Provincial Health Human Resource Planning & Guide for Health Authorities

March 2008

Acknowledgement

It is through the commitment of the Human Resources Steering Committee *and Alberta Health and Wellness* that this Guide has been developed. Their dedication of staff resources and the authority to proceed made this work possible.

Members of the Workforce Planners' Group spent many hours developing and editing this document. Their dedication brought this work to life. Employer representatives include:

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- Judy Bloom, Capital Health
- Mary Ellen Hoogers, Aspen Regional Health
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Section A:
Provincial Health Human Resources Planning

Introduction

Alberta Health and Wellness (AHW) and health authorities each have roles and responsibilities in Health Human Resource (HHR) planning that are both distinct and complementary. The Ministry's role is to provide strategic direction and leadership in support of provincial HHR planning. Health authorities are responsible for the planning, delivery and management of health services within their respective areas of jurisdiction (as referenced in the *Regional Health Authority Act* found at www.qp.gov.ab.ca/catalogue/).

In 2003, the Provincial Comprehensive Health Workforce Plan (CHWP) was developed in a consultative process with multi-partner involvement and was approved by both AHW and the health authorities Council of Chief Executive Officers (CEOs). The Provincial CHWP established a framework for workforce planning that is built on a foundation of four building blocks which are:

1. Building Planning Capacity
2. Adequate Supply
3. Appropriate Utilization; and
4. Healthy Workplaces

One outcome of the building planning capacity building block is HHR planners have the ability, tools and information to research, develop, implement and execute workforce plans. The workforce plans ensure the optimal number, mix and distribution of health service providers, recognizing that as the health care system shifts in response to changes, so must planning for the workforce.

In addition, one associated challenge noted by HHR planning partners was that it is difficult to implement provincially coordinated HHR planning processes in the absence of consistent and comparable HHR information. A recommendation for moving forward was that all health authorities would commit to ensuring workforce planners communicate best workforce planning practices with each other, and wherever possible, collaborate on planning practices and joint workforce strategies.

The purpose of this Guide is to provide information for partners that will facilitate the overall understanding of:

- HHR planning at the provincial level; and
- the importance of integrating the work between provincial and health authority business planners (who are focused on strategies, partnerships, capital/facility plans, services to be

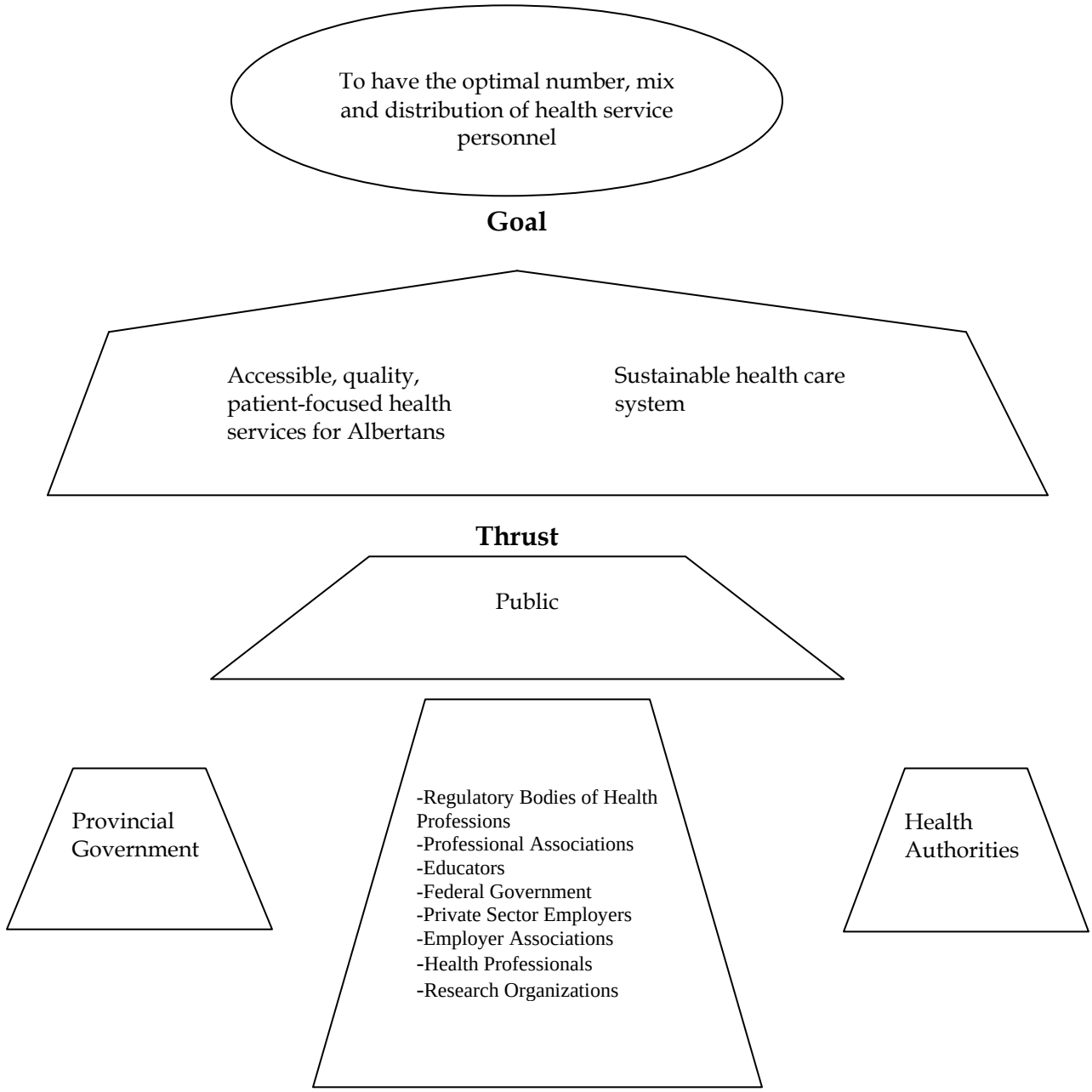
delivered, and related financial information, etc.) and provincial and health authority workforce planners, and clinical leaders (who are focused on the human resources required to implement business strategies).

What Is Health Human Resources Planning?

HHR planning, also referred to as workforce planning, is the analysis, evaluation, forecasting and management of the supply and demand of human resources, aligning with the employer's strategic plan. "Health Human Resource Planning" in this document is used interchangeably with the term "Workforce Planning".

