to insist that training and recruiting HSP must be a priority.

8. Major campaigns and communications (please include links if possible).

HSA continues to lobby for the provincial government to include all health care and community social service workers under the mental health presumptive clause of our Worker's Compensation program. You can see our campaign video here: https://www.youtube.com/watch?v=9H5rWn6ygBM

Our Constituency Liaison program will resume lobby activities, focusing on the impact of HSP shortages and the need for further investment in Child Development Centre, specifically in the areas of Early Intervention Therapies, early years mental health services, and autism funding.

The HSA Member Engagement team is focusing their efforts on the campaign for paid sick leave for all workers. You can see the email tool they are asking members to sign here: http://paidsickleave-hsabc.nationbuilder.com

9. Health and Safety—report any important developments in this area:

Major developments in Health and Safety include the inclusion of COVID-19 and related viruses as a presumptive claim by WorkSafe BC. This legislation was fast-tracked through the regulatory process and is now in effect.
Revised Ministry of Health policy has clarified the use of masks by all parties in health care settings including workers, patients, and visitors**.**
There has also been progress on regulatory limits on ionizing radiation on the eye, bringing British Columbia in line with international standards.
Pre-consultations are underway to update and improve WorkSafe regulations on workplace violence, workplace conduct, and bullying and harassment.
HSA has long advocated for a provincial health and safety centre for the health care sector. The Ministry advanced this item and we have now secured approval under the Societies Act for the formation of the centre. A board of directors has been named, and the organization's chairperson is being hired.

10. Monitoring violence in the workplace—are there specific incidents to be noted, or overall measures that have been implemented, regarding violence in the workplace?

In an effort to better understand the experiences of system racism in health care and community social service sector, HSA launched a Racism at Work survey. This survey invited members who identify as Black, Indigenous, or Person of Colour (BIPOC) to complete the survey and share their personal experiences and insight on the issue of racism in the workplace.

The results of the survey were extremely insightful and informative. Stemming from the survey, a group of BIPOC members formed a working group to generate a series of recommendations for the union to consider. The final report was released in August, and has sparked renewed commitment from union leadership.

You can find the full report here:
https://hsabc.org/sites/default/files/news/web%20Confronting%20racism%20with%20solidarity%20report.pdf

11. Health Human Resources (HHR)—are there shortages of skilled professionals? And are there any initiatives being used to increase recruiting, training, and retention of health science professionals?

We continue to experience severe shortages in a number of professions, and are working with the Ministry of Health as they review the provincial workforce strategy. A department within the bureaucracy was established with a specific focus on allied health professionals.

We continue to lobby the Minister of Health and Minister of Advanced Education regarding the need for increased training spaces for allied health professions, as well as the need for rural training opportunities. We have seen some progress in key professions:

- *Sonographers:*
  - 8 new training seats at CNC in Prince George
  - 16 new training seats at Camosun College in Victoria, 2020, 32 in 2021.
- *Physiotherapists*
  - 20 new seats in UNBC in Prince George, 2020
  - 20 new seats in Fraser Valley, 2022
- *Occupational Therapists*
  - 8 new seats at UBC, 2020
  - 16 new seats in UNBC, 2022

One area that needs immediate attention is Medical Laboratory Technologists. BC is facing severe shortages in this area, and the forecast retirements in the next five years will put the province in a crisis regarding this critical profession.

Government, employers and the union agree there are severe shortages of PT, OT, SW, MRI tech, Diagnostic Medical Sonographers, Medical laboratory Technologists and Perfusionists. They are not alone. Respiratory therapists who are at the forefront of the COVID battle, are in many cases earning more than $10/hour less than they could earn elsewhere in the country. Dietitians, Speech Language Pathologists, psychologists, and pharmacists are also experiencing difficulties recruiting and retaining professionals.

12. Workforce challenges related to aging—has your union put in place any strategies for recruiting or retaining related to the looming shortages based on the aging health care professional workforce? Has your government? Are there any studies or analyses of the issue that you can share?

The Health Science Professional Bargaining Association works on a joint Recruitment and Retention Committee

While we are working with the government and employer agency on recruitment and retention issues, looking at such strategies as increased training seats in the various schools, increasing opportunities for foreign trained grads, financial incentives for recruitment or isolated positions, we are of the view that until the wages in the province are competitive we will not be able to keep those we train, or that are currently working here.

The Municipal Pension Plan, the pension plan for the vast majority of our members, is in the midst of a long-awaited update that includes the removal of some incentives for early retirement. If passed, these changes will come into effect on January 1, 2022.

13. Are there privatization initiatives planned or proposed for your province that impact the health care system? Where do you see the pandemic increasing or decreasing the move towards privatization?

Nothing to report

14. Any other major activities to report:

HSA just held its 49th annual convention on November 16 and 17. Due to COVID restriction, the event was held virtually via webcast. While this format was new to both organizers and delegates, it was successful in completing the work of the union. We are looking ahead to our next convention in spring 2021, with an eye to enhancing the online convention experience in the case we are still not able to host large gathering.

15. Are there any specific issues or topics that you would like to see addressed at future CHPS meetings?

HSA is still interested in inviting federal health minister Patty Hajdu to meet with CHPS at a future meeting.

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Constituent Report

CHPS Organization: Health Sciences Association of Alberta (HSAA)

1. **Number of health professionals that are members of constituent union:**

   26,870

2. **Have you noticed any changes or trends overall, and in specific disciplines?**

3. **Comments on government or on the current political climate:**

   We're worried that our answer to this is becoming redundant. How many ways can you say: "things are bad and getting worse"? In spite of spiking COVID-19 case numbers, Jason Kenney and his crew continue to attack the public health-care system and health-care workers. Here's some of the "hits" since last we met:

   - Passed Bill 30 to allow for private surgical clinics (also referred to as charter clinics). Along with a $200 million private orthopedic surgery facility announced, the government has also announced plans to help First Nations develop chartered surgical clinics on reserves.

   - Bill 30 also reduces balance of professional vs. private representation on professional colleges.

   - At the same time, the government passed Bill 32 to demand that union members "opt in" to the portion of their dues that is deemed to be spent on political activities. Regulations that include the definition of political as well as the method for members to opt in are expected early in 2021.

   - Announcement of the privatization of at least 11,000 jobs in health care.

   - Announced layoffs of hundreds of nurses once the pandemic is over.

   - Along with the rest of the country, Alberta is facing the largest deficit in our history, which the government views as its top priority.

- Jason Kenney and the UCP's popularity has fallen dramatically and they are now tied with the NDP in the latest polls with rumours that their internal polls put them behind.

- Fall session bills include repeals of advances made under the NDP to OHS and WCB laws.

4. Collective bargaining update:

HSAA/AHS Interest Arbitration

As part of the last round of negotiations, HSAA/Alberta Health Services (AHS) agreed that we would reopen the wages clause of our collective agreement in the third year. If, after negotiating, there was no agreement at the table, both parties agreed to mandatory arbitration to decide on wage increases, if any. For HSAA, arbitration was scheduled to be concluded by Nov. 30, 2019. Bill 9, the Public Sector Wage Arbitration Deferral Act delayed that date with a new deadline of March 15, 2020.

- The Employer's opening position was 0% in year three. Our opening position was 5%.
- The Government instructed AHS to change their opening position from 0% to -5%.
- Interest Arbitration was held on January 27,2020. HSAA received the decision on February 4, 2020, from Arbitrator David Jones where he concluded that no change in wage rates is justified in the third year of the collective agreement.

Bill 21- Ensuring Fiscal Sustainability Act 2019. Within the Bill is the Public Sector Employers Act. This Act allows the Minister to issue directives that an employer must follow during and after engaging in collective bargaining or a related process. This may include directives respecting the term of a collective agreement an employer may propose or agree to, and fiscal limits the employer must operate within when engaging in collective bargaining or a related process. The government states this is ensuring that the costs of collective agreements bargained by public sector employers are aligned with the Province's fiscal realities.

Bill 21 also includes amendments to the Alberta Labour Relations Code (the Code). One amendment is to allow for replacement workers hired by the employer for the purpose of performing the work of an employee in the bargaining unit during a strike or lockout. After either party serve notice to begin negotiations for an essential services agreement, an employer shall elect to use the services of either designated essential services workers or replacement workers to perform essential services during a strike or lockout. Replacement

workers were previously prohibited by the NDP government with respect to essential services under the Code.

Our current bargaining with our major employer—Alberta Health Services—may be delayed until March 31, 2021. This is a year after the expiry of the current agreement. Delays have been attributed to COVID. While these are frustrating, they have also guaranteed our members some job security during this waiting period.

5. **Significant grievances, arbitration, or legal decisions:**

6. **Can you share examples where the pandemic exposed deficiencies in our health care system and what responses are being implemented or may be needed?**

7. **Updates on COVID-19:**

- **COVID OH&S update (PPE, screening, infection prevention, etc.)**
  Access to specialized PPE: There have been rare instances of members having medical reactions to specific brands of PPE such as masks or gloves, during normal times the employers occupational health nurses support these members in finding suitable alternatives, however during the pandemic there has been an inadequate capacity to address these concerns in a timely manner. HSAA has elevated these member concerns to the highest levels of the employers Contracting Procurement and Supply Management teams in Addition to workplace Health and Safety, this has resulted in finding alternative products that meet the needs of affected members in addition the unions advocacy on this issue has led to the employer creating a dedicated occupational health resource to manage these cases when they occur in a timely manner.

  Appropriate PPE to Reduce Staff Exposures: Many HSAA members were being restricted from work duty due to the employers' refusal to expand the use of full COVID PPE to more types of patient interactions. In some cases, members are being told to wear full contact and droplet precautions only when working with a probable or confirmed COVID case. However there have been many cases of patients that initially screen negative and are later found to be positive requiring staff that interacted with that patient to isolate and not attend work for a significant period of time creating undue hardship for our members. HSAA HSW is advocating for more widespread use of PPE to reduce unnecessary low risk exposures that require members to isolate.

  Work Restricted Members: HSAA has also been advocating to ensure members are appropriately compensated and kept whole when they are required to isolate and miss work, we are working hard to hold the employer accountable

to Collective Agreement requirements, and insuring their own internal policies are being applied fairly.

- **COVID HHR update (workload, burnout, training, staffing levels, etc.)**

- **COVID backlog—how is the surgical backlog being addressed?**

- **COVID in general (any other COVID-related issues to report?)**
Reports of outbreaks at Healthcare facilities are still being received, with a majority of the most concerning outbreaks occurring at non-AHS locations. Misericordia hospital was shut down in July to control and address outbreak with phased reopening mid August.

  - CMOH Order prohibited staff members and contracted providers from providing in-person services at any health care facility other than the Misericordia Community Hospital for the 14 days following any day a staff member or contracted provider works at the Misericordia Community Hospital.
  - HSAA worked with all affected Unions and Employers to ensure the safety of patients, staff, physicians and visitors. HSAA was in discussions with Covenant Health and Alberta Health services to ensure any adverse affects of CMOH Order on Members was mitigated as much as possible.
  - HSAA was also in discussions with Covenant Health and Alberta Health Services with respect to challenges arising from the diversion of patients from the Misericordia Community Hospital to Alberta Health Services (AHS) that has resulted in severe staffing difficulties at AHS Acute Care Sites within Edmonton as well as the Employer's other Edmonton acute care site.

8. Major campaigns and communications (please include links if possible).

HSAA continues its I ♥ Public Health Care campaign with the distribution of thousands of lawn signs across the province this summer and fall. Our Member Engagers are in place and beginning their work identifying and recruiting natural leaders at the Local Unit level to deliver our messages of anti-privatization and support for public health care.

We are also beginning a short member-to-member campaign, in which we are hoping to have personal conversations with every member before the end of January. We are booking off a number of our board members as well as identified members to make these calls with a message about the value of HSAA, including our "political" involvement (everything we do is political). Thank you to our sister NUPGE unions for chipping in with activists to help us in this effort.

9. **Health and Safety—report any important developments in this area:**

Mental Health Conference: Currently the Working Stronger , Workplace Mental Health Conference that HSAA has partnered with the Canadian Mental Health Association to bring to Alberta is scheduled for an in person event in March 2021 , however there are indications that this will likely change due to the ongoing severity of the pandemic. We will continue to leverage our longstanding relationship with the Canadian Mental Health Association and are in frequent discussions with their senior leadership to ensure the value of our sponsorship dollars of this event and ensure a meaningful learning opportunity for our member advocates in whatever form this event needs to occur.

Health and Safety Committee Course: HSAA's Alberta Labour formal Health and Safety committee training for our reduced capacity fall sessions in both Calgary and Edmonton are full. This will result in HSAA members that have been appointed by their local units as member advocates on local worksite health and safety committees receiving required training to lead these committees.

Legislative Changes: In July 2020, the UCP Government began steps to changing, and possibly rolling back, worker friendly OHS Act Legislation that was introduced by the NDP. They quietly released the Reforming the Occupational Health and Safety Legislation in Alberta feedback survey for any and all persons to complete. The survey was completed, and feedback submitted by HSAA August 12, 2020. The general tone used in the background information provided for the document parallels the UCP employer friendly perspective and was indicative of the direction they are trying to go with legislation.

10. **Monitoring violence in the workplace—are there specific incidents to be noted, or overall measures that have been implemented, regarding violence in the workplace?**

11. **Health Human Resources (HHR)—are there shortages of skilled professionals? And are there any initiatives being used to increase recruiting, training, and retention of health science professionals?**

12. **Workforce challenges related to aging—has your union put in place any strategies for recruiting or retaining related to the looming shortages based on the aging health care professional workforce? Has your government? Are there any studies or analyses of the issue that you can share?**

13. Are there privatization initiatives planned or proposed for your province that impact the health care system? Where do you see the pandemic increasing or decreasing the move towards privatization?

Announcements about the privatization of lab services have been reported by us in the past. The Request for Proposal will be published by the end of November, with a decision projected for spring of 2021.

We have previously reported the announcement of the privatization of laundry in hospitals. We anticipate further privatization of food services.

See above for announced introduction of private or “charter” surgical clinics. This is being spun as a way to ease the pressure on the public system.