TAB 1

Provincial Comprehensive Health Human Resources Plan Framework



TAB 2

Planning Cycles

HHR planning is a complex and multi-dimensional process that requires collaboration amongst all partners, both internal and external to the organization.

The following three tables illustrate some of the inherent complexities:

1. AHW HHR Planning Cycle
2. Health Authority Human Resource Planning Cycle
3. Health Authority Business/Financial Planning Cycle

AHW HHR Planning Cycle

Ad Hoc	January 30	February 28 Deadline	June 30 Deadline	November 1
Surveys and reports may be requested throughout the year to support responding to emerging issues related to HHR planning	Health Workforce Template contents confirmed	Health Workforce Template (for utilization by AHW as well as by HBA Services) distributed to health authorities	All Health Workforce Templates and surveys received; review begins by AHW (e.g. regulatory bodies, other ministries, other employers, particular sectors, Physician Resource Planning committee, etc.)	Annual Workforce Report prepared providing a summary of HHR data and information received by June 30 inclusive of information available from: o Ongoing general environmental scanning paying particular attention to trends and data o Available forecasting tools/models o Searchable inventories of HHR strategies (including research agendas) o Other organizations' work plans o Health authority Health Plans and Business Plans
HHR planning forums/meetings may be organized throughout the year to support responding to emerging issues related to HHR planning		Other health workforce surveys (for utilization by AHW and for sharing with stakeholders as appropriate) distributed (e.g. to regulatory bodies, other ministries, other employers, particular sectors, Physician Resource Planning Committee, etc.)	Ministry of Advanced Education and Training information provided and received and utilized (i.e. related to programs, seats, FLE information, etc)	
		Requests to Ministry of Employment, Industry and Immigration and Ministry of Advanced Education and Training and Provincial Nominee Program information for required reports (and others as determined to be4 necessary)	Ministry of Employment, Immigration and Industry information on immigration received and utilized; Canadian Occupational Projection system (COPS) Forecast from November utilized	
			AHW Provincial Nominee Program report received and utilized	

The following two tables outline the health authorities' workforce and business/financial planning cycles and illustrate some of the complexities in planning.

Health Authority Health Workforce Planning Cycle

Ad Hoc	March 30	June 30	December
Completion and submission of ad hoc Workforce Sector Surveys and Reports	Receive Health Workforce Template from AHW	Deadline for submission of Health Workforce Template (for review and utilization by AHW and HBA Services). AHW will utilize information to generate provincial reports throughout the year on supply and demand issues but in particular to generate the Annual Workforce Report	Provide input into annual Health Workforce Template contents

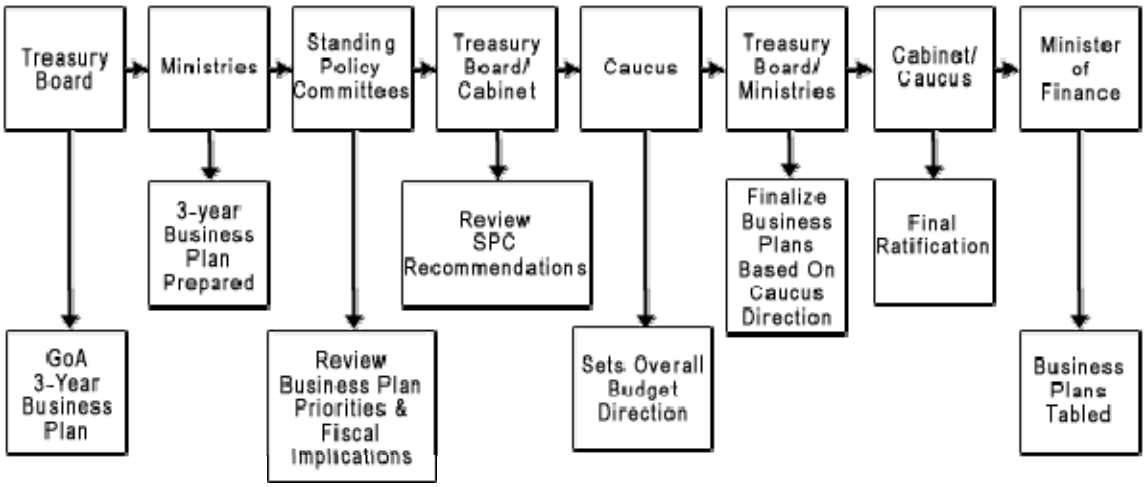
Health Authority Business/Financial Planning Cycle

Ad Hoc	February 28	March 31	May 15 August 15 November 15 February 15	July 31	October 31 January 31 April 30	December 30
Completion and submission of ad hoc Surveys and Reports	Three Year Plan approved (by mid-February after Ministry has met with HA to discuss Health Plan and Performance Targets)	Budget is announced (mid-March). Submit finalized One Year Business Plan (Workforce Measures required)	Submit Quarterly Performance Report to AHW (Workforce measures are not required)	Submit Annual Report (Workforce Targets required) and Quarterly Financial Report to AHW	Submit Quarterly Financial Report to AHW	Submit Three year updated Health Plan and preliminary One Year Business Plan to AHW (Workforce Measures Required)

Treasury Board Fiscal and Business Plan Decision Model

The following information is included to provide the context in which AHW operates within the governmental process. This information is helpful to understand the decision points in the governmental process.

Treasury Board requests Ministries develop Three-Year Business Plans based on the Government Business Plan. Ministries take the draft Business Plan to the appropriate Standing Policy Committee for review. Treasury Board assesses the overall implications of Ministry requests. This fiscal assessment is then taken to Caucus. Caucus sets the overall budget parameters based on Ministry requests and Treasury Board's fiscal assessment. Treasury Board and Ministries develop revised budget plans based on Caucus direction. Revised budget plans are reviewed by Cabinet and Caucus. Cabinet and Caucus give overall ratification to the fiscal plan and Government business plan.



Treasury Board is a legislated committee. Its role, as set out in the *Financial Administration Act*, is to formulate general management policies relating to the business and affairs of Crown and Provincial agencies, and perform any acts it considers necessary to ensure that those policies are carried out.

Treasury Board meets at the call of the chair.