14. Any other major activities to report:

15. Are there any specific issues or topics that you would like to see addressed at future CHPS meetings?

November 19–20, 2020
11 am (EST)
Videoconference

Constituent Report

CHPS Organization: HSAS

1. **Number of health professionals that are members of constituent union:**

   4090

2. **Have you noticed any changes or trends overall, and in specific disciplines?**

   No

3. **Comments on government or on the current political climate:**

   Sask Party re-elected for 4th term—Majority Government. A new Health Minister has been appointed—Paul Merriman. Last week the Ministry of Health and Chief Medical Health Officer announced a new public health measure of mandatory masks worn in all public places in communities with a population larger than 5000. This has drawn a lot of public attention and conversations, along with a second open letter signed by Sask. physicians, advising Government that their measures are not enough to address the covid 19 Pandemic.

4. **Collective bargaining update:**

   The bargaining process has been successful in securing a new Collective Agreement for our membership which became effective August 30, 2020. The new agreement will cover the period of **April 1, 2018 to March 31, 2024** and include the following general wage increases.

   April 1, 2018 - 0%
   April 1, 2019 - 0%
   April 1, 2020 - 1%
   April 1, 2021 - 2%
   April 1, 2022 - 2%
   April 1, 2023 - 2%

5. Significant grievances, arbitration, or legal decisions:

The most recent arbitration victory this year comes out of our private contract at North East—EMS (NEEMS) concerning the payment of the market supplemented wage rates attached to our main HSAS/SAHO Collective Agreement. The Employer was of the position that Employees were entitled to market adjustments but not market supplements. The union believed that the language in the NEEMS Collective Agreement clearly outlined that the rates paid to EMS employees within the main HSAS/SAHO Collective Agreement were to be matched by this Employer when paying NEEMS employees. Below is an excerpt of the written decision on the file from Arbitrator Daniel Ish:

"It is difficult not to conclude that the words "to reflect the wage rates established in the SAHO/HSAS collective agreement covering the years covered by this Agreement" are anything but clear. Those words, together with the opening words of Article 26, on an objective interpretation, capture the intention of the parties to match the salaries of the NEEMS employees with those employed in the public health sector in the province. Further, and importantly, these words contemplate that the operative SAHO comparable salaries will be the ones determined by SAHO for the years covered by the NEEMS Agreement even though the SAHO new contract had not been ratified at the time the NEEMS contract was ratified on July 17, 2013. To not read those words to have that meaning, would in effect read them out of the agreement. This would be contrary to general principles of interpretation. As Arbitrator Hood said an arbitrator must give "meaning to all words and without unnecessarily rendering words superfluous". (SaskTel 2009 at para 36)

The employer relied upon the last paragraph of Article 26 and Article 27 to argue that any such wage liability was contingent upon the employer receiving funding from the Health Region. The last paragraph of Article 26 refers to "future HSAS/SAHO Agreements" while Article 27 refers to "subsequent provincial SAHO Agreements". Given the meaning ascribed to the primary provisions of Article 26, as set out above, these clauses must refer to SAHO agreements that come into existence following the years covered by the NEEMS Agreement. I agree with the union submission that the 2013-2018 SAHO collective agreement cannot be both a future agreement and an agreement covering the same years as the NEEMS Agreement. Quite clearly the SAHO 2013-2018 covers the years of the NEEMS Agreement.
It is my conclusion that the NEEMS employees are entitled to the same wages that were paid to the SAHO employees for the years covered by the NEEMS Agreement, including not only base wages and market adjusted wages but also wages adjusted by a market supplement."

6. **Can you share examples where the pandemic exposed deficiencies in our health care system and what responses are being implemented or may be needed?**

The deficiencies are everywhere. The deficiencies were present pre-covid and were evident even more so during the Pandemic. The Pandemic revealed the serious issues of understaffing, PPE issues, and generally lack of communication. The responses to the deficiencies are driven by a military themed approach of do what you want, don't worry about the unions; the CBAs do not apply here.

7. **Updates on COVID-19:**

- **COVID OH&S update (PPE, screening, infection prevention, etc.)**
- **COVID HHR update (workload, burnout, training, staffing levels, etc.)**
- **COVID backlog—how is the surgical backlog being addressed?**
- **COVID in general (any other COVID-related issues to report?)**

Communication and providing information from the SHA has been lacking with respect to requests for information on who is deployed where and duties outlined. Staff have been moved without following the CBA or the LOU and this has been an ongoing issue during the past number of months during Covid 19. HSAS Members have been deployed to Covid testing sites or other work involved with contact tracing. Often staff have been moved leaving their home positions vacant, meaning services to the public have been affected. Not all services provided by HSAS Members have returned to the levels of pre-Covid across the province or in a consistent manner.

Stress levels have been high as the SHA and Government have determined that services should continue to resume in the face of rising cases. Again, this has not been consistent across the province where in some places services have resumed, and in other areas, some services have not resumed. Last week a new Public Health Measure was implemented where mandatory masking in public places was required in all communities with a population larger than 5000. This followed a plea in a written letter signed by over 400 Sask. physicians for Government to do more to address the rising numbers of Covid 19 in Saskatchewan. On Saturday November 14, over 300 new cases of Covid were reported. Frontline staff are facing challenges and stress from families of patients in acute care facilities where families do not wish to follow the rules for visitation or are not willing to accept the limitations on visitations. Even with policies in place, staff are feeling stressed.

The SHA is now looking at increasing their staffing levels to increase capacity for contact tracing to address the recent outbreaks throughout the regions in the province. These staff will include licensed and non-licensed professionals. In addition, the SHA has recruited retirees, as a supplementary workforce, to return to assist with the management of the Covid Pandemic, including recruitment of Public Health Nurses, in addition to using the labour pool. This is in response to the increasing numbers of Covid positive cases in the past number of weeks. As of November 10, the health care unions were notified of the need for 66 FTEs of licensed health care professionals, 28 FTEs of non-licensed health care professionals and 4.2 document assistants (?) for the entire province (Regina, Saskatoon, and the four regions of NW, SW, NE, SE. This need is in addition to what already exists in the contact tracing work.

Daily briefings with the Ministry of Health and the SHA continue with the five health care unions—CUPE, HSAS, SEIU-West, SGEU, and SUN.

PPE continues to be an ongoing issue related to the SHA with continued discussions around re-purposing of N95s. The SHA has suggested using these 'expired but tested' masks first to deplete the stockpile which exists prior to using "new" N95 masks. The SHA received an exemption from the Ministry of Labour Relations and Workplace Safety (LRWS) to use N95 masks that were stored in a "pandemic warehouse" that have since passed the manufacturers recommendation date in May 2020. The masks were sent to Nelson Labs in Salt Lake City Utah for testing. They were tested for inspiratory and expiratory filtration. The majority of these masks "passed" filtration (>95% filtration) meeting NIOSH standards.

This exemption stated that the SHA could use these masks if all other masks (not past expiration date) had been used and this exemption was good until October 1, 2020

The SHA has applied for an extension to this exemption (no timeframe given—at least another 6 months)

Concerns:

- The testing was done not long after the pandemic hit and have not been retested
- Why did some masks pass testing and others did not. Primarily Kimberley Clark masks failed the testing.

The SHA has reached out to Nelson lab with concerns from the union partners and have not received "acceptable" answers to date

- No updates on the frequency of testing
- Nelson lab stated that their testing is good and will not go any further

The masks that did not pass testing have been placed aside and "may" be used as a substitute for surgical masks if there is a shortage

The SHA is now planning on applying for a "new" exemption such that they can use the expired N95 masks while still having masks available; the pandemic stock would become part of their inventory

- "first in, first out" philosophy

SHA would like to replenish the pandemic warehouse such that they always have the proper PPE available. They would like this exemption to be in effect until October 2021.

The SHA has begun reprocessing N95 Masks using Striker Reprocessing and VIDO-InterVac

They have applied for a LRWS Exemption to use these masks, however they must re-apply with 2 separate applications and the masks must be tested by a third party

- Concerns:
    - Mixed literature on success of reprocessing
    - Were the masks in the studies used for prolonged periods of time?

Reprocessed masks would be a 3rd line contingency

As the supply chain for N95 masks from overseas is pressured, there may be opportunities to acquire N95 masks locally. Since these masks would not be NIOSH approved, it would require a new application to LRWS to show that they are equivalent to NIOSH standards

- Nelson Lab in Utah is no longer accepting new applications to have products NIOSH approved

It was reported that the National Research council is looking into the capacity for the testing to be done in Canada.

With respect to the Exemption process, the five health care unions have requested that they be involved in this process as it is a provincial issue, and it should not just involve the local OH & S Committees, who may not have all of the information and context to make an informed decision. The SHA intends to move forward and have the local OH & S Committees sign off on these exemptions and appear to be ignoring the request by the health care unions.

As a result of rising COVID-19 cases and hospitalizations, the SHA Executive Leadership Team is reactivating SHA's Emergency Operations Centre (EOC). The EOC will be fully operational starting the week of November 16-20. Concerns that the EOC will be headed up by neurosurgeon and OHS lead for SHA with no LR component.

SHA's EOC operated from March until June 2020 before being stood down. Since that time, the SHA has had a Public Health Incident Command Centre in place to focus on the offensive strategies (i.e. testing, contact racing, outbreak management, etc), while the SHA's more traditional service lines like acute care, continuing care, and primary health care focused on resuming regular services and maintaining the SHA's various acute care surge plans (i.e. the defensive

strategies). The functions of the Public Health Incident Command Centre have been embedded in the EOC structure.

The EOC will centralize these functions and be accountable for mobilizing and coordinating resources to strengthen the SHA's Health System Readiness Plan (i.e. both offensive and defensive strategies) to respond to the potential for sustained high COVID case counts over the winter months. The overall aim is to contain, delay and mitigate COVID-19 as much as possible through the SHA's offensive strategies while ensuring we have the capacity to care for both COVID-19 patients and others requiring emergency and urgent care.

The situation is fluid and changes from day to day. Generally the theme from the beginning of the Pandemic has been "this is a pandemic, the CBAs do not apply here".

With regards to the surgical backlog, a news report of October 2020 indicated that at least 10% of the surgical backlog should be eliminated.

This past week there was a change in criteria for Health Care Workers with regards to risk and exposure to Covid 19. When the patient is **not** exhibiting respiratory symptoms (cough, sneezing) and the HCW is wearing a mask, but not eye protection, the exposure was deemed to

be **low risk and the HCW should self- monitor only—as opposed to self-isolating. This is a significant change in process and it is suspected that this is due to ever-decreasing availability of staff as the exposures increase.** Unions received notification on November 15 that there would be a change to the criteria for Health Care Workers with regards to risk assessment and exposure to Covid 19 in the workplace that the risk assessment should be based on the symptoms exhibited by the patient/resident/client at the time the health worker was exposed, **not** the 48 hours prior to the time of symptom onset.

8. Major campaigns and communications (please include links if possible).

Existing and ongoing campaigns have been shared previously at CHPS. All can be viewed on our website - www.hsas.ca—News and Media—Look For Us.

The Communications Committee will be meeting to plan for 2020-2021 in light of fewer opportunities to reach the public; eg: decreased attendance at theatres, gyms, restaurants.

9. Health and Safety—report any important developments in this area:

HSAS continues to be involved in the processes establishing representation on OH & S Committees throughout the Sask. Health Authority, since the amalgamation of the 12 former health regions into one health authority. In

addition, HSAS OH & S Committee is working to develop processes to collect meeting minutes from each of the committees, as the minutes are not stored centrally, at this time. This is in spite of the fact that we are almost 3 years into a single health authority. In addition, communication has been made with the Employer regarding the selection processes of HSAS Members being appointed to OH & S Committees.

There are also extra demands for OH & S committees to be established at some testing sites throughout the province. Most employees working at the Drive through testing sites have been pulled from the labour pool. Therefore there are challenges in determining who is eligible to be on the OH & S Committee.

10. Monitoring violence in the workplace—are there specific incidents to be noted, or overall measures that have been implemented, regarding violence in the workplace?

The SHA released a statement from Scott Livingstone, CEO, the week of November 11th, asking that the public be kind to Health Care Workers. Apparently, there were numerous reports of individuals not being kind to contact tracers who were experiencing verbal abuse when they contacted individuals through the contact tracing process.

11. Health Human Resources (HHR)—are there shortages of skilled professionals? And are there any initiatives being used to increase recruiting, training, and retention of health science professionals?

Pre-Covid times, in Saskatchewan, there was (and is currently) a shortfall in all of our professional groups. Unfortunately, the shortfall was not evident in the number of vacancies advertised. The Employer did their level best to minimize the fact that there were problems with understaffing and not infrequently, the Employer chose not to fill temporary vacancies or even permanent ones.

Now during this time of Covid-19, postings for varied occupations to carry out work at testing and assessment centers and contact tracing which includes Assessor Coordinators, Social Workers, Occupational Therapists as a few examples. Vast majority of positions are for a year- long position and temporary.

12. **Workforce challenges related to aging—has your union put in place any strategies for recruiting or retaining related to the looming shortages based on the aging health care professional workforce? Has your government? Are there any studies or analyses of the issue that you can share?**

Article 28 of the HSAS&SAHO CBA allows members who terminate from the Employer (as in the case of a retirement) and who are rehired within a year, to recapture certain benefits of employment:

ARTICLE 28 - PORTABILITY OF BENEFITS AND SENIORITY

Any HSAS member who terminates from one (1) Employer and who is employed within one (1) calendar year by the same or another Employer covered by this agreement, shall transfer:

(a) unused sick leave credits up to 190 days;

(b) most recent vacation accrual rate and years of continuous employment considered in the calculation of the same;

(c) seniority accumulated at time of termination;

(d) unused family leave credits;

(e) most recent salary step if employed within the same classification, or recognition of previous experience as per Article 18.05, whichever is greater.

The Employer, in an attempt to circumvent this language, has issued directives to 'not' hire back HSAS members within that 1-year window. Other than what is in the CBA, no strategies have been implemented for recruitment or retaining of health care professionals related to shortages.

13. **Are there privatization initiatives planned or proposed for your province that impact the health care system? Where do you see the pandemic increasing or decreasing the move towards privatization?**

Supplementary workforces -if not enough people to provide services from within the SHA. Retirees have been hired to assist with the various areas related to Covid from frontline staff to Management, in testing and assessment centres, as an example. There are two field hospitals planned if needed and there is a plan to contract private pharmacy services to provide care in the field hospitals. These field hospitals are on stand by and not being used as of this date of this report.

14. **Any other major activities to report:**

Other than the Covid 19 Pandemic, there are no other major activities to report.