Annual Report Process

The purpose of the Ministry Annual Report is to provide: accountability to the Legislative Assembly and the electorate; communication of useful information to the public and other ministry stakeholders; and to meet the legislative requirements of the *Government Accountability Act*. Each ministry's Annual Report will be based on the Three-Year Business Plan for the corresponding year, will comply with all relevant legislation, will be released at the time

specified by the Treasury Board, and will comply with the "spirit" of the *Standards for the Preparation of Ministry Annual Reports*.
Treasury Board will set the date for the release of the Ministry Annual Reports. Consistent with current practice, there will be a coordinated release of all Ministry Annual Reports. Draft Ministry Annual Reports are generally required for Standing Policy Committees review in August and public release will be mid to late September.

Caucus

Each party holds a caucus of all its members to discuss emerging issues and strategies. The government Caucus is comprised of the ruling party's elected Members of the Legislative Assembly (MLAs). It reviews all government legislation in light of various committee findings, public opinion, party philosophy, and government and department business plans.

The following committees are comprised of Cabinet and Caucus Members:

(a) **Standing Policy Committees**

The Alberta government's decision-making process centers on its Standing Policy Committees, introduced in 1992. There are six permanent committees which review and make recommendations on policies, programs and legislation. Each has the authority to review public submissions pertaining to their particular areas of responsibility. They also monitor existing programs, services and legislation. Committees consider the budgetary implications of proposals as well as implementation and communications strategies. They annually review budgets of departments associated with their portfolios, to provide comments and suggestions for consideration by Ministers in preparing their upcoming Annual Budget and Three-Year Business Plan.

(b) **Standing Policy Committee on Health and Community Living**

The Committee will review and make recommendations on policies, programs and legislation and hear public and private submissions pertaining to aboriginal affairs and northern development, children's services, community development, health and wellness and seniors and community supports programs (e.g., AISH and PDD). It will also monitor existing programs, services and legislation. In addition, the Committee's deliberations will include consideration of the budgetary implications of each proposal as well as implementation and communications strategies.

Health Authority Reporting

You can find more detailed information on health authority planning on the Alberta Health and Wellness website:

http://www.health.gov.ab.ca/regions/RHA_home.html#accountability

You can contact the Health Workforce Planning branch of AHW (1-780-427-3677) for information and demand issues related to health workforce and the Labour Relations branch for information on supply issues (1-780-427-1987).

Health authorities are required by law to develop health plans, business plans, capital plans and annual reports. These plans and reports are made available to the public, to ensure health authorities are accountable to Albertans.

The purpose of the Health Plan is to:

- Provide health authorities with a mechanism to set out the long-term direction for effective governance of it's health region
- Communicate with the minister how a health authority has laid out plans that align with the ministry business plan
- Indicate what achievements are planned to meet both the regional health authority's and government's expectations and
- Promote accountability through compliance with legislated requirements.

The purpose of the Business Plan is to:

- Communicate how the health authority expects to achieve the next year's expected results of the three-year Health Plan, including measures and targets.
- Describe planned tactical and operational approaches and implementations, and
- Indicate how available financial and other resources are to be deployed.

The purpose of the Capital Plan is to:

- Improve the overall planning and management of the health infrastructure.
- Communicate future capital expenditures needed to effectively maintain or modify the asset base to support service delivery strategies.
- Provide a context for assessing provincial capital project priorities as the basis for annual decision on project approvals.

- Provide a preliminary estimate of the operating cost implications of proposed capital investment.

The purpose of the Annual Report is to:

- Be a key public accountability document for reporting how the health authority has discharged its legislated responsibilities and any other responsibilities delegated by the Minister,
- Provide a means for highlighting the health authority's accomplishments, progress and results achieved over the year, including explanation for any significant variation between actual results and those expectations planned in the three-year Health Plan, and to
- Be a vehicle for communication to residents of the region and people of Alberta.

Health and business plans state a health authority's responsibilities, the results to be achieved and how progress will be measured. Progress is reported in quarterly reports and in the annual report.

Along with making health authorities accountable to Albertans, plans indicate how health authorities work with each other and their communities, community health councils, professional and technical committees and other stakeholders.

Main Sources of Information in Support of Provincial HHR Planning

The Health Workforce Template

The Health Workforce Template (Template) is a collaborative exercise between HBA Services and AHW. The Labour Funding Impact (LFI) Survey, previously distributed by HBA Services, has been consolidated into the Template. The Health Workforce Division of AHW annually distributes the Template to health authorities by May. The Template is completed and submitted back to both HBA Services and AHW by June 30th. It requests the last year's actual FTE and headcount figures as well as projected health profession FTEs for the next three, five and 10 years.

Copies of the Template can be requested from AHW Workforce Division or HBA Services, Information Services business unit.

Annual Provincial Health Workforce Report

The data from the Health Workforce Template is consolidated by AHW along with data submitted to AHW from professional regulatory bodies, Advanced Education and other sources as available and is used to create an Annual Provincial Health Workforce Report designed to:

- support provincial HHR planning;
- provide current information to report to Ministry executives and the Alberta public;
- provide a consistent baseline of information to identify future areas of need; and
- provide information relative to the operations of the Ministry.

Information included in Annual Provincial Health Workforce Report:

Section	Comments
Profession Definition	From Health Professions Act
Professional Regulatory Bodies Registration Information	From the Registrars
Education/Training	This section includes a program location(s) section that outlines the programs, type of program (Bachelor, Masters, Doctorate, Certificate, etc.), and institution
Employment	This section summarizes the data received from the

Section	Comments
	health authorities.
Wage/Salary Comparisons	This section includes the wage information for the profession
Workforce Trends	This section provides graphs of workforce trend data for the profession. It includes information on: ⏩ Registrations (historical trend) ⏩ Total Headcount Enrollment (by degree type) ⏩ Projected Workforce Shortage/Surplus (using a per 10,000 population ratio comparison)
Current Issues/Challenges Identified from Research	This last section is gathered from a variety of sources, most of which include at least some stakeholder discussion. The main elements of this section include: ⏩ Issues regarding Quality of Work Life ⏩ Critical factors influencing demand ⏩ An interpretation of the projection results

Ad Hoc Surveys

For example: sector specific requests for information.

Annual Supply/Demand Surveys

For example: Health Workforce Template, survey of regulatory bodies titled "Survey to Health Professions".