15. Are there any specific issues or topics that you would like to see addressed at future CHPS meetings?

Benefits (Extended Health and Enhanced Dental) and trends. For example, with these plans, are premiums 100% paid by Employer, or are costs shared between

Employer/Employee? Is the trend that benefits are being decreased because of rising costs, or increased usage? Another interest is the transition from Health and Welfare Trusts to Employee Life and Health Trusts and what transition are Unions facing?

Pensions.

Communications specialty meeting with Communications teams similar to some of the meetings held in the past few months with subgroups such as EMS, OH & S. It would be beneficial to have some dialogue separate from the CHPs meeting to learn from other unions about their Communications work and implementation.

Constituent Report

CHPS Organization: MGEU

1. **Number of health professionals that are members of constituent union:** 9543

2. **Have you noticed any changes or trends overall, and in specific disciplines?** None at this time.

3. **Comments on government or on the current political climate:**

   Manitoba's Progressive Conservative (PC) Party is one year into their four year mandate and Brian Pallister is the Premier. The main focus of the Pallister government has been across the board cuts and privatization. Even in the COVID era, where many government's across Canada have chosen to spend to stimulate the economy, the PC's have made program announcements that are ill-conceived and have not amounted to any significant support or spending. Where they have been forced to expand services, they have turned to the private sector (Dynacare for testing, Morneau-Shapell for counselling, 24-7 InTouch for business support, etc).

   There is virtually no government department/funded entity that is not being reviewed or transformed in some major way. Education reform was expected this spring, but was delayed because of the pandemic, so is expected in the spring of 2021. Health Restructuring continues and has now entered a third phase of consolidation in rural Manitoba. Justice is also undergoing change including early releases, a shrinking inmate population, and the closure of a correctional facility (potentially more to come), meanwhile community supports have not increased.

A recent Angus Reid poll showed that Premier Pallister has the third lowest approval rating amongst his Provincial counterparts when many Premiers saw a bump in popularity during the pandemic. There is widespread speculation that Pallister will not complete his term and likely retire in within the next two years.

4. Collective bargaining update:

We are collecting proposals shortly from the membership. The committee to have a package created following the expiry of the agreement in 2018. We are now including issues that address the pandemic and other issues that have come forward since the bargaining committees last round of meetings has with members.

Our next dates to meet will be late October. Communications will be sent to the members shortly soliciting proposals.

5. Significant grievances, arbitration, or legal decisions: None

Can you share examples where the pandemic exposed deficiencies in our health care system and what responses are being implemented or may be needed? Confusion over changes to the system... initially spoke to PPE required in different settings and health care roles and also different standards with asymptomatic vs. suspect / confirmed COVID positive. Have since implemented the Green / Orange / Red risk levels.

Confusion created by the changing provincial risk levels, multiple sources of information, difficult to find standards vs. recommendations, social media vs. credible sources, etc...

Confusion also created by exceptions for isolation and quarantine if you are an essential or health care worker.

6. Updates on COVID-19:
COVID OH&S update (PPE, screening, infection prevention, etc.)

Shared Health, Manitoba's healthcare guiding agency through the pandemic, reports a good reserve of PPE.

Manitoba has filed a $13.5 million lawsuit against a US company that supplied N95 respirators which consistently failed testing.

MB Workplace Safety and Health has allowed extension of service for PPE, exceptions to standards if internationally sourced or repurposed PPE is independently tested, and use of topical treatment for skin degradation related to PPE.

- **COVID OH&S update (PPE, screening, infection prevention, etc.)**
  There have been approx 40 infections reported in healthcare workers, with approx 200 quarantines necessary because of close contacts. Public Health recently reported that patients failing to disclose symptoms and positive tests whiles seeking medical care have resulted in quarantines of entire support teams.

  Manitoba is asking for "volunteers" to assist in healthcare settings for non-skilled work. Family has been encouraged to assist in personal care homes. A volunteer family member will be assigned to regular work as opposed to focusing on their family member.

- **COVID HHR update (workload, burnout, training, staffing levels, etc.)**
- **COVID backlog—how is the surgical backlog being addressed?**
- **COVID in general (any other COVID-related issues to report?)**

In Corrections settings...
Medical staff have been moved between institutions to assist with managing outbreaks. At least one institution moving to establishing cohorts assigned to particular shifts/units. 2/3rds of Manitoba institutions report covid cases in staff and/or inmate populations.

Approx 30 personal care homes report outbreaks. Some experiencing as high as 125 resident infections.

Hundreds of school exposures have been reported in the previous 2 weeks.

Major campaigns and communications (please include links if possible). This campaign aims to engage MGEU members on workplace mental health, raising awareness of mental health as a workplace issue, helping members have conversations about mental health, connecting members with mental health resources and supports, and providing members with tools and information to advocate for more psychologically healthy workplaces.

The campaign website HealthyMindsatWork.ca is now live**.**

For a sneak peak of some of this content, you can visit https://www.youtube.com/watch?v=xd_VobbVPkk.

Our main campaign messages are:

- MGEU's *Healthy Minds at Work* campaign advocates for workplace mental health by working with members and employers to create more psychologically healthy work environments.

- Workplaces play an essential role in promoting positive mental health, and preventing/reducing mental health injuries and illness.

- Employers have a responsibility to promote a psychologically safe and healthy workplace and to protect employees from psychological harm.

- MGEU is here to help members advocate for mental health in the workplace.

Health and Safety—report any important developments in this area:

Covid Related Developments

As of November 4, 2020: COVID Deaths - total of 85 –mainly related to the demographic of 60+, unfortunately many are related to outbreaks in personal care homes. However, Public Health has reported deaths of males in their 40's. We have had several clusters related to particular workplaces, however, Government and Public Health report the transmissions took place in the community, car pooling, communal living, etc.

There seems to be a theme coming from Government that transmissions are happening in the community and there is avoidance of acknowledging that transmission is related to congregate settings such as work or schools...

113 HealthCare workers have tested positive since the beginning of the pandemic. Of these workers, 36 are healthcare aides, 30 are nurses, nine are physicians or physicians in training, seven are social/support workers, five are

medical clerks, three are pharmacists, and 23 fall into a combined category. Seventy (70) of these workers got the disease from close contact with a known case, 11 got it from travel, and for the rest the source is unknown.

All personal care homes in the Winnipeg region have moved to Red risk level. No new admissions will be allowed in personal care homes with an outbreak. All new admissions to other homes will be isolated for 14 days.

The daily number of Manitoba infections has increased in recent weeks, reaching a daily high of 450. Receiving daily provincial updates on COIVD testing and test positive cases. The number of testing sites has increased, testing approx. 2100 per day. The infection rate is hovering just shy of 10% at times. Typically, approx 80% of cases are within the Winnipeg and Metropolitan region. Winnipeg raised its risk level to Orange mid-October and subsequently to Red on November 2. The remainder of the province was moved to the Orange risk level on Nov 2 as well.

Approximately 3,500 active cases and 2,800 individuals who have recovered from COVID-19.

Approximately 130 people in hospital and 20 people in intensive care.
ICU's at 95% capacity

Government has contracted a private firm to establish additional testing sites. MGEU is calling upon government to hire additional staff for the provincial lab running samples.
Backlog in test results and contact tracing, sometimes as long as 7 days...

Coalition of Dr's requesting a tightening of the Public Health orders: ranging from further restrictions to group size, restrictions to faith-based gatherings all the way up to a "shut-down".

7. Monitoring violence in the workplace—are there specific incidents to be noted, or overall measures that have been implemented, regarding violence in the workplace?

Manitoba's Public Health order enables business owners to "remind" patrons of recommended protective measures.

There have been reports of conflicts in public settings regarding mask use. There has been at least 1 criminal charge related to violence against a retail worker

where the worker made multiple attempts to inform a patron of the employers mask policy.

Manitoba has authorized multiple agencies such as Public Health Inspectors, Workplace Safety and Health Officers, Natural Resource Officers, Police, By-Law Enforcement Officers, etc to enforce the Public Health orders. Although enforcement capabilities have been increased, we have not experienced a significant rise in penalties being handed out.

MB Premier has floated the idea of a curfew.

8. **Health Human Resources (HHR)—are there shortages of skilled professionals? And are there any initiatives being used to increase recruiting, training, and retention of health science professionals?**
Positions are being posted and filled as needed.

9. **Workforce challenges related to aging—has your union put in place any strategies for recruiting or retaining related to the looming shortages based on the aging health care professional workforce? Has your government? Are there any studies or analyses of the issue that you can share?**

Accommodations are being done on individual basis.

10. **Are there privatization initiatives planned or proposed for your province that impact the health care system? Where do you see the pandemic increasing or decreasing the move towards privatization?**
Cuts and privatization is always an issue with this government.

11. **Any other major activities to report: None at this time.**

12. **Are there any specific issues or topics that you would like to see addressed at future CHPS meetings?** None

November 19 - 20, 2020
11 am (EST)
Videoconference

Constituent Report

CHPS Organization: The Ontario Public Service Employees Union (OPSEU)/Le Syndicat des employés de la fonction publique de l'Ontario (SEFPO)

1. Number of health professionals that are members of constituent union:

OPSEU/SEFPO represents 25,000 hospital professionals in more than 250 classifications of occupations, in over 80 hospitals across this province. Some of these classifications include medical laboratory technologists and technicians, radiation technologists, respiratory therapists, laboratory assistants, phlebotomists, perfusionists, pharmacists and pharmacy technicians to name a few.

Our members provide paramedical services such as lab tests, ultrasounds, CT and MRI scans. Furthermore, they also provide therapeutic and rehabilitative services in areas such as social work, physiotherapy, occupational therapy and nutrition.

In addition, OPSEU/SEFPO also represents approximately 35,000 other medical professionals in sectors such as Ambulance services, Hospital Support, Canadian Blood Services and Diagnostics, Mental Health and Addictions, Long Term Care, and Community Health.

2. Have you noticed any changes or trends overall, and in specific disciplines?

See question #11.

3. Comments on government or on the current political climate:

Decades of chronic underfunding for public health care have become even more apparent during the COVID-19 pandemic. In our public hospitals, this results in increased “hallway health care”. Capacity in Ontario’s hospitals has been further strained with the number of COVID-19 cases once again on the rise in Ontario. Not only do hospitals need to receive increased funding to account for inflating health care costs, but also to bring back services that have been privatized or outsourced from the hospitals. OPSEU/SEFPO has also been calling for the government to establish a fulsome human resources plan to address recruitment and retention issues, particularly in labs and diagnostic imaging where many workers are approaching retirement. These problems are exacerbated by the government’s attempts to reorganize health care in Ontario. The Ontario Health Team model, which we reported on last year, is flawed, and opens the door to private organizations having even further influence and control on what should be public services. In the long-term care and home care sectors,

public dollars are funneled into corporate hands where that funding is then skimmed for shareholder profits. Private operators cut corners on staffing and other resources to squeeze out every bit of profit from these services. This has had well-documented disastrous results in the context of COVID-19. However, the staffing problems in these sectors cannot be resolved only by increased funding. Home care and long-term care must also be fundamentally reoriented to address the precarity embedded in the sector, which, at its core, requires these services to not only be publicly funded, but publicly delivered by well-compensated and secure workers. The Ontario Health Teams model moves Ontario further from this goal, and risks deepening inequality of access. Regarding how the current political climate affects our health care system, areas of note include:

Bill 124, Protecting a Sustainable Public Sector for Future Generations Act, 2019
Bill 124, passed in 2019, violates public sector workers' constitutional right to collective bargaining by effectively cutting their wages for three years. Bill 124 limits public sector workers' wage increases to just one per cent per year for three years. Since inflation is almost certainly higher than one per cent, Bill 124 effectively cuts their wages. This bill particularly attacks a group of predominantly female workers who provide important public services. OPSEU/SEFPO filed a charter challenge in March 2020 and is also asking the court to order the Ford government to cover the costs of all wages lost because of Bill 124, plus damages and the union's legal expenses.

Pandemic Pay
On April 25, the Ontario government announced it will provide temporary pandemic pay to frontline healthcare workers who were at risk of exposure to COVID-19 in congregate care settings. The initial list of eligible workers excluded a significant amount of staff who also deal with COVID-19 patients. After a series of conversations with government officials, OPSEU/SEFPO succeeded in expanding the list, but it was not everything we asked for.

OPSEU/SEFPO continued to call on the government to compensate and protect all workers affected by the pandemic. The exclusionary nature of the program caused much derision and division amongst frontline workers and members. However, while pandemic pay was not the panacea of equal wage adjustments, it had put low-wage jobs on the radar and made it clear to the public that front line workers need to be compensated fairly and properly for their work.

Bill 195, Reopening Ontario (A Flexible Response to COVID-19) Act, 2020
Bill 195 replaced the provincial emergency declaration made in March and hands the power to change, revoke, and extend emergency measures to cabinet, rather than the legislature, for up to two years. It is a needless infringement on workers' democratic rights and a complete abuse of power. Specifically, the bill allows employers to single-handedly make decisions to change shifts, vacations and redeploy workers without their unions being involved.

Ambulance
The clearest evidence that the "hallway health care" crisis extends beyond the walls of hospitals can be found right outside the door: ambulances waiting with their patients outside the entrance—sometimes for hours—before a bed opens up inside. It's a terrible waste of time and resources that could be better spent on things like community paramedicine programs which have been proven successful when partnered with appropriate social, health and mental health services. Demands on the system are growing by six per cent per year because of Ontario's aging demographics.
To improve patient care, OPSESU/SEFPO recommended that the government:

- Reduce ambulance offload delays by investing in more hospital beds. The hospital bed crisis has had a system-wide domino effect, and its ripples are being felt on the frontlines of emergency medicine.
- Invest in the entire ambulance system in order to meet the annual growth in demand:
    - Invest in increased staffing and resources to allow the appropriate triage of patients when 911 is called and the authority to either "treat and refer," or" treat and transport to alternative destination."
    - Provide our 911 dispatch system with better tools to prioritize calls; including seamless integration and information sharing between all Ambulance Communication Centres.
    - Invest in single paramedic response units, backed up by ambulances, in order to speed up response time and reduce the number of times when no ambulances are available to respond, which is on the rise.
    - Build a registry of life-saving defibrillators and invest in more public defibrillators and CPR training.
    - Expand community paramedic programs that deliver non-emergency, in-home services and reduce the number of 911 calls.
- Invest in appropriate tools, resources and staffing at Ontario's Central Ambulance Communications Centres (CACCs) and hire more permanent, full-time Ambulance Communications Officers (ACOs). Too often, staff are working on a contract basis, with little job protection and high exposure to trauma and PTSD. This has undoubtedly resulted in high staff turnover and understaffing.