Miscellaneous Reports as Available

For example: Ministry of Advanced Education reports, immigration reports as available through the Provincial Nominee Program or from the Ministry of Human Resources and Employment, the Canadian Occupational Projection System Forecast, Alberta's Occupational Demand and Supply Outlook produced by the Ministry of Human Resources and Employment, Physician Resource Planning Committee Reports, the Provincial CHWP, CIHI reports, Quality of Work Life Reports, etc.

For further information, call AHW at 1-780-427-0235.

Utilization and Decision-Making Frameworks

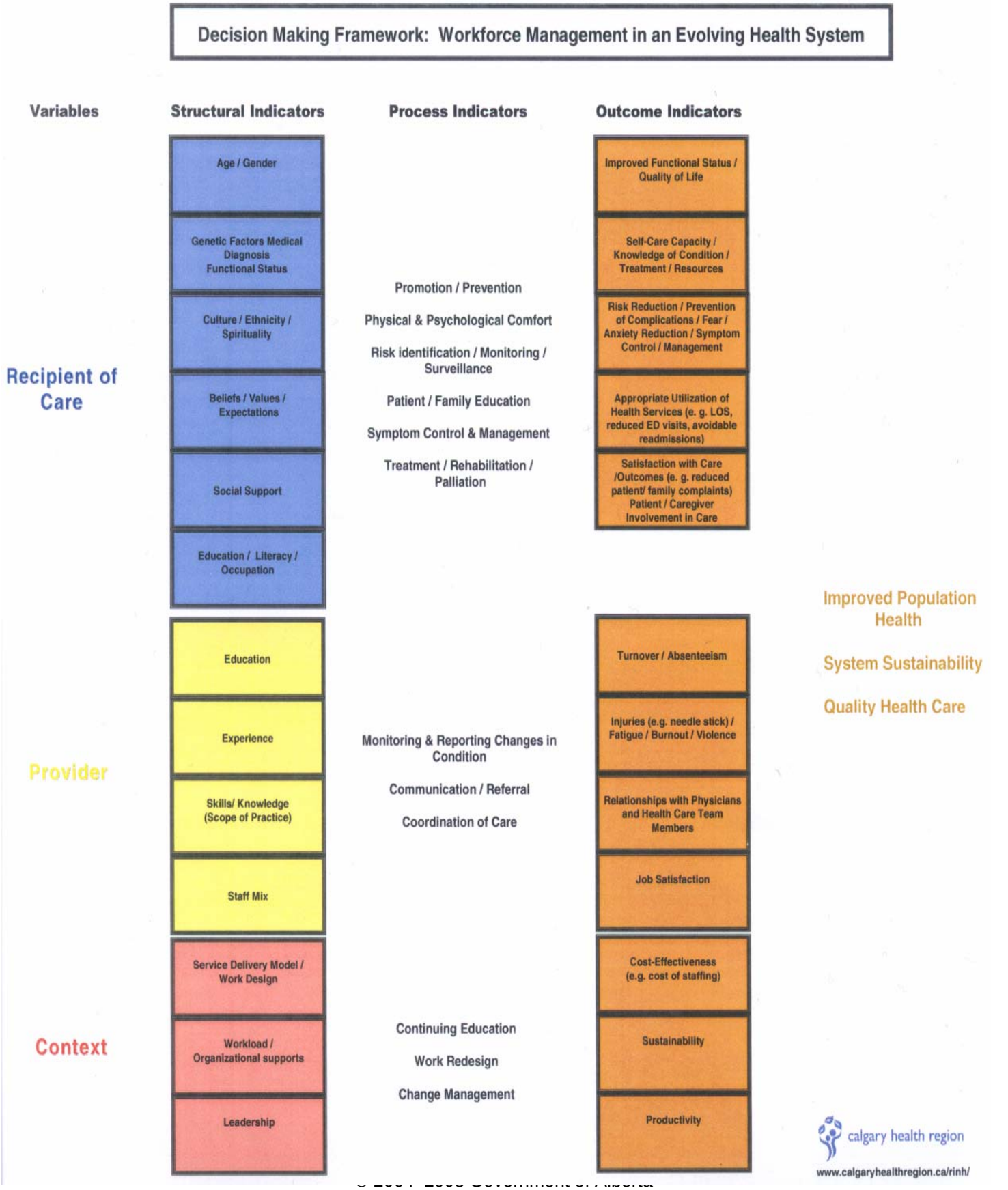
The goal of the building block "Appropriate Utilization" is to strive for effective and efficient utilization of HHR with reference to specific client group needs. The outcome is that health care services for Albertans will be provided by the most appropriate providers with reference to specific client group needs.

Significant research has been done in the Calgary Health Region to develop and implement a decision-making framework relative to optimal utilization of the workforce relative to population needs. Following is information about the Calgary Health Region decision-making framework (as of September 2005).

Components of the Calgary Health Region Decision-Making Framework:

- ***Recipient of Care:*** define the patient/client/resident population and the complexity and predictability of care needs and activities required to meet needs.
- ***Provider of Care:*** define the skills, competencies, educational preparation, legislated scope of practice, and practice standards for care providers.
- ***Context:*** assess the internal and external practice environment (including geography, public expectations etc), philosophy and model of care, and environmental supports affecting care delivery.
- ***Monitoring:*** requires determination and collection of indicators for monitoring dimensions of each of the components above.

For more information contact the Nursing Office at the Calgary Health Region or see www.calgaryhealthregion.ca/rinh/.



Standard Alberta Health Human Resource Data Set

The Health Workforce Planners' Working Group developed the HHR Data Set which were approved by the Human Resources Steering Committee. Each health authority committed to implement these within their health authority. The Data Set includes the following and are outlined in detail in Section B Tab 11 of in this Guide:

- Introduction
- Annotations
- Acronyms
- Difficult to Recruit Posting
- Employee
- Employee head count
- Employee age
- External hires
- Internal hires
- Length of service
- Length of time to fill a vacancy
- Long term disability
- Posting
- Retirement age
- Separation
- Sick leave usage
- Turnover
- Vacancy
- WCB experience

Definitions of regulated occupations and unregulated occupations are outlined in Section B Tabs 12 and 13 of this Guide.

TAB 8

Forecasting Models

To do effective HHR planning, it is important that supply and demand forecasting be conducted by partners on a continuous basis with regular data analysis and outcomes assessments. Regardless of methodology used, supply forecasting models must provide an accurate mechanism for anticipating the numbers of health professionals available now and in the future. Similarly, demand forecasting models must provide a consistent mechanism that estimates the number of health professionals required to meet future service demands.

There are currently two forecasting models being used or under development within AHW. They include:

- Physicians Forecasting Model; and
- LPN Information Strategic Planning (ISP) Initiative.

Physicians Forecasting Model

The physician supply forecasting model uses demographic factors (e.g., age group, gender, specialty, etc.) to forecast inflows (new graduates and immigration) and outflows (retirements, deaths, emigration, etc.), and applies them to the latest College of Physicians and Surgeons information to generate future numbers of physician specialties.

The current physician demand model starts with total physicians broken down by specialty and health authority. Immediate service needs and future service needs are identified in consultation with each of the health authority Medical Directors. In the future, the physician demand model methodology will use service utilization and project on the basis of demographic trends and population growth.

LPN ISP Initiative

This initiative will provide estimates of the supply of licensed practical nurses (LPN) in the medium-term (2006-2010) based on:

- annual net growth rates (i.e., combined rates of entry to and exit from the workplace);
- current supply of LPNs (based on active registration); and
- current age distribution of the current supply of LPNs.

The supply-based model utilized for this study was developed by the HHR modeling group working under the auspices of the Nursing Effectiveness, Utilization and Outcomes Research Unit, University of Toronto (O'Brien-Pallas, L., Alksnis, C., & Wang, S (2003B) Bringing the future into focus: Projecting RN Retirement in Canada).

Further information on both models is available by calling AHW at 1-780-427-3677.

Performance Measures

Performance measures are set out in the *Guide to Health Authority Accountability* document distributed annually by AHW. Health Authority Health Plans indicate how the health authority has aligned its strategic direction with the Ministry's Business Plan, what steps it will take to meet government expectations and which measures and targets will be use to assess performance.

The broad health authority "business" goals of improving human resource utilization and ongoing availability are aligned with the Ministry's goal related to workforce. The success of the health authority plans, and their component strategies, is determined through measurement of defined performance measures as set out in the *Guide to Health Authority Accountability* document.

A. Performance measures to be reported to AHW in the Health Plan based on the November 2005 *Guide to Health Authority Accountability,* include the following**:**

Area/Goal	Factors & Actions	Measures
3.7 Workforce Regions will secure and retain an adequate and appropriate supply of health care workers to meet identified health needs	**Healthy Workplaces** indicates the outcomes of actions to create workplace environments that will have a positive impact on job and professional satisfaction and safety, which in turn impact recruitment, retention and productivity. • Action: mental well-being programs are developed and delivered to health care staff. **Separation Rates**: indicates the outcomes of actions to recruit and retain sufficient numbers of health service providers to meet health service requirements.	• Comparison of individual RHA WCB premium rate to WCB industry rate for Hospitals/Acute Care Centres, Health Units and LTC Centres • Hours of sick leave usage as a percentage of total earned hours • LTD incidents per 1000 insured persons • Total number of separations (April to March) over average total employee head count as of March 31 • Number of RN separations (April to March) over total RN head count as of March 31

Results of performance measures are to be shared between health authorities.

Section B:
Health Human Resources Planning Guide for Health Authorities

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Health Human Resources Planning Guide for Health Authorities

Purpose

Albertans want timely access to high quality, effective, patient-centered, safe health services. To meet public expectations, health authorities must plan and manage their health delivery systems, including planning for the HHR required to provide care within their system.

People are the health care system's greatest asset. Alberta's health authorities' ability to provide access to high quality, effective, patient-centered and safe health services depends on the right mix of health care providers with the right skills in the right place at the right time.

HHR planning is the analysis, evaluation, forecasting and management of the supply and demand of human resources, aligning with the employer's strategic plan. Health authorities engage in HHR planning to ensure that they have the HHR they require to meet their business plan objectives of accessibility, sustainability, and quality services.

Building Planning Capacity strives for workforce planning capacity that allows planners to:

- anticipate changes in the roles of various health providers;
- build plans based on service delivery structures and on appropriate assignments of work in relation to the qualifications, skills and training of various health providers;
- anticipate trends in the workforce;
- look at changing health needs in the population; and
- evaluate health outcomes based on HHR planning decisions.

As a result, workforce planners have the ability, tools and information to research, develop, implement and execute workforce plans that ensure the optimal number, mix and distribution of health service providers. This Guide has been prepared in order to assist in achieving this goal.

HHR planning integrates with business planning and does not need to be a time-consuming and cumbersome process.

Benefits of HHR Planning

- Provides evidence based rationale for training and retraining initiatives, employee development, career counseling, and recruitment strategies.
- Provides data to inform health authorities on issues such as vacancies, separations, and demographics.
- Supports evidence based forecasting.
- Supports appropriate health human resource utilization.
- Assists in the preparation for changes in service delivery.

TAB 10

Planning Cycles

The following two tables outline the health authorities' workforce and business/financial planning cycles and illustrate some of the complexities in planning:

Health Authority Health Workforce Planning Cycle

Ad Hoc	March 30	June 30	December
Completion and submission of ad hoc Workforce Sector Surveys and Reports	Receive Health Workforce Template from AHW	Deadline for submission of Health Workforce Template (for review and utilization by AHW and HBA Services). AHW will utilize information to generate provincial reports throughout the year on supply and demand issues but in particular to generate the Annual Workforce Report	Provide input into annual Health Workforce Template contents

Initiate workforce planning data collection Template (see Tab 15, page 40)

- Discuss plans with external planners to be ready for the December 30th Business Plan

TAB 10

Health Authority Business/Financial Planning Cycle

Ad Hoc	February 28	March 31	May 15 August 15 November 15 February 15	July 31	October 31 January 31 April 30	December 30
Completion and submission of ad hoc Surveys and Reports	Three Year Plan approved (by mid-February after Ministry has met with HA to discuss Health Plan and Performance Targets)	Budget is announced (mid-March). Submit finalized One Year Business Plan (Workforce Measures required)	Submit Quarterly Performance Report to AHW (Workforce measures are not required)	Submit Annual Report (Workforce Targets required) and Quarterly Financial Report to AHW	Submit Quarterly Financial Report to AHW	Submit Three year updated Health Plan and preliminary One Year Business Plan to AHW (Workforce Measures Required)

Initiate workforce planning data collection Template (see Tab 15, page 40)

- Discuss plans with external planners to be ready for the December 30th Business Plan

TAB 11

HBA Services
Business Services for Alberta's Health Boards

Alberta's Health Workforce Planners' Group

Workforce Planning Definitions

Version 1.0 – Drafted & Approved by HRSC May 2005
Version 1.1 – Revised September 27, 2006

VERSION HISTORY

VERSION	VERSION DATE	SUMMARY OF CHANGES	CHANGES MARKED
0	2006-Jan-17	1st Draft received by HISCA	No
.1	2006-May-10	Draft with some of feedback incorporated	Yes
.1	2006-Aug-18	Revised with WPG employer representatives	No
.1	2006-Sep-27	Revised with WPG employer representatives	No

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Introduction

What is the provincial scope of this project?