Hospital Professionals and Support
Chronic underfunding of hospitals is harming the delivery of acute care services. Hospitals face impossible decisions in choosing which health services will be cut. Hospital professionals play a key role in enhancing patient recovery, and when the services they provide are cut, the entire system is weakened.

To truly begin addressing “hallway health care” in our hospitals, OPSEU/SEFPO has recommended that the government:

- Increase funding by at least 5.3 per cent per year to meet population needs and conduct health care planning.
- Impose a moratorium on hospital closures and mergers.
- Improve hospital bed capacity to meet population needs.
- Expand inpatient and outpatient physiotherapy services across all hospitals in Ontario. The demand is exceeding the service, and better access to physiotherapy reduces the time patients spend in hospital.
- Bring privatized lab testing and diagnostic testing (X-ray, nuclear medicine, MRI) back into our hospitals as a public service. The benefits of providing more immediate results to physicians, quality inspection control and reducing patient travel far outweigh the fictional savings that have produced a private parallel health system that is actually costing Ontarians more.
- Bring back services into hospitals such as cataract procedures, hip and knee replacements, colonoscopies/endoscopies, diagnostic imaging and physiotherapy. They have all been privatized and outsourced over the years, leading to higher costs and lower-quality care.
- Establish a human resources plan to address recruitment and retention issues. Specifically, there are many classifications in areas such as labs and diagnostic imaging in which a significant percentage of employees are about to reach retirement age.

Mental Health and Addictions

Chronic underfunding and understaffing mean that people can’t get the mental health care they so clearly need. Understaffing is particularly dangerous for thousands of mental health workers, who are facing increasing exposure to violent assaults. If staff are not safe, neither are patients.

To address this growing crisis, OPSEU/SEFPO advises that the government must:

- Invest in facilities and in increasing staffing levels and implementing better risk assessment procedures, including the system-wide use of the Violence, Aggression and Response Behaviours Tools (VARB) for assessing security, conducting organizational risk assessments and assessing individual client behaviour.
- Extend PTSD presumptive legislation for frontline mental health workers who have experienced trauma, so that these workers are entitled to WSIB. By extending the legislation, mental health care workers would have faster access to the resources and treatment they require. This would improve health outcomes and reduce longer-term health care costs.
- Invest in more supportive housing for mental health and addictions patients that is appropriately staffed. Supportive housing is an integral resource for mental health and addictions patients, but improved investment is required. These

homes must also be staffed at appropriate levels by professionals, including Social Workers, Occupational Therapists, Recreational Therapists, Registered Nurses and Registered Practical Nurses.

- Provide all mental health and addictions services on a fully public, non-profit basis with full public accountability. Like many other health sectors, the mental health and addictions sector has been plagued by costly privatization schemes.

Long-Term Care

The Ford government has earned praise for its pledge to create 15,000 new long-term care beds, but it must do more: the waiting list for long-term care beds is more than double that, at roughly 40,000.

And even when an Ontarian does get a long-term care spot, they face the lowest standards in Canada, and among the lowest care levels among comparable jurisdictions even though patient acuity and the complexity of care are growing.

Since 2010, only those with high or very high care needs have been deemed eligible for long-term care, and many of them have cognitive or behavioural problems. Staff are increasingly overworked and expected to do more with less.
Government must:

- Increase long-term care staffing levels to ensure a minimum care standard of four worked hours of personal care, per resident, per day, is achieved. Long-term care residents deserve the highest quality of care possible.
- Invest more to reduce the large and growing wait list for long-term care by creating more publicly owned and managed long-term care facilities. With the proliferation of privately operated homes, residents are increasingly forced to pay massive out-of-pocket costs or face an impenetrable wait list for publicly funded long-term care. As a result, residents and their families are suffering.
- Provide appropriate staff training to minimize exposure to workplace violence, including training on responsive behaviours. Today, nearly half of long-term care residents exhibit some level of aggressive behaviour.
- Strengthen and enforce minimum standards of care such as hire more full-time staff and ensure that residents receive a minimum of four hours of care per day. People living in long-term care must be able to count on safe, professional, and high-quality care. Minimum standards must be strengthened for all long-term care facilities, particularly those that are privately owned and managed. And those standards must be enforced by an appropriate number of professional frontline OPS inspectors.

Community Health and Home Care

Chronic underinvestment and understaffing in our community health, public health, and home care are driving up costs and intensifying “hallway health care” because more people than necessary are ending up in hospital.

The province's already stretched municipalities are being forced to pick up the slack for the Ford government's cuts to public health programs, like infectious disease control and smoking cessation programs.

In 2020 an international medical journal published a report confirming what OPSEU/SEFPO community health care workers have been saying for years: the province is not providing enough home care, and hospitals are being left to pick up the slack.

But a dangerous feedback loop is developing. As hospital overcrowding reaches crisis levels, patients are being sent home and into home care too early. They'll either have to suffer in silence, go back to hospital or—in the worst-case scenario—die without the care they need.

To address the shortcomings of community health and home care, OPSEU/SEFPO advises that the government must:

- Immediately increase investment to cover the true cost of home care. Home and community care workers need the resources to keep people at home safely and to ensure positive patient outcomes.
- End home care contracting-out by exploring all options for termination or non-renewal of existing contracts with provider agencies and focus on investing in a fully public, non-profit home care system instead; one where quality patient care is the focus.
- Promote fairness and stability in Ontario's home and community care sector by reviewing the work being done by registered nursing staff to improve the recognition of their skills and abilities.
- Abandon the 70/30 public health cost-sharing plan with municipalities and return to funding 100 per cent of important public health programs.

Canadian Blood Services and Diagnostics

The blood diagnostic, donation, and distribution systems are the literal lifeblood of Ontario's health care system., but there remain vast differences in the wages and working conditions of the people working in the systems—which are overseen and supplied by a mix of public and private organizations—even if they're doing exactly the same kinds of work.

For example, the 1,000-plus lab professionals working in Toronto for the private corporation LifeLabs are paid less and have vastly inferior working conditions than others doing similar work in the industry.

Consistency is the key to safety, and the government must invest in ensuring that all of the workers in our blood systems have the tools, supplies, and working conditions they need.

OPSEU/SEFPO has recommended that the government take the following actions:

- Invest in ensuring fairness for laboratory technicians, regardless of their workplace. The diagnostic testing done by laboratory staff at Public Health Ontario is vital work that prevents public health crises like Walkerton, SARS, and other outbreaks. This work keeps our communities safe, and it is vital to the health of all Ontarians. But public services are stronger when workers are treated fairly. OPSEU/SEFPO is calling on the government to harmonize the pay and working conditions for all laboratory technicians, regardless of whether they work in community hospitals or community-based laboratories.

- Maintain the ban on private blood and plasma-product collection to ensure the ongoing safety of Ontario's blood supply, and invest in public plasma collection facilities. Investing in public plasma collection facilities would reduce our dependency on world markets for the fractionated plasma products used to produce medications, much of which is collected by paying donors. To achieve the highest quality and standards of safety, the government must stem the growth of private clinics.

4. Collective bargaining update:

There are no major tables in bargaining at this time. Our Central hospital agreement expires on March 31, 2022. We will spend all of 2021 in the lead-up to this bargaining—conducting a membership bargaining survey, holding a pre-bargaining conference and demand set, requesting disclosure in advance of bargaining and signing a Memorandum of Conditions for Joint Bargaining.

Pharmacy Technicians: at our last meeting we reported the preliminary award from Arbitrator Diane Gee which established a substantial change in the job of Registered Pharmacy Technician and ordered the parties to negotiate a new wage grid. The parties were unable to agree and the impasse over wages went back to Arbitrator Gee for a decision. On January 6, 2020 the arbitrator awarded a 6% wage increase retroactive to June 30, 2016. Unfortunately many of our non-participating hospitals were not able to implement this new rate before they were hit with wage controls under Bill 124.

A subsequent dispute arose when hospitals failed to pay the retroactivity to any Registered Pharmacy Technician that was no longer employed as of the date of the award. OPSEU took the dispute back to Arbitrator Gee who ruled in OPSEU's favour, directing the hospitals to pay retroactivity to all employees covered by the grievances even if they were no longer employed at the hospital.

5. Significant grievances, arbitration, or legal decisions:

Health and Safety/COVID:

ONA court injunction –Lack of access to PPE
CITATION: Ontario Nurses Association v. Eatonville/Henley Place, 2020 ONSC 2467
COURT FILE NOs: CV-20-639606-0000 and CV-20-639605-0000
DATE: 20200423

The court said that employers are ordered to provide nurses with access to fitted N95 facial respirators and other appropriate PPE when assessed by a nurse at point of care to be appropriate and required (para 96). It went on to order employers to implement administrative controls such as isolating and co-horting of residents and staff during the COVID-19 crisis as set out in the PH directives 3 and 5.

The judge also criticized the employer argument that they owed more of a duty of care to the public at large than nurses and other medical staff (who were focused on their own narrow interests)…

> *[93] I can imagine that the irony of that submission is not lost on the Applicants (sic Nurses). One need only read the affidavits of the individual nurses in this Application record to understand that they spend their working days, in particular during the current emergency situation, sacrificing their personal interests to those of the people under their care. And given the nature of the pandemic, they do this not only for the immediate benefit of their patients but for the benefit of society at large. To suggest that their quest for the masks, protective gear, and cohorting that they view as crucial to the lives and health of themselves and their patients represents a narrow, private interest seems to sorely miss the mark.*

ONA April 29 Grievance decision—Stout
One of the biggest disputes in the COVID-19 crisis is whether the virus is spread by air or limited to droplet/contact. The unions were keeping abreast of the research provided by Occupational Health Clinics for Ontario Workers (OHCOW) that increasingly made the case that, at best the science was unclear but that emerging evidence also included short-range aerosol transmission of COVID-19. This court decision made the link between the point of care risk assessment and considering the issue of evolving science and as such was very important to workers trying to obtain the most protective PPE. In para 46, "Any other considerations that are appropriate given the then current science, evidence and Directives respecting COVID-19 transmission, N95 masks and PPE and the then current COVID-19 circumstances at the Home."

The decision also addressed the intimidation and reprisals that workers said came along with asking for and pursuing appropriate PPE. In para 49/50,

> *"The nurses who exercise their right to access fitted N95 facial respirators and other appropriate PPE (as noted above) when assessed at point of care to be appropriate and required, shall not be intimidated, threatened or coerced in any way, including but not limited to threatening to impose a penalty or discipline, because the nurse acted in accordance with her/his rights under this Award."*

Various Ontario Labour Relations Board (OLRB) settlements/decisions regarding health and safety appeals by unions
All of the healthcare unions filed various appeals when inspectors responded to workplace complaints and failed to write orders for employers to act. Below is a summary of the issues that were addressed in many of the settlements and/or consent orders:

- Requirements for employers to inform employees and the union daily of patient cases and patient deaths of COVID, and staff cases and staff deaths
- Employers to assess PPE on ongoing basis, and make all efforts to obtain adequate supplies of PPE
- To act in accordance with directive 5 (which meant that if a HCW's PCRA found that they needed specific PPE that it must be provided)
- Visitors wear PPE in accordance with Ontario Directive 3
- Employers must use administrative procedures like co-horting of patients and staff
- Provide copies of written masking policies to Joint Health and Safety Committee
- Staffing reports to be sent to union staff weekly
- Training in infection control, PCRA, donning and doffing
- Work at only 1 site (inc volunteers and temp staff)
- If short of a certified worker, get a JHSC member certified
- Weekly schedules for inspectors to inspect specific long term care homes
- Even if some PPE is secured, the employer will keep sufficient PPE supplies readily available in a variety of sizes in areas where presumed or confirmed COVID-19 is regularly treated,
- Employer will communicate efforts to secure PPE stock, and if run short, will do contingency planning in consultation with the unions,
- The organizational risk assessment will be continuously updated and provided to the Joint Health and Safety Committee

Other significant decisions in healthcare:

Peterborough Regional Health Centre - Blondeau, false allegations—Elizabeth McIntyre - 2019 CanLII 128804
This case was a termination which was upheld by the arbitrator. The grievor had made complaints that a colleague had breached the privacy policies of the hospital. It was

established in the hearing that the complaints were not only unsubstantiated but false and in bad faith—that is, the grievor had deliberately lied about a colleague breaching privacy protocol in an attempt to get her fired. The significance of this case is that it is likely to be extended to complaints about harassment—where there is a complaint of harassment that is made in bad faith, the complainant could face extremely serious discipline. We, of course, knew this was possible, but we are beginning to see it manifesting.

Waypoint Centre for Mental Health Care - Meal Breaks—James Hayes - 2020 CanLII 71321

This was a case in which the employees had been working through lunches based on a health and safety concern that they personally identified. They believed that leaving over the lunch break would put their colleagues in harms' way. While the arbitrator found that the health and safety concerns were valid on their face he nonetheless dismissed the grievance because the grievance was about overtime.

> *"The difficulty that I have is that this important health and safety issue is brought forward by means of an overtime claim pursuant to quite a conventional overtime collective agreement provision. And the claim is advanced notwithstanding a longstanding Working Alone Policy and Procedure that was carried forward in 2017 by a Working Alone Plan that is directly applicable to the nurses affected by this Grievance. The specific concerns have not been raised either internally at the facility or with the Ministry of Labour. While the nurses' concerns on their face appear credible, they have not yet been met with a detailed response from the Employer. It would not be appropriate to say more at this point given the narrow contractual dispute presently at issue."*

The significance of this decision is that unions can't litigate health and safety issues indirectly through a side door.

Waypoint Centre for Mental Health Care—John Stout - Salary Grid - 2020 CanLII 5704

This was a classification grievance for a new position at Waypoint. It is significant because the Arbitrator in this case did not feel constrained by any existing grid. The collective agreement did not contain the typical language requiring and arbitrator to pay attention to established relativities between existing classifications. The result was that the Arbitrator established a new wage grid which was in between the Union's and Hospital's proposals.

6. Can you share examples where the pandemic exposed deficiencies in our health care system and what responses are being implemented or may be needed?

This question is addressed in other areas of our report.