- The Health Workforce Planning Group's data definitions have been designed by health authority representatives, including representatives from the Alberta Cancer Board and HBA Services. They have been identified as data definitions that should be adopted by all health authorities in Alberta. The Human Resource Steering Committee (HRSC) has reviewed and approved these definitions for use.

What are the benefits to Alberta if this becomes a provincial standard?

- Health authorities are the primary organizations that provide health care to the citizens of Alberta. Health authorities are better able to communicate and compare their needs and problems with each other when they all have confidence that information is provided based on the same assumptions. Better coordination between health authorities can help knowledge and expertise spread between organizations, with greater opportunity for shared responses or actions.

How will existing provincial standards be incorporated into this standard?

- Currently, there are no existing provincial standards with regards to HHR calculations. These definitions are a first step towards health authorities defining a standardized approach to human resource communication and measurement.
- "Health Workforce" refers to the general pool of individuals who have trained and are employed in health occupations. When health authorities representatives speak of the health workforce, they are generally implying the health professions that their health authority(s) employs to deliver service.

What types of data does the standard cover and why (business requirements)?

- These standards identify definitions that are frequently used by human resource planners/managers in the course of their work in health authorities. They also identify standardized methods of calculating values for comparison between health authorities. Better coordination between health authorities can help knowledge and expertise spread between organizations, with greater opportunity for shared responses or actions.

Who has contributed/participated in the work to date?

- The Health Workforce Planners' Group membership has contributed to the discussion and development of these data definitions.
- Regional representatives have acted as the primary contributor.

How was the standard developed, i.e. process?

- Consultation amongst the regional representatives occurred over a few months, at the end of which the data definitions were developed. These were then presented to the HRSC, which approved them for use among the health authorities. Approval through the Health Information Standards Committee for Alberta (HISCA) will standardize their use in human resource planning throughout health authorities and Ministry functions in the province.

Privacy Impact Assessment (PIA) status:

- Not applicable.

Data Elements

Annotations

Active Employee: an employee currently employed**.**

Calendar Day: includes all days of the week from Monday to Sunday.

Date: written as DD/MM/YYYY.

Employees are engaged by employers and have an explicit (written or oral) or implicit employment contract as determined by the Canada Revenue Agency.

Employers are individuals/groups/organizations who have engaged one or more persons to work for them as "employee(s)". Employers have a "contract of service" with their employees whereby the employee agrees to work for the employer for either a specified or indeterminate period of time, and is remunerated for the services provided. (Canada Revenue Agency, T4001. Employers Guide – Payroll Deductions and Remittances).

Full-time Employment: as defined by the collective agreement or terms and conditions of employment.

Number of Days: includes both the first (e.g., first day posting is open) and last (e.g., day the competition actually closed) dates.

One Year: constitutes 365.25 days.

Percentage: a way of expressing a proportion, a ratio or a fraction as a whole number by using one hundred as the denominator.

Position: role occupied by an employee for a wage.

Rate: a quantity or amount or measure considered as a proportion of another amount of measure (e.g., at a rate of $3.00 per/hour).

Ratio: quantitative relation between two similar magnitudes determined by the number of times one contains the other integrally or fractionally (e.g., the ratio of 1:3).

Reporting Period: typically April 1 to March 31 but may vary as required. Caution: formula calculations are based on annualized data.

Wage: amount of money paid for some specified quantity of labour**.**

Acronyms

DOB: Date of Birth

FTE: Full-Time Equivalent

LAPP: Local Authorities Pension Plan

LOA: Leave of Absence

LTD: Long-Term Disability

OT: Occupational Therapist

ROE: Record of Employment

STD: Short-Term Disability

WCB: Workers' Compensation Board

Posting

Any notice of an employer's available regular or temporary full-time/part-time employment opportunity. Excludes casual postings.

Difficult to Recruit Positions

A Length of Time to Fill a Vacancy posting which is greater than 60 calendar days.

Formula - Percentage of Difficult to Recruit Positions

All postings taking greater than 60 calendar days to close in the reporting period	Plus	Number of postings closed after greater than 60 calendar days	Divide by	Total number of postings closed within the reporting period	Equals	Percentage of difficult to recruit positions
40	+	15	/	1000	=	**5.5%**

Employee

A person employed by the employer.

- **Regular Full-Time:** one who works full-time on a regularly scheduled basis.
- **Regular Part-Time:** one who works less than full-time on a regularly scheduled basis.
- **Casual:** One who works on a call-in basis and is not regularly scheduled.
- **Temporary Full-Time:** one who works for a fixed time period or on a temporary full-time basis where there is an absent incumbent (e.g., on maternity leave, LTD, WCB, sick leave, etc.) or need for temporary work (i.e., projects, increase in workload, seasonal etc.) requires to be back-filled. There may, or may not, be a fixed end date.
- **Temporary Part-Time:** one who works for a fixed time period or on a temporary part-time basis where there is an absent incumbent (e.g., on maternity leave, LTD, WCB, sick leave, etc.) or need for temporary work (i.e., projects, increase in workload, seasonal etc.) requires to be back-filled. There may, or may not, be a fixed end date.

Employee Head Count

- **Total Employee Head Count:** all individuals considered employees of the employer on a specific day. Employees with multiple positions will be counted once. Employee Head Count figures are not FTE figures. Total employee head count includes:
  - regular/temporary full-time and part-time employees;
  - casual and relief employees;
  - individuals on authorized leaves of absence (i.e., WCB, STD, LTD, etc.); and
  - seasonal and student employees if they receive T4s.
- **Total Regular Full-Time Employee Head Count:** all individuals considered regular full-time employees on a specific day. Regular full-time employees employed in more than one position will be counted once. Do not include regular part-time, temporary, or casual employees and independent contractors.
- **Total Regular Part-time Employee Head Count:** all individuals considered regular part-time employees on a specific day. Regular part-time employees employed in more than one position will be counted once. Employees include only regular part-time employees. Do not include regular full-time, temporary, or casual employees and independent contractors.
- **Total Active Employee Head Count:** all individuals considered active employees on a specific day. Active employees employed in more than one position will be counted once. Employees include only active employees. Do not include persons on authorized leave.