7. Updates on COVID-19:

- **COVID OH&S update (PPE, screening, infection prevention, etc.)**

PPE: Ontario's Directive 5 has been updated to provide N95 protection for healthcare workers caring for suspected, probable, or confirmed patients in hospitals and long-term care and retirement homes. For non-COVID suspected patients, N95 protection is not standard; a regulated health care worker must perform a point of care risk assessment to determine whether a N95 is required. If a PCRA determines that a N95 is required, then any worker involved in the care receives the equal level of protection. While these improvements help increase the levels of PPE in certain circumstances, the disadvantage is that non-regulated healthcare workers must rely on the regulated HCW to do the assessments and to decide on the level of PPE. Also, workers doing PCRAs to obtain the PPE still leaves PPE obtainment burden on the workers' shoulders rather than as an employer "obligation to provide" item.

- **COVID HHR update (workload, burnout, training, staffing levels, etc.)**

Pandemic Survey
The Ontario Federation of Labour (OFL) convenes bi-weekly meetings with Ontario's healthcare unions (OPSEU, ONA, CUPE, SEIU, Unifor, and USW) to compare notes and share resources during the COVID-19 pandemic.

The group provided input into the development and launch of a pandemic survey project. Ontario H&S system partners Occupational Health Clinics for Ontario Workers (OHCOW) and the Institute for Work & Health (IWH) conducted healthcare worker and non-healthcare worker pandemic surveys to identify whether worker perceptions of infectious disease practices and adequacy of PPE were correlated with symptoms of depression and anxiety. The surveys showed that the less confidence workers had that they were being protected in the workplace from COVID-19, the higher the prevalence of depression and anxiety symptoms. Workers who reported that they felt protected with adequate PPE and infection control practices in the workplace had the lowest levels of anxiety and depression symptoms — even lower than workers who worked from home.

- The paper has been published here https://journals.sagepub.com/doi/10.1177/0706743720961729.

- To watch the presentation of healthcare results see https://www.youtube.com/watch?v=fG5NLmxv9A0&feature=youtu.be

- **COVID backlog—how is the surgical backlog being addressed?**

- **COVID in general (any other COVID-related issues to report?)**

Some employers implementing mandatory testing for COVID-19
OPSEU has observed that, while none of the PH and/or other government guidance advises or requires employers to implement "mandatory testing," some employers are withholding work or hours, or threatening to sanction workers who refuse to have a COVID-19 test. Public Health (PH) guidance contains screening questions, forms, and apps that should be used each day prior to work to limit spread of COVID-19. These questions aim to identify people with symptoms or who have been exposed or have travelled. Essentially, the "screen" can be considered a "fit for work" questionnaire because it identifies anyone who screens positive so that measures to reduce potential spread can be applied. PH guidance also advises COVID-19 testing (swabbing) for certain workers and situations (ie when they have been exposed or have symptoms). PH and/or other government guidance also recommends, but does not mandate, broad testing in specific sectors—such as long term care in order to have an idea of population health and extent of COVID-19 in the community.

The problem arises when employers "require" workers to be tested for COVID-19 as a condition of work (such as bi-weekly in the long term care sector). Nothing in PH guidance makes testing workers mandatory. OPSEU believes that this kind of interpretation runs afoul of workers' rights:

- First, OPSEU believes that mandatory testing as a condition of work goes beyond existing PH and/or other government guidelines for COVID-19 that recommends daily screening or broad testing for certain sectors or workers.

- Also, OPSEU believes that testing is not effective as a (fit-for-work) screening measure. It takes time (sometimes a few days) for results to come back, it represents only that moment in time, and even if positive, the person continues to work if they are asymptomatic. Also, mandating a biweekly test for workers at the same time as allowing visitors, patients, and caregivers in and out for days or weekends with no requirement for testing limits the effectiveness (and therefore we say removes the justification) for subjecting staff to mandatory testing.

- Ontario's Human Rights Commission, in answering a question regarding an employer requiring "me to do a medical test related to COVID-19 like take my temperature, states that "testing may be permissible under the Code if the testing is shown to be effective and necessary in circumstances." Regarding COVID-19, the OHRC further states that "organizations should only require the least intrusive means of testing necessary in the circumstances" and "any form of medical testing should be effective at assessing an employee's ability to safely perform work, or to protect people receiving services or living in congregate housing." But it is important to note that the OHRC was not assessing the acceptability of mandatory swabbing, and that swabbing is not meant (and is not effective) as a fit for work measure. Employees already have a fit-for-work screening process in place when they report to work daily.

- Ontario's *Occupational Health and Safety Act* (OHSA) states that even prescribed testing (ordered by Regulations) is voluntary. Swabbing for COVID-19 has not been prescribed by Regulations.

- Furthermore, employers should ward off COVID through prevention measures, not rely on a testing strategy.

For all these reasons, OPSEU recommends that all programs for worker testing for COVID-19 be voluntary. Employers should develop testing programs in consultation with the unions and Joint Health and Safety Committees. Like they do with influenza programs, employers should develop education and awareness materials, provide information and training on the benefits, outline how it fits into their infectious disease program, have measures to provide accommodation if needed, encourage workers to participate, and ensure that there are no negative consequences for workers who do not participate.

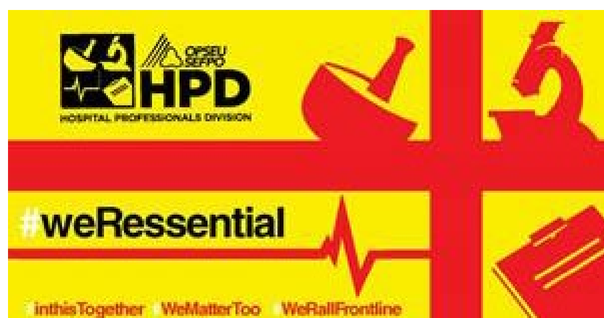
8. Major campaigns and communications

Hospital Professionals Division (HPD) awareness campaign

A select amount of HPD highest ranking members were prepared in March to participate in a lobby day to highlight critical issues within the sector, however, unfortunately due to the pandemic this event was postponed. As the pandemic rushed through the hospitals, members spent their days not only saving lives but also battling for sufficient PPE, fighting for the implementation of proper Health and Safety measures, and staffing/redeployment issues.

The HPD campaign was truly reignited when the government announced its ill-prepared plan surrounding pandemic pay as mentioned in question 3. The exclusion of various hospital professionals from the pandemic premiums reactivated the sector, and with members' support, the following actions were taken during Summer 2020 *(please note this list is illustrative and not exhaustive)*:

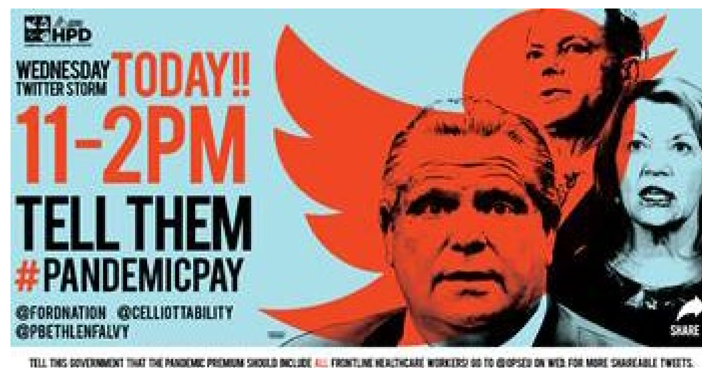
- Petitions presented in the legislature by various MPPs.
- Online days of actions, Facebook posts, t-shirts, and lawn signs.



- Video dProfessionals across the Province of Ontario who continue to be excluded from Pandemic Pay.

- **Online letter** writing campaign to the Premier, Christine Elliott, and Peter Bethenfalvy regarding exclusion of professions from Pandemic pay.

- **Twitter storms** bombarding the accounts of the Premier, Minister of Health, and President of the Treasury Board for several hours weekly.



- **Media coverage**
  - Intubation can cause a patient to cough right into your face": A respiratory therapist describes life on the front lines
  - Front-line health-care workers calling on province to expand pandemic pay
  - Front-line workers frustrated at being left off pandemic pay list
  - Lab techs, X-ray techs and other hospital workers say 'We matter, too"
  - "Thousands more" Ontario frontline healthcare workers need pandemic pay: union
  - Frontline workers calling on province to expand pandemic pay program
  - Frontline workers upset at no pandemic pay
  - Front-line hospital workers left out of Ontario pandemic pay
  - 'Forgotten front line' in Lambton, Ont. calls for pandemic pay bump
  - Front-line health-care workers calling on province to expand pandemic pay
  - Protestors demand COVID-19 pandemic pay for all at-risk frontline workers

- Front-line workers upset at omission from pandemic pay list
- Pandemic pay has created a 'two tier' system in Ontario hospitals: physiotherapist
- ‘Essential and excluded:’ Healthcare workers rally in region for pandemic pay
- PANDEMIC PAY: Ottawa hospital workers protest exclusion
- A segment of Ontario’s medical professionals feels ‘neglected’ from pandemic pay
- Front-line hospital workers left out of Ontario pandemic pay

- **Social distance province-wide rallies**

To raise awareness of the issues our hospitals are facing and to express frustrations about the lack of respect, recognition, and continued exclusion from pandemic pay, rallies were held in:

- **Windsor—**Windsor Regional Hospital and Hotel Dieu Grace Healthcare
- **Chatham—**Chatham-Kent Health Alliance, Sarnia—Bluewater Health
- **London—**London Health Sciences Centre
- **Kitchener / Waterloo—**St. Mary’s Hospital and Grand River Hospital
- **Guelph—**Guelph General Hospital
- **Cambridge—**Cambridge Memorial Hospital
- **Orillia—**Orillia Soldier’s Memorial Hospital
- **Oshawa—**Lakeridge Health
- **Hamilton** - St. Joseph's Healthcare Hamilton
- **Perth and Smiths Falls—**Perth and Smiths Falls District Hospital
- **Ottawa—**The Ottawa Hospital / CHEO / Queensway Carleton Hospital
- **Thunder Bay—**Thunder Bay Regional Health Sciences Centre
- **Niagara** - Niagara Health System, Eastern Ontario Regional Laboratory Association (EORLA)
- **Scarborough** - Scarborough Health Network - Birchmount Hospital, and Scarborough Health Network General Hospital
- **Toronto** - Baycrest Health Sciences, Humber River Hospital
- **Queen’s Park**, with many more.

Photos from the events are available here.

- **OPSEU/SEFPO Media releases and OPSEU/SEFPO Communications**
  - OPSEU’s Thomas to Ford: The time for clear, decisive and strong action on this pandemic is now
  - OPSEU letters to Ontario government officials re CMOH Directives
  - OPSEU President demands stronger leadership from senior medical experts
  - Frontline worker rights during COVID-19 Pandemic
  - We want to hear from you; take our COVID-19 workplace survey
  - OPSEU to provide financial support for eligible members
  - OPSEU calls on federal government to extend pandemic pay to all front-line health workers

- Letter to Premier Ford: Expand pandemic pay
- OPSEU celebrates Health Professionals' Week

OPSEU/SEFPO also sent a submission to the Ministry of Health discussing how decades of underfunding, unanticipated costs, capacity issues, staffing, and PPE shortages have plagued our hospitals, as well as, provide key recommendations for the Ontario government to consider in future planning and decision making. Read the full document here.

Paramedics & Ambulance Communications
OPSEU/SEFPO's Paramedics & Ambulance Communications has continued to engage and alert its members and the public via their twitter page with over 2500 followers.

Hospital Support
Our Hospital Support sector created this informative info-graphic to build sector engagement. They also participated in a solidarity building campaign in response to the issues with pandemic pay by adding these social media picture frames for one week at telling them that all frontline health workers deserve recognition. In total we had close to 3000 messages sent.

Canadian Blood Services & Diagnostics
At the beginning of the year CBS announced staffing cuts to a number of their donation sites as a cost saving measure. The sector responded in full force, leafletting and holding info pickets at sites which as a result of the cuts saw longer wait times. The following flyers were distributed to the public and posters were displayed at workplaces.

When the pandemic hit, CBS workers had to fight tooth and nail for PPE. OPSEU/SEFPO issued the following press release in response.

OPSEU/SEFPO Long-Term Care sector
For OPSEU/SEFPO's Long-Term Care sector, 2020 has been taken up by COVID-19 issues, as in most other healthcare sectors. Our members have had to push their employers hard for proper PPE, increased staffing, and safe protocols for COVID-19 in their workplaces throughout the year.

OPSEU/SEFPO supported our members in long term care by posting COVID-19 directives from the government around PPE, safe COVID-19 practices and workplace rights. Union leaders and staff have regular check-ins with sector leaders and locals to ensure that their concerns are being addressed. Our COVID-19 triage team deals with urgent issues that come up in all sectors in every region.

Our members have also participated in Ontario Health Coalition events focused on the emergency situation in long-term care, including the May 1 Online Day of Action to Fix Long-Term Care, and the October 8 Day of Action on Long Term Care.

OPSEU/SEFPO has submitted numerous reports, submissions and expert advice to the government on addressing the crisis in long-term care. These reports include a May 2020 proposal to bring long-term care under government management, and a submission to Queen's Park on Bill 218, demanding that the government remove the requirement to prove "gross negligence" in order for families to sue long term care homes for negligence. Sector Chair Joan Corradetti appeared before the Ministry of Long-Term Care's Staffing Study Advisory Group to provide her input on staffing issues in the long-term care sector. President Thomas urged the government to offer free tuition to community colleges for PSW training programs to attract more workers to the field. OPSEU/SEFPO has also issued numerous press releases and statements demanding these changes to the long-term care system, and emphasizing the strong public support for addressing the emergency in long-term care.

Sector chair Corradetti testified before Ontario's Long-Term Care COVID-19 Commission in October 2020, and OPSEU/SEFPO also sent a written submission to the commission, calling for the entire long-term care system to be brought in-house as a publicly-owned, publicly run service, staffed by many more frontline PSWs and RPNs, mandatory staff-to-resident ratios, higher wages, full-time hours and better working conditions in order to retain frontline staff, and for each resident to get a minimum of 4 hours of care per day.

OPSEU/SEFPO Ontario Public Service long-term care home inspectors

COVID-19 really highlighted what long-term care home inspectors have known for years: the long-term care inspection system is broken in Ontario. The government has completely given up on even attempting to carry out proactive, full annual inspections of every long-term care home. They have changed to a "risk-based" model where the vast majority of inspections are driven by complaints or critical incidents. And those inspections only cover the incident itself, nothing else in the home. If a home has a critical incident or complaint-based inspection, that counts as their one annual inspection.

In March 2020, inspectors were told by their managers in the Ministry of Long Term Care to stay home and do inspections remotely by phone. When senior management was planning for a return to onsite inspections in April and May, they had no plans in place for PPE for inspectors—they suggested that inspectors ask LTC homes for PPE when they arrived to inspect them. OPSEU/SEFPO told the ministry that this safety plan was unacceptable and demanded ministry-issued PPE. As a result, the ministry provided PPE once inspectors started onsite inspections again in June 2020.

At the end of May, Premier Doug Ford told the media that long-term care inspectors refused to enter long-term care homes and blamed the union, despite the fact that no work refusals had ever occurred. OPSEU immediately corrected the record by releasing a timeline of events plus recommendations for fixing the inspection system, and President Thomas demanded a retraction from the Premier. A few days later, the Premier gave a shout-out to long-term care inspectors at a press conference, praising their work during the pandemic.

At the beginning of November, OPSEU/SEFPO sent a submission to Ontario's Long-Term Care COVID-19 Commission on behalf of inspectors, telling them that to fix the long-term care system, we need proactive, full annual inspections for every long-term care home, enough inspectors hired to carry out those inspections, proper COVID-19 protocols and PPE for inspectors doing onsite visits, and for all long-term care homes in Ontario to be publicly-owned and operated instead of for-profit, since for-profit homes have many more critical incidents and deaths than non-profit and publicly-run homes.

Mental Health and Addictions
The pandemic saw a dramatic rise in demand for mental health and addictions services. Government investments in response to the pandemic fell short of what is needed to address surging waitlists for mental health and addictions services. Research shows that COVID-19 disproportionately impacts racialized and lower-income people. Systemic racism and poverty must be taken into account in the delivery of services. Mental health and addictions professionals, like many other essential pandemic workers, face burnout and employers must be proactive in protecting employee mental health during this period.

In October OPSEU/SEFPO made a submission to the Minister of Health: *Expanded, culturally sensitive, mental health and addictions services save lives and money, https://opseu.org/news/opseu-sefpo-recommendations-to-minister-of-addictions-and-long-term-care-expanded-culturally-sensitive-mental-health-and-addictions-services-save-lives-and-money/110750/ ,* outlining recommendations to strengthen and invest in community mental health and addictions services.

Community Health Care Professionals
This sector is in the midst of restructuring with the passing of *Bill 175, Connecting People to Home and Community Care Act.* On June 18, 2020, Warren (Smokey) Thomas, President of OPSEU/SEFPO, submitted the union's brief on Bill 175 to the Standing Committee on the Legislative Assembly, https://opseu.org/news/opseu-submits-recommendations-on-bill-175-home-and-community-care/108065/.

When Bill 175, the *Connecting People to Home and Community Care Act*, was introduced in February healthcare stakeholders expressed immediate concerns about what appeared to be the government's intention to ram through these changes with little feedback or input. The legislation was quickly passed without fulsome public consultation. The writing of the regulations took a back seat due to the global COVID-19 pandemic however are now back on track and the government is moving quickly on

them. The changes outlined in the Bill are concerning to OPSEU/SEFPO, which represents employees both in the LHINs who work in care coordination roles and as frontline community healthcare workers. OPSEU/SEFPO agrees that home and community care need reform, however, this bill does not address systemic challenges such as understaffing and the lack of full-time, permanent positions, insufficient pay, and attracting and retaining workers.

The government targeted specific cuts to local public health programs prior to the pandemic. Furthermore, as part of heath restructuring, the provincial government announced plans to reduce Ontario's public health units from 35 to 10, through amalgamations. An advisor was appointed to conduct consultations in 2019, and report back to the government. Due to the coronavirus, the deadline for the submissions to the Ministry of Health's consultations was extended until March 31, 2020. Although the government has now experienced the crucial role of local public health to effectively coordinate local public health initiatives as a first line of defense against the pandemic, concern remains that in 2021, the ministry will proceed with amalgamations and further cuts.

The community home care sector is grossly underfunded and the proliferation of for-profit providers has resulted in the undercutting of adequate wages, benefits and full-time work to ensure that profits are transferred to shareholders. On October 1, the government announced an investment of $461 million toward a temporary wage increase for Ontario's personal support workers (PSWs) and direct support workers (DSWs), in an effort to improve workforce retention during the pandemic. President (Smokey) Thomas has also called upon Premier Ford to offer full tuition support for PSWs through the colleges, which would provide an incentive for PSW students and address the province's long-standing PSW shortage, https://opseu.org/news/opseu-applauds-the-ford-governments-461-m-support-for-ontarios-psws/110577/.

9. Health and Safety—report any important developments in this area:

The Ontario Federation of Labour (OFL) hosted two important webinars (October 13 ad 15, 2020) for activists to develop strategies regarding health and safety during the COVID-19 pandemic. These webinars were organized and hosted by the OFL and the healthcare unions OPSEU, CUPE, ONA, SEIU, Unifor, and USW. Almost 100 activists participated. At the events, unions talked about knowledge activism, discussed our experiences and strategized by sector. The planning group developed the following resources:

- A COVID-19 Health and Safety Rights Guide for Health Care Workplaces: https://ofl.ca/wp-content/uploads/2020-10-08-OFL-Section21-Guide.pdf

- Resource Catalogue for Health and Safety English https://ofl.ca/wp-content/uploads/Knowledge_Activism_OHS_Catalogue_COVID19_EN-1.pdf and French https://ofl.ca/wp-content/uploads/Knowledge_Activism_OHS_Catalogue_COVID19_FR-1.pdf

8. Monitoring violence in the workplace—are there specific incidents to be noted, or overall measures that have been implemented, regarding violence in the workplace?

Workers have observed noted that workplace violence has increased during the COVID-19 pandemic. One large mental health hospital reported to its Workplace Violence Committee a spike in workplace violence incidents in May 2020—an increase from approximately 2 per month to 5. To address the increase, the organization implemented measures such as: engaging behaviour therapists, extensive care plans, keeping risk flags and comfort plans up to date, daily review staff huddles, team review, ad hoc meetings, and adding programming options to the units such as colouring, themed fun-days, and other opportunities for patients to expend energy and keep busy as everyone deals with the COVID-19 restrictions.

9. Health Human Resources (HHR)—are there shortages of skilled professionals? And are there any initiatives being used to increase recruiting, training, and retention of health science professionals?

The supply of Registered Medical Laboratory Technologists has declined to critical levels. OPSEU and the CSMLS have been sounding the alarm for years. According to CSMLS data, Ontario is short as many as 300 MLTs and 50% of the current workforce is eligible to retire in the next five years. In order to meet the skyrocketing demand from Employers scrambling to ramp up their COVID-19 testing capabilities, the Michener Institute, one of the top educational facilities for technical professions, recently introduced a training program that will prepare 600 students to work in the lab to reduce the workload of Techologists and Assistants. These workers would be put through a two-day course online and then given two hours of in-lab training. The Michener Institute would be looking for individuals who already have a science background and university degree at the bachelor's or master's level to qualify for the training. In a Global News interview a Senior Director stated that their intent is to take "an educational strategy that extends the clinical team that supports the lab and the testing that's needed for COVID-19," adding that they are hoping to attract those who are already working in a lab in a research capacity.

OPSEU's hospital division is keeping a close watch on this development. We have grave concerns that individuals occupying this position might be asked by their employers to do work that only can only be done by a Registered Technologist. We have recently become aware that this may already be happening at our Public Health labs where members report the new Technicians are analyzing threshold settings, conducting QC validity testing and interpretation. OPSEU will vigorously pursue any encroachment into the work of Registered Technologists.

12. Workforce challenges related to aging—has your union put in place any strategies for recruiting or retaining related to the looming shortages based on the aging health care professional workforce? Has your government? Are there any studies or analyses of the issue that you can share?

None that we are aware of.

13. Are there privatization initiatives planned or proposed for your province that impact the health care system? Where do you see the pandemic increasing or decreasing the move towards privatization?

Please see Question #3.

14. Any other major activities to report:

15. Are there any specific issues or topics that you would like to see addressed at future CHPS meetings?

November 19–20, 2020
11 am (EST)
Videoconference

Constituent Report

CHPS Organization: New Brunswick Union of Public and Private Employees (NBUPPE)

1. **Number of health professionals that are members of constituent union:**

   There are 3,800 members covered by NBUnion in Health Care; Medical Science Professionals(MSP), Specialized Health Care Professionals(SHCP),Professional Services for Students in the Public School System(PSPS) and 4 Nursing Homes.

2. **Have you noticed any changes or trends overall, and in specific disciplines?**

   Continuing shortages in many of our professional categories; Psychologist, Lab Technologists, Sonographers, Respiratory Therapist, Social Workers, Physiotherapists, Audiologist, Occupational Therapists, Health Information Professionals, and Pharmacists. We are also experiencing shortages in our Nursing Homes of Licensed Practical Nurses and Resident Attendants (PCWS). This was in existence pre-Covid and there does not seem to be any clear strategy for recruitment or retention in the near future.

3. **Comments on government or on the current political climate:**

   We had 2 years of a minority Government and had an election in September with the Conservative Government of Blaine Higgs returning but this time in a majority. Higgs took advantage of his handling of the Covid crisis to increase his seats. We are expecting this Government to start implementing austerity measures of some kind in the near future. He had announced closures of some emergency services in some of the smaller hospitals pre-election and quickly reversed this but now that he has a majority we expect there will be some king of restructuring in health. We have heard that the Health Networks were given a directive to come up with plans for restructuring by July 1st of 2021.

   On November 17th the Government delivered its Throne speech. Now with a majority government Higgs “promises to "renew and reinvent" how public services are delivered to provide better value to taxpayers.” The speech mentioned plans for reforms to local governance and health care, specifically mentioning lessons learned in the pandemic and more "co-operation" in the

health system. “Higgs told reporters he wants to see less overlap and duplication both within the two regional health authorities and between them.”

Other interesting items from the Throne speech is a review of the Official Languages Act which is always a contentious issue and Higgs is also going to review the language proficiency requirements for government jobs.

On the labour front the PCs are bringing back a controversial bill on binding arbitration that was strongly opposed last year by unions representing police officers and firefighters. Basically the Municipalities ability to pay would have to be considered in any decision during binding arbritation.

4. Collective bargaining update:

We are in bargaining with our Nursing Home groups at this moment. One contract has been ratified but not signed yet. The hard stand the Government had taken with CUPE’s Nursing Home groups with multiple court action and delays on the legitimacy of the Essential Services in Nursing Homes Act which limited the ability to have an effective strike due to the high designation rates of Nursing Home workers continued since last report. While CUPE is intended to pursue this to the Supreme Court, an agreement was reached which saw a **6** year contract and a total GEI of **9.75**% (1.25/1.50/1.50/1.50/2.0/2.0). A far cry from the CUPE mandate of 20% over 4 years. There were commitments made to reduce sick time through a yet to be determine incentive programs and a $100 premium towards licensing fees for LPNs. There is a current study ongoing for Hospital LPNS and any gains from the study will be automatically applied on a go forward basis to Nursing Home LPNs. For our Homes we are essentially being offered the same monetary package as CUPE.

We have not started negotiations on our Hospital groups with both of those contracts having expired March of 2019. Covid has create backlogs as all negotiations were suspended but we are starting up again but virtually for now. Both our Health Care groups are starting a huge joint job evaluation study which will form the basis of negotiations with these 2 groups and we anticipate it will take at least a year to complete. To avoid further delays due to Covid we will be proceeding with this study virtually on November 30th. Needless to say this study will be more extensive than the Pay Equity exercise that was concluded in 2017 and we have a huge hill to climb in tempering expectations particularly from groups that did not see adjustments with Pay Equity.

5. Significant grievances, arbitration, or legal decisions:

We have a pretty significant case right now that is awaiting a decision. The basis of the case is whether casual employees in our Medical Science Professional group are eligible to receive the Maternity Leave top up (Supplemental Insurance) where there is no specific language excluding them from this benefit.

6. **Can you share examples where the pandemic exposed deficiencies in our health care system and what responses are being implemented or may be needed?**

One of the biggest impacts has been to our long term care sector. While we have had isolated outbreaks so far the deficiencies of being able to care for patients in residential facilities with inadequate staffing including lack of qualified and trained staff has really become apparent. Compounding the matter the layouts of these facilities, aging infrastructure, lack of equipment, etc. makes it near impossible to contain an outbreak within the facility. All four facilities affected so far in New Brunswick were managed by a Rapid Response Team from our ExtraMural Services managed by Medavie. However, if all these outbreaks had incurred concurrently or had become more widespread we are not confident Medavie would have had enough resources. The Government has already requested to train volunteers in public services willing to step up to create a pool of candidates in the event of large outbreaks in Long Term Care Facilities. NBU, NBNU and CUPE are presently meeting with Government to come up with an agreement to limit employees to one facility which would include Nursing Home and Hospitals but the Special Care residential facilities have not been included in these plans so far as they are non-unionized and privately owned.

The other major issue was accessing physician during the lock down and restricted services. Early on EVisit was created online to allow access to clients through a virtual platform. So far it has proved quite popular with 85 per cent of all doctor visits done through this platform early in the crisis. With several thousands New Brunswickers not having a primary care physician and relying on walk in clinics for access to health care it also allowed these people to be able to renew prescriptions virtually. If further investigation or procedures were required they were then referred to emergency care which also helped to alleviate unnecessary visits to Emerge during this time. It is not known if this service will continue beyond November.

7. **Updates on COVID-19:**

- **COVID OH&S update (PPE, screening, infection prevention, etc.)**

While the Government insists that we have adequate PPE supplies it continues to be a problem for health care workers being able to access N-95 when they feel they need them.

- **COVID HHR update (workload, burnout, training, staffing levels, etc.)**

Out outbreaks have been predominantly in LTC and our hospitals have not had major hospitalization of Covid patients as of yet. Workload has in some cases

reduced due to limited or cancelled services. Initial concerns with reopening of schools but this seems to be stable right now with no major closures of schools. Stress is elevated with the feeling of “dread” if we get a huge outbreak.

- **COVID backlog—how is the surgical backlog being addressed?**

  For the last several months surgeries are being performed but still lots of last minute cancellations and plenty of delays. Waiting lists are much longer. Interesting aside where some dental practices are advertising for people to get appointments in by end of year before their insurance runs out for this year.