Employee Age

The age of an employee at a point in time.

Average Employee Age
Calculated by dividing the sum of all employees' ages (measured in years) by the total number of employees employed by the employer at a point in time.

Example: An employer has four employees with the following DOBs:

Employee 1 12/10/1970	Employee 2 03/02/1946	Employee 3 14/08/1964	Employee 4 29/09/1979

Current date – 31/03/2005

Formula – Average Employee Age				
Sum of the difference between the current date and each employee's DOB	**Divide by**	**Total Employee head count in sample**	**Equals**	**Average employee age**
{[(31/03/2005)-(12/10/1970)] + [(31/03/2005)-(03/02/1946] + [(31/03/2005)-(14/08/1964)] + [(31/03/2005)-(29/09/1979)]}	/	4	=	**39.94**

External Hires

The number of persons hired who were not already employees of the employer during the reporting period expressed as a rate per 100 (percent) of the total employee head count at end of reporting period.

External Hire Percentage

Example:
An employer has a total employee head count of 500 on March 31, 2009. Over the reporting period there are five external hires.

Formula – External Hire Percentage				
Total number of new hires during the reporting period	**Divide by**	**Total employee head count at end of reporting period**	**Equals**	**External hire percentage**
Reporting period – Fiscal Year 2004, 3rd Quarter (i.e., October 1 to December 31, 2004)				
5	/	500	=	**1.00%**

Internal Transfer

A change from one job to another within an employer.

Internal Transfer Percentage
The number of internal transfers in a reporting period expressed as a rate per 100 (percent) of the Total Employee Head Count.

Example:
An employer has a Total Employee Head Count of 17 OTs. Two OTs leave their full-time positions and another retires from a full-time position. Two part-time OTs take the vacated full-time positions and one casual OT takes the part-time position. A temporary employee moves into the retiree's full-time regular position.

Formula – Internal Transfer Percentage				
Total number of internal transfers during the reporting period	**Divide by**	**Total employee head count at end of reporting period**	**Equals**	**Internal transfer percentage**
2 + 1 + 1 = 4	/	17	=	**23.53%**

Length of Service

The difference between an employee's hire date with the employer and the last day of the reporting period. This date reflects continuous employment with a specific employer, inclusive of approved LOAs:

Formula – Length of Service				
Employee's hire date	**Minus**	**End of reporting period**	**Equals**	**Length of service**
05/10/1999	-	31/03/2005	=	**5.40 years**

Average Length of Service

The total Length of Service of all employees at end of reporting period divided by the Total Employee Head Count at end of reporting period. This reflects continuous employment with a specific employer, inclusive of approved LOAs:

Formula – Average Length of Service				
Total length of service (in years) of all employees	**Divide by**	**Total employee head count**	**Equals**	**Average length of service**
10,000 years	/	500	=	**20.0 years**

Length of Time to Fill a Vacancy

The number of calendar days between the day the posting was originally opened and the day the posting closed. The posting is considered closed when a candidate has accepted the position. Re-postings (same posting as original posting but with new dates) are considered from their original date.

Formula – Length of Time to Fill a Vacancy				
Date posting was originally opened	**Minus**	**Date posting closed**	**Equals**	**Length of time to fill a vacancy**
01/09/2004	-	01/02/2005	=	**153 days**

Average Length of Time to Fill a Vacancy
The sum of the number of calendar days between the day the posting was open and the day the posting closed for each posting divided by the total number of postings over the reporting period.

Formula – Average Length of Time to Fill a Vacancy per Classification				
The sum of the number of calendar days between the day the posting was open and the day the posting closed for each posting (01/04/2004 – 31/03/2005)	**Divided by**	**Total number of postings over the reporting period. (01/04/2004 – 31/03/2005)**	**Equals**	**Average length of time to fill a vacancy per classification**
Posting for Physical Therapist I: 34 days Posting for Physical Therapist III: 62 days Posting for Physical Therapist I: 21 days Posting for Physical Therapist I: 15 days Posting for Physical Therapist II: 19 days Sum 155 days	/	5 postings	=	**31 days**

Formula – Average Length of Time to Fill a Vacancy – Difficult to Recruit Positions				
The sum of the number of calendar days between the day the posting was open and the day the posting closed for each difficult to recruit position posting (01/04/2004 – 31/03/2005)	**Divided by**	**Total number of postings over the reporting period (01/04/2004 – 31/03/2005)**	**Equals**	**Average length of time to fill a vacancy – difficult to recruit positions**
Posting for Physical Therapist I: 65 days Posting for Physical Therapist III: 63 days Posting for Physical Therapist II: 175 days Sum 303 days	/	3 postings	**=**	**101 days**

Note: Roman numeral numbers I, II and III represent Physical Therapists classification levels in collective agreements.

Retirement Age

The age of an employee on his/her date of retirement.

Factors which may indicate retirement: There is no compulsory retirement age for employees. Typically, the employee's ROE will indicate the reason for termination is G: "Retirement". A person must have two years of plan participation to be eligible to receive a pension from the LAPP. In addition, an employee is considered to have retired if they are at least 55 years of age and they have no continuing employment relationship with the employer once terminated from the organization.

Average Retirement Age
The sum of all regular/temporary full-time/part-time retiring employees' age(s) at their date of retirement, divided by the total number regular/temporary full-time/part-time employees who retired within the reporting period. Average Retirement Age may also be calculated per classifications (i.e., Registered Nurses, Physical Therapists, Occupational Therapists, etc.):

Formula – Average Retirement Age				
Sum of all regular/temporary full-time/part-time retiring employees' ages(s) at their date of retirement within the reporting period	**Divide by**	**Total number of regular/ temporary full-time/part-time employees who retired within the reporting period**	**Equals**	**Average retirement age**
690	/	12	=	**57.50**

Separation

Occurs when an employee voluntarily terminates employment from the organization for any reason or when an employee is terminated from the organization, including layoffs. Includes casuals.

Separation Percentage
The total number of employees leaving the employment of the employer for any reason in the reporting period expressed as a rate per 100 (percent) of the Total Employee Head Count.

Example:
An employer has a Total Employee Head Count of 17 OTs. Two OT employees leave the employer in 2002/03 and one person retires.

Formula – Separation Percentage				
Total number of employees who have left the employer	**Divide by**	**Total employee head count**	**Equals**	**Separation percentage**
2+1 = 3	/	17	=	**17.65 %**

Turnover

The total number of separations plus the number of internal transfers.

Turnover Percentage
The total number of separations plus the total number of internal transfers expressed as a rate per 100 (percent) of the total employee head count:

Formula – Turnover Percentage						
Number of separations	**Plus**	**Number of internal transfers**	**Divide by**	**Total employee head count**	**Equals**	**Turnover percentage**
4	+	3	/	17	=	**41.18%**

Vacancy

A position, not including casual, is vacant when the employer creates a posting and intends to fill the position.

Vacancy Percentage
The total number of postings not closed over the reporting period expressed as a rate per 100 (percent) of the total number of postings. Do not include casual position postings.

Example:
An employer posted 120 postings and filled 100 in 2003/04.

Formula – Vacancy Percentage						
Total number of postings (excluding casuals) in the reporting period	**Minus**	**Total number of postings closed**	**Divide by**	**Total number of postings (excluding casuals) over the reporting period**	**Equals**	**Vacancy percentage**
120	-	100	/	120	=	**16.67%**

Workforce Planning

The analysis, evaluation, forecasting and management of the supply and demand of human resources in alignment with the employer's strategic plan.

TAB 12

Definitions: Regulated Occupations

(Definitions determined as per the *Health Professions Act*)

Status information provided as of May 16, 2006. Please confirm each profession's status on their college's website.

REGULATED OCCUPATIONS

1. Licensed Practical Nurse (LPN) – Proclaimed 2003

In their practice, LPNs do one or more of the following:

(a) apply nursing knowledge, skills and judgment to assess patients' needs;
(b) provide nursing care for patients and families; and
(c) provide restricted activities authorized by the regulations.

Advanced training:

- Orthopedic Specialty
- Dialysis Specialty
- Advanced Foot Care & Operating Room Specialty

2. Medical Laboratory Technologist (MLT) – Proclaimed 2002

In their practice, MLTs do one or more of the following:

(a) collect and analyze biological samples, perform quality control procedures and communicate results that have been critically evaluated to ensure accuracy and reliability;
(b) teach, manage, and conduct research in the science and techniques of medical laboratory technology; and
(c) provide restricted activities authorized by the regulations.

3. Medical Radiation Technologist (MRT) – Proclaimed 2005

In their practice, medical diagnostic and therapeutic technologists do one or more of the following:

(a) apply ionizing radiation and other forms of energy to produce diagnostic images;
(b) evaluate the technical sufficiency of the images;
(c) use ionizing radiation and other forms of energy for treatment purposes;

(d) take part in patient care through interdisciplinary, peer and public education, patient counseling, radiation protection, management and research related to matters described in this subsection; and

(e) provide restricted activities authorized by the regulations.

4. Occupational Therapist (OT) – Pending

In their practice, OTs do one or more of the following:

(a) in collaboration with their clients, develop and implement programs to meet everyday needs in self care, leisure and productivity;
(b) assess, analyze, modify and adapt the activities in which their clients engage to optimize health and functional independence;
(c) interact with individuals and groups as clinicians, consultant researchers, educators and administrators; and
(d) provide restricted activities authorized by the regulations.

5. Pharmacist – Pending

In their practice, pharmacists promote health and prevent and treat diseases, dysfunction and disorders through proper drug therapy and non-drug decisions and, in relation to that, do one or more of the following:

(a) assist and advise clients, patients and other health care providers by contributing unique drug and non-drug therapy knowledge on drug and non-drug selection and use;
(b) monitor responses and outcomes to drug therapy;
(c) compound, prepare and dispense drugs;
(d) provide non-prescription drugs, blood products, parenteral nutrition, health care aids and devices;
(e) supervise and manage drug distribution systems to maintain public safety and drug system security;
(f) educate clients, patients and regulated members of the Alberta College of Pharmacists and of other colleges in matters described in this section;
(g) conduct or collaborate in drug-related research;
(h) conduct or administer drug and other health-related programs; and
(i) provide restricted activities authorized by the regulations.

6. Physiotherapist (PT) – Pending

In their practice, physical therapists do one or more of the following:

(a) assess physical function;
(b) diagnose and treat dysfunction caused by a pain, injury, disease or condition in order to develop, maintain and maximize independence and prevent dysfunction; and
(c) provide restricted activities authorized by the regulations.

7. Registered Nurse (RN) – Proclaimed 2005

In their practice, RNs do one or more of the following:

(a) based on an ethic of caring and the goals and circumstances of those receiving nursing services, registered nurses apply nursing knowledge, skills and judgment to:
  (i) assist individuals, families, groups and communities to achieve their optimal physicals, emotional, mental and spiritual health and well-being;
  (ii) assess, diagnose and provide treatment and interventions and make referrals;
  (iii) prevent or treat injury and illness;
  (iv) teach, counsel and advocate to enhance health and well-being;
  (v) coordinate, supervise, monitor and evaluate the provision of health services;
  (vi) teach nursing theory and practice;
  (vii) manage, administer and allocate resources related to health services;
  (viii) engage in research related to health and the practice or nursing; and
(b) provide restricted activities authorized by the regulation.

8. Registered Psychiatric Nurse (RPN) – Proclaimed 2005

In their practice, RPNs apply nursing knowledge and skills and judgment and do one or more of the following:

(a) work with individuals of all ages, families, groups and communities;
(b) assess and help address physical, mental, emotional and spiritual health needs;
(c) develop diagnoses and plan, implement and evaluate nursing care and make referrals;
(d) teach, counsel, and advocate to enhance health and well-being;
(e) coordinate, supervise, monitor and evaluate the provision of health services;
(f) teach nursing theory and practice;
(g) manage, administer and allocate resources related to health services;
(h) engage in research related to health and the practice of nursing; and
(i) provide restricted activities authorized by the regulations.

9. Respiratory Therapist (RT) – Pending

In their practice, RTs do one or more of the following:

(a) provide basic and advanced cardio-respiratory support services to assist in the diagnosis, treatment and care of persons with cardio-respiratory and related disorders; and
(b) provide restricted activities