- **COVID in general (any other COVID-related issues to report?)**

  Mandatory masks in public facilities but no full order as of yet. Seems to still be lots of people not wearing masks. Recent cases appears to be in younger population rather than the elderly and more travel related outside the Atlantic Bubble.

8. Major campaigns and communications (please include links if possible).

We had done some media on LTCs.

9. Health and Safety—report any important developments in this area:

A lot of focus has been predominantly on Covid. We had made some inroads on some of our members in Mental Health being forced to transport clients in their own vehicles and as a result being forced to take on extra insurance on their own to protect themselves. This has been resolved but many members still do it as they feel some obligation to assist their clients leaving them open to health and safety concerns as well as liability.

10. Monitoring violence in the workplace—are there specific incidents to be noted, or overall measures that have been implemented, regarding violence in the workplace?

There are ongoing committees in our Hospitals as a result of WorkSafeNB changes. All workplaces must also conduct risk assessments. The court case against the 71 year old gentlemen that assaulted 2 Nurses at a Hospital in Moncton has gone to Court and he was found guilty. Sentencing is not concluded yet but the Crown was only recommending a few months’ jail time and 2 months’ probation and the Defense wanted no jail time and sentencing to be served in the community. To note the man in question stated to the Judge he was sorry but if the nurses had done their job properly it would not have happened and he refuses any counseling or treatment.

11. Health Human Resources (HHR)—are there shortages of skilled professionals? And are there any initiatives being used to increase recruiting, training, and retention of health science professionals?

Surveys were sent out in late September by Government to health care workers. The New Brunswick Department of Health (DH) is developing a Comprehensive Health Human Resources (HHR) Supply and Demand Analysis of the healthcare workforce to plan and anticipate HHR challenges over the coming years across multiple professions and/or occupations. Several professions and occupations have been targeted for further exploration. This survey seems to go beyond the issues around the current Covid pandemic. There had been a committee to look at specific shortages of psychologists in the province but nothing concrete has come out of that consultation so far.

12. Workforce challenges related to aging—has your union put in place any strategies for recruiting or retaining related to the looming shortages based on the aging health care professional workforce? Has your government? Are there any studies or analyses of the issue that you can share?

NBU has not initiate any specific strategy on the aging workforce although we have brought this to the Governments attention for the last 15 years. There has been some specific studies going on for the last 4 years around lab services and much talk about restructuring lab services but no major movement yet. They could be looking at more centralized services and movement of personnel to larger hospitals leaving Point of Care machines and lab assistants or nurses to operate those. Nothing definite yet but we are anticipating there will be something this mandate.

13. Are there privatization initiatives planned or proposed for your province that impact the health care system? Where do you see the pandemic increasing or decreasing the move towards privatization?

Nothing on the radar yet. In the early stages of the lock down private health care providers were also shut down. We have concerns they may try and move more therapeutic service such as physiotherapy, Occupational Therapy, Speech Language and Audiology into private delivery.

14. Any other major activities to report:

The transfer of Paramedics from CUPE to NBU as a result of a classification review by Government is at the Labour Board. The actual hearing will be in mid-January and at this time all the parties involving are going through documents and evidence to be admitted. This is being done virtually as well.

15. Are there any specific issues or topics that you would like to see addressed at future CHPS meetings?

Not at this time.

Respectfully submitted,

Joyce Aucoin, CLRO
Coordinating Labour Relations Officer

joyce@nbu
1-800-442-4420

November 19–20, 2020
11 am (EST)
Videoconference

Constituent Report

CHPS Organization: (Please Identify)

1. Number of health professionals that are members of constituent union:

1. Client Services and Program Administration Category	
Audiologist 18	-
Chef 14 - 15	1
Community Mental Health Nurse	-
Dietitian 17	29
Dental Hygienist	5
Food Service Manager 10, 12, and 14	1
Health Information Coordinator (new*)	1
Hospital Chaplain 18	3
Housekeeping Supervisor	-
Nurse Educator 17A	-
Nursing Supervisor 18c and 19b	1
Occupational Therapy Worker 12-13	10
Pharmacist 18A	30
Pharmacist 20A	1
Psychometrician	-
Planning Officer 4P (new*)	-
Professional Officer 16-21 (new*)	6
Program Officer 15-19 (new*)	14
Psychologist 18, 19, 20B and 21A	8
Social Worker 15-20	59
Speech Language Pathologist 18B	17

Speech Language Pathologist 19A	-
Supervising Homemaker 14 and 16	1
Client Services and Program Administration Category = Total	
2. Client and Program Support Category	
Addiction Worker 8	33
Day program Worker 9	3
Dental Assistant	14
Development Worker 12-13	7
Education Officer 15	-
Home Support Worker 9	79
Hospital Librarian 16	0
Info Technology Officer	2
Occupational Therapy Worker 10-11	14
Regulatory Inspector 4 (new*)	
Social Service Worker 10-18	40
Client and Program Support Category = Total	
3. Licensed Practical Nurse Category	
LPN	388
Orthopedic Technologist	2
4. Resident Care Worker Category	
Resident Care Worker	546
Patient Care Worker	38

2. **Have you noticed any changes or trends overall, and in specific disciplines?**

Wait times for psychological assessment is decreasing due to successful recruitment. Wait times for psychiatry services has decreased in the province despite challenges in retaining psychiatrists.

The province's Recruitment and Retention Secretariat is considering means to recruit more social workers, psychologists, LPNs and RCWs.

3. **Comments on government or on the current political climate:**

The PEI Government recently became a "majority" government led by the Conservatives with the Green Party and the Liberals holding seats in the legislature. The Conservatives have a one seat advantage in the legislature. A Liberal MLA resigned recently, and a by-election occurred 3 weeks ago to determine the new MLA for the district. The Speaker though, is currently a Conservative and as a result the Conservatives do not have a working majority

Nonetheless, the Government has been quite functional due to the efforts of the Premier to ensure some level of collaboration. Relations between the government and PEI UPSE and has been functional and courteous in most cases. Earlier in 2020 President Jackson was appointed to the Premier's Council which has a mandate to address the economic future of PEI post-COVID-19. The Premier's Council has been meeting since May. Additionally, PEI UPSE submitted a position paper on many of the key issues related to post-COVID-19 economic restructuring

4. **Collective bargaining update:**

The collective agreement between UPSE and Health PEI expired on March 31, 2020. The UPSE bargaining team met in February to review the membership's proposal forms in order to develop a comprehensive bargaining package. UPSE exchanged packages with Health PEI on October 6, 2020. Negotiations took place from October 21-23 and from November 12-13. Negotiations will resume from November 25-27, 2020.

UPSE and Tremploy have signed a new three-year collective agreement with a 100% ratification vote in support of the new contract.

The newly organized Atlantic and Tourism Hospitality Institute Bargaining Unit has been at the table several times in the last 3 months. Another day is scheduled for December 14 and we are hopeful to have a deal ratified by the end of the year.

Holland College Faculty bargaining was delayed due to the Covid-19 pandemic. It was originally scheduled for May. The parties exchanged packages on October 30, 2020. No further dates have been scheduled.

5. **Significant grievances, arbitration, or legal decisions:**

UPSE has filed a policy grievance under article 14.28 of the collective agreement which outlines that no employee shall be required to work a double shift without his/her consent. The employer has been asking employees at the end of their shifts to work double shifts saying that no one else is available. Employees then feel obliged to take the shift even if they don't want to. UPSE contends that this is a clear violation of the collective agreement. The ggrievance has been put into abeyance and the issue has been moved to the current collective agreement negotiations to see if UPSE can get a resolve prior to moving towards arbitration.

6. **Can you share examples where the pandemic exposed deficiencies in our health care system and what responses are being implemented or may be needed?**

While not truly a deficiency, the PEI's health system's re-organization in the spring to ensure acute COVID treatment at our major hospital, saw some services (i.e. mental health services, surgery postponements) reduced or changed to other facilities. Though this re-organization was a logical response to the threat of the virus, PEI's low number of COVID cases and few or no admissions for COVID, resulted in significant changes in the sites of health delivery and an underutilization of our major hospital.

There are shortages in all of the major nursing professions and PPE availability has been a challenge.

7. **Updates on COVID-19:**

- **COVID OH&S update (PPE, screening, infection prevention, etc.)**

With emerging evidence that COVID may now be airborne UPSE President, Karen Jackson, has made a request to the employer that any health care workers employed at the screening center wear N-95 masks while on duty. The request is being considered by the employer's joint response team.

- **COVID HHR update (workload, burnout, training, staffing levels, etc.)**

Workload remains high due to staff shortages and burnout of existing staff is high. Staffing levels are stretched due to staff shortages (vacant positions) and re-deployment to other sites. In long term care, staff is limited to working in one facility (members cannot work in more than one long term care home).

Compassion and COVID fatigue is also an issue that we need to be aware of as well as the fact that government is looking at hiring travel nurses to fill vacancies.

- **COVID backlog—how is the surgical backlog being addressed?**

The surgery backlog on PEI was not as bad as feared as the QE Hospital is now doing some surgery on the weekends and have increased operating room hours.

- **COVID in general (any other COVID-related issues to report?)**

We have been fortunate up to this point to have no community spread in our province; however; we must remain vigilant to ensure the health safety of all Islanders.

8. Major campaigns and communications (please include links if possible).

The PEI Union of Public Sector Employees (UPSE) along with the National Union of Public and General Employees (NUPGE) donated $5000 to food banks across Prince Edward Island recently.

Karen Jackson, UPSE President, thanked NUPGE for their contribution and stressed how important food banks are in our communities. She said, "the pandemic has put increased demand on our Island food banks and UPSE and NUPGE are proud to give back to our Island communities on behalf of our members."

The UPSE Women's Committee also made a $3,000 donation to food banks across the Island for the purchase of feminine products. Many women and girls in PEI do not have adequate finances to purchase these products.

9. Health and Safety—report any important developments in this area:

- PEI has recently established regulations under *the Occupational Health and Safety Act* to require that all employers address harassment in the workplace. In keeping with legislation in other Canadian jurisdictions, the new regulations:

  - Provide a definition of harassment to clarify what is unacceptable behaviour in the workplace.
  - Set out the requirement for all employers to develop a policy to prevent workplace harassment.

The new regulations came into effect on July 1, 2020.

- WCB of PEI is currently consulting employers in the province regarding a future amendment of the OHS Act. The intention of the amendment is to loosen the confidentiality restrictions on health and safety violations in Island workplaces. Specifically, it addresses communications of violations where there is a public interest in knowing about the violation(s). Currently, health and safety violations are addressed through an order posted in the worksite. PEI UPSE believes that,

in most cases it would better serve the public interest if some or all violations are more widely known. Currently, it is not publicized beyond the workplace unless charges are laid against the employer. The laying of charges under the *OHS Act* are rare.

PEI UPSE advocates that employers who do not follow the *OHS Act* should be identified. This allows for any parties who may possibly engage with the employer will be aware of the past history of workplace safety and act accordingly. New or potential workers at the worksite who might not otherwise know this information, will likely be forewarned. The amendment will put more pressure on employers to follow the *OHS Act* and safer workplaces will result. PEI UPSE encouraged the WCB and the Minister to proceed with the amendment.

10. Monitoring violence in the workplace—are there specific incidents to be noted, or overall measures that have been implemented, regarding violence in the workplace?

PEI UPSE has been conducting a campaign over the past three years to reduce violence in the workplace. While the campaign has raised awareness of the problem and the dangers in the workplace, the employer has been slow to work to reduce violence. In 2019, UPSE conducted a survey of its health care workers and the results demonstrated that 97% of health care workers had seen or experienced a violent incident, assault or threatening behavior at work.

The results of the survey have been shared with the employer and recognized but meaningful measures to address violence have not yet been implemented. A provincial Violence in the Workplace Advisory Committee has been established with UPSE participation.

11. Health Human Resources (HHR)—are there shortages of skilled professionals? And are there any initiatives being used to increase recruiting, training, and retention of health science professionals?

YES.

- To name some: Resident Care Workers, Social Workers, Psychologists, Registered Nurses, Licensed Practical Nurses, Admin Support

- Presently there are financial incentives programs with a return in service commitment for the following:

- Graduate RNs

- Graduate Nurse Practitioners

- Experienced RNs
- Experienced Nurse Practitioners
- At the present time, these are the only financial incentive programs. There are no such programs for Health and Social Care Professionals.
- Incentives are also being considered for LPNs and RCWs

12. Workforce challenges related to aging—has your union put in place any strategies for recruiting or retaining related to the looming shortages based on the aging health care professional workforce? Has your government? Are there any studies or analyses of the issue that you can share?

A newly formed RCW Recruitment task group will have its first meeting week of Nov 9th. (UPSE has representation on it). It involves a forum for multiple stakeholders (including UPSE representation) involved with education, funding and employment of RCWs to identify the barriers, gaps and/or limitations that may affect RCW recruitment. From this initiative, a list of recommendations will be developed, and work groups will be struck.

Recruitment committees have been struck on the addition of Mental Health and Addictions roles expanding in the next few years. There are Recruitment Strategy working groups for Nursing, Social Worker and Psychologists as well.

13. Are there privatization initiatives planned or proposed for your province that impact the health care system? Where do you see the pandemic increasing or decreasing the move towards privatization?

UPSE opposes the privatization of healthcare in the province. This includes the investment of tax dollars in Medavie, a private company, for the delivery of some of the home care services in Prince Edward Island. The pandemic provides an opportunity for Medavie to expand services in homecare. UPSE is keeping a close watch on this possibility. We are also seeing government make a move to hire travel nurses to fill vacant LPN and RN positions.

14. Any other major activities to report:

15. Are there any specific issues or topics that you would like to see addressed at future CHPS meetings?

November 19–20, 2020
11 am (EST)
Videoconference

Constituent Report

CHPS Organization: Association of Allied Health Professionals (AAHP)

1. **Number of health professionals that are members of constituent union:** 750

2. **Have you noticed any changes or trends overall, and in specific disciplines?**
   N/A

3. **Comments on government or on the current political climate:**
   - A new Premier was appointed in August—Premier Andrew Furey (Liberal Party) to replace Premier Ball who stepped down early. The Liberals still hold a minority Government and due to the change in leadership, an election must be called by August 2021.
   - There has been some rumors that an election would be called this Fall, however, this has not happened to date.
   - A new 12 person "**Provincial Economic Recovery Team**" has been appointed, Chaired by Dame Moya Green. The team is heavily weighted by private sector business people, though Mary Shortall (President NLFL) is also a member. This said, the Team members will provide input to the final reports but the responsibility for the final report and its content will be that of the Chairperson.
   - PERT's mandate (https://www.gov.nl.ca/releases/2020/exec/1022n02/is to come up with a that will respond to the Province's immediate fiscal challenges and plot a new course forward **within 3 years!** . They have to provide an interim report to Government by February 28, 2021 with a final report due by April 30, 2021.
   - Given this mandate, there is significant concern re: the impacts for public sector employees and unions.
   - At the same time, Government has also established a **Task Force on Health Care** ("NL Health Accord"), chaired by Dr. Pat Parfrey and Sister Elizabeth Davis https://www.gov.nl.ca/releases/2020/exec/1105n03/. Its mandate, as outlined in the Mandate Letter to Minister Haggie, will focus on delivering a 10-Year Health Accord with short, medium, and long-term goals for a health care system that better meets the needs of Newfoundlanders and Labradorians.
   - The AAHP will be sitting on this task force along with Senior Leadership from other health care unions, the CEO's of the Health Authorities, Medical Association, Dean of Medical School, Government, and other community/academic stakeholders. As of the writing of this report, the full list of participants has not been released yet. The first meeting is November 19th.

- It is not clear how, or even whether, these two task forces will interact—but already the respective Chairs have been in the media with commentary re: the significant costs of health care in our Province.

4. Collective bargaining update:

- The AAHP served notice to Government in June 2020. However, due to the "Good Neighbor Agreement", neither party is obligated to commence bargaining until the Agreement is ended, or as may be mutually agreed.
- This past year, NAPE and RNUNL entered into contract extension agreements that extends the date of their contract expiries to 2022. Other public sector unions have opted to pursue collective bargaining at this point, including the AAHP. There has been some minor movement with other bargaining units with respect to setting negotiations dates etc. The AAHP expects to have a better picture as to when bargaining may commence within the next month.

5. Significant grievances, arbitration, or legal decisions:

- https://www.canlii.org/en/nl/nllrb/doc/2020/2020nllrb5/2020nllrb5.html?resultIndex=2
- In 2018 the AAHP filed a complaint with the Labour Relations Board re: the Employer's decision to introduce a new Disability Case Management Service model which included the introduction of 13 Disability Case Managers (DCM), classified as Managers. As a result of this change, eight union employees (4 AAHP Members/Occupational Therapists and 4 RNUNL/Nurses Members) were laid off as they were previously doing recovery management and return to work planning and supports, functions that would now be included in the DCM role. The new DCMs also included some functions previously carried out by HR employees.
- The AAHP contended that effectively, the vast majority of the work of the new DCMs was previously carried out by bargaining unit employees and as such, the DCMs should be bargaining unit as well.
- In May 2020, the LRB finally ruled in favour of the AAHP. The employer subsequently made application for a judicial review in the Supreme Court NL and for a Stay in the interim until the case was heard.
- The Stay was granted with COVID-19 issues and challenges forming basis of decision as the employer argued it would be virtually impossible to proceed with implementation and potential impacts, especially if the decision was eventually overturned. At the same time, the RNUNL filed for intervenor status in the Judicial Review noting that they agreed with the LRB Decision, so we presume they may be looking to have their RNUNL members reinstated. The RNUNL did not challenge the employer's decision when the changes were implemented.
- It is now expected that the case for RNUNL intervenor status will be heard in early 2021 and subsequently the judicial review by mid-2021.

- We have an arbitration coming up in February 2021 re: potential human rights violations on the basis of disability related to COVID and immunocompromised individuals.

6. **Can you share examples where the pandemic exposed deficiencies in our health care system and what responses are being implemented or may be needed?**
   - In September 2020 the AAHP participated in a "Lessons Learned" session with all the Health Authorities, Public Sector Unions for Health Care, Newfoundland and Labrador Medical Association, Pharmacy Association and Government. The purpose was to get a picture of the things that worked well, and those that didn't in the first wave of COVID to better assist in the event of a second wave. It was not comprehensive nor official—i.e. there would be a written report but not official recommendations for action at this point—it was more of an immediate planning tool in preparation for the Fall. Common/high level issues identified within health care included:
     - PPE supply deficiencies
     - Significant communication deficiencies:
       - Within Health Care authorities (e.g. messages from the top would be confused/misinterpreted as they were pushed down the line to front line);
       - Between Government and the Health Care authorities (e.g. at times, Government would make announcements that the we and the Health Care authorities would hear on TV at the same time—as such, the Health Care system would be placed in situation where there were expectations from employees and public but no planning/preparedness to act resulting in frustration/anger/confusion and delays as the Health Care authorities moved to implement;
       - Between Government/Health Care and Unions—we had to push for regular communications and meetings in the beginning
       - Between Government Departments (e.g. Dept of Education responsible for Daycare arrangements—Dept. of Health had no idea of criteria processes etc)
     - Lack of Pandemic Preparedness: Unlike H1N1, this time around there was no upfront engagement with the unions nor sharing of plans etc. This also applied to the frontline—most of our Members had no idea of what the latest Pandemic Readiness Plan for COVID was and we had to ask about it.
     - Lack of recognition of the role of Unions as a key partner: Again, the unions had to fight at first to get Government to engage with us
     - Differing philosophies with Government on "Precautionary Principle". We are bordering on potential bad faith re: their interpretation and ours (Health Care Unions). Despite having signed a PPE protocol agreement as

agreed to by the Minister, we differ in our interpretation of "point of care clinical assessment" to determine PPE needs when treating patients. There is/was a sense that "PPE supply management" was taking precedence.

- Specific to AAHP, it has become clear the limited professional resources, especially within LTC. For example, we have one SLP responsible for 5 LTC centers in St. John's Metro! This posed significant concerns in the midst of the first wave and there we no additional SLPs available even it the employer was willing to hire. The LTC restrictions and limited resources caused significant frustrations for our Member, some of whom were assigned to one LTC center full-time when normally they may have only required 0.25 FTE at that same site.
- Employee Accommodations (e.g. due to immunocompromising medical conditions): At the beginning of the Pandemic, the health authority was NOT prepared to deal with this. They tried to apply the same criteria as in normal times with their existing policies—however this was different in that we were not dealing with individuals with physical/medical conditions that prevented them from working all regular duties. In our examples, the individual was fully capable of performing all duties, just not in the environment they regularly worked.

7. Updates on COVID-19:

- **COVID OH&S update (PPE, screening, infection prevention, etc.)**
  - This seems to be working ok now. Perhaps one of the best joint committees we have is our PPE committee that meets weekly and where we receive very detailed updates re: PPE supplies on hand, projected, orders etc.
  - The Health Authorities have/are adding lots of additional staff, or at least they are looking for them (retired nurses, students etc) for the influenza shots.

- **COVID HHR update (workload, burnout, training, staffing levels, etc.)** o
  - We are aware of significant issues for some disciplines in other bargaining units that are ongoing, however, these issues are not as extreme among our Members.
  - This said, we are seeing limitations on staff in disciplines such as Psychologists and Respiratory Therapists such as not being able to take leaves of absences etc.

- **COVID backlog—how is the surgical backlog being addressed?**
  - Health authorities have identified five priority areas for "catch-up"—most of these do not directly involve our Members. Normal constraints related to our Anesthesia Assistants continue from a staffing resource perspective but these existed prior to COVID.

- **COVID in general (any other COVID-related issues to report?)**

8. **Major campaigns and communications (please include links if possible).**
   - In February 2020 we launched new media campaign with video/anthem, new logo, new brand etc. based on Together, We Make Life Better. Video can be found here: https://www.youtube.com/watch?v=-XblhgFURn8
   - Then COVID hit. We haven't done a lot with this since due to the pandemic but will be looking to do more in new year with promotional items etc to send to members.
   - In summer 2020, we did a slight variation on our new logo/theme with template pics of AAHP Members at work with a "Stronger Together" and then a customized tag line for the profession highlighted.

9. **Health and Safety—report any important developments in this area:** N/A

10. **Monitoring violence in the workplace—are there specific incidents to be noted, or overall measures that have been implemented, regarding violence in the workplace?** No

11. **Health Human Resources (HHR)—are there shortages of skilled professionals? And are there any initiatives being used to increase recruiting, training, and retention of health science professionals?**
    - Labour Market Adjustments for Pharmacists
    - Signing Bonuses and Bursaries for selected health professionals (note these are not guaranteed)
    - Seat purchases for University—Physiotherapists and Occupational Therapists
    - Guaranteed part-time hours for traditionally "casual" Respiratory Therapists

12. **Workforce challenges related to aging—has your union put in place any strategies for recruiting or retaining related to the looming shortages based on the aging health care professional workforce? Has your government? Are there any studies or analyses of the issue that you can share?** No. Out Government still has a focus on employee budget management through "attrition"!

13. **Are there privatization initiatives planned or proposed for your province that impact the health care system? Where do you see the pandemic increasing or decreasing the move towards privatization?**
    There are no new privatization initiatives associated with COVID. There are several P3 long-term care homes under construction as announced 3plus years ago. HOWEVER—given the newly announced Health Care Task Force and the Provincial

Economic Recovery Team, and the associated messaging, it is expected that there will likely be a push towards privatization in recommendations!

14. **Any other major activities to report:** No

15. **Are there any specific issues or topics that you would like to see addressed at future CHPS meetings?**

Attachment 1:

Signing Bonuses (for Health Professionals including Registered Nurses)

Signing bonuses are available for selected positions in 26 health occupations groups. Positions deemed difficult-to-fill are those that have been subject to active (but unsuccessful) recruitment for two months or more. Below is a list of health professional groups in which selected positions may be eligible for a signing bonus. Other conditions may apply.

Audiologist	Electroneurophysiology Technologist (EEG)
Clinical Dietitian	Nuclear Medicine Technologist
Medical Laboratory Technologist	Orthopedic Technologist
Combined LX Technologist	Eastern Health Only:
Medical Radiation Technologist	Orthopists
Occupational Therapist	Prothetist/Orthetist Clinician
Pharmacist	Medical Physicist
Physiotherapist	Radiation Therapist
Clinical Psychologist	Dosimetrists
Recreation Development Specialist	Cardiovascular Perfusionists
Registered Nurse	Medical Flight Specialist (Happy Valley-Goose Bay)
Nurse Practitioner	
Social Worker	
Speech Language Pathologist	
Licensed Practical Nurse	
Personal Care Attendant	

1. A maximum of two signing bonuses may be provided to an individual with a required service obligation equaling two years (3900 or 3640 hours as applicable) with the bonus to be paid annually. Single-year signing bonuses are permitted, with a service obligation of one year (1950 or 1820 hours as applicable).
2. A one-year signing bonus will be paid at the start of employment.
3. A two-year signing bonus will be divided into one payment per year for two years and will be paid at the start of employment and on the one year anniversary of the employees start date (after completion of 1950 or 1820 hours).
4. Signing bonuses will not be provided to any individual in an existing position in a difficult-to-fill occupation with a RHA or any Government of NL Department, Agency, Board or Commission within the previous three months.
5. A signed service agreement is required for each individual receiving a signing bonus. If conditions of the service agreement are not fulfilled the individual must repay a prorated portion of the signing bonus.

See below the amounts of signing bonuses that may be available based on location. Please contact the RHAs to discuss whether a signing bonus may be available for a position.

A	Positions in communities on Trans Canada Highway	$3,000	$6,000
B	Positions in communities not on Trans Canada Highway and excluding C and D	$5,000	$10,000
C	Positions in Labrador-Grenfell Health Authority excluding D	$6,000	$12,000
D	Positions on the coast of Labrador	$8,000	$16,000

HEALTH PROFESSIONAL BURSARIES

The awarding of bursaries for difficult to fill Health Professional positions is based on vacancies that exist within each Regional Health Authority (RHA). Bursaries are available to students who sign a service agreement.

Below is a list of eligible Health Professional occupations*.

Audiologist	Laboratory/x-ray Technologist	Orthoptist
Behaviour Management Specialist	Diagnostic Imaging Technologist	Paramedic (Advanced Care)
Cardiology Technologist	Dosimetrist	Pastoral Care Clinician
Cardiopulmonary Technologist	Electro Neurophysiology Technologist	Personal Care Attendant
Cardiovascular Perfusion Technologist	Genetic Counselor	Pharmacy Technician
Child Management Specialist	Laboratory Technologist	Prosthetist-Orthotist Clinician/Technician
Clinical Dietitian	Licensed Practical Nurse	Radiation Therapist
Clinical Occupational Therapist	Managers (clinical and non-clinical)	Recreation/Development Special
Clinical Pharmacist	Medical Physicist	Respiratory Therapist
Clinical Physiotherapist	Nuclear Medicine Technologist	Social Worker
Clinical Psychologist	Orthopaedic Technologist	Speech-Language Pathologist

** Other Health Professional Occupations may be considered*

The bursary is a maximum of $10,000 with a required service obligation of 3900 or 3640 hours (as applicable). A maximum of $5,000 with a

1950 or 1820 (as applicable) hour service obligation is also available. For Physiotherapy and Occupational Therapy in St. John's, the bursary is generally $3,000, with a 1950 or 1820 (as applicable) hour service obligation. Bursaries are available to students only.

CHPS Members

NUPGE Components

- B. C. Government and Service Employees' Union
- Canadian Union of Brewery and General Workers
- Health Sciences Association of Alberta
- Health Sciences Association of British Columbia
- Manitoba Government and General Employees' Union
- New Brunswick Union of Public and Private Employees
- Newfoundland & Labrador Association of Public and Private Employees
- Nova Scotia Government and General Employees Union
- Ontario Public Service Employees Union
- PEI Union of Public Sector Employees
- Saskatchewan Government and General Employees' Union

Independent Unions

- Association of Allied Health Professionals Newfoundland and Labrador
- Health Sciences Association of Saskatchewan
- Manitoba Association of Health Care Professionals

Get in touch with us

Anil Naidoo
NUPGE
Email: anaidoo@nupge.ca
Phone: 1-613-228-9800
Fax: 1-613-228-9801

Val Avery
HSABC/NUPGE President
Email: vavery@hsabc.org
Phone: 1-604-517-0994

15 AURIGA DRIVE
NEPEAN, ONTARIO
CANADA / K2E 1B7

[613] 228-9800
FAX [613] 228-9801

www.nupge.ca

national@nupge.ca

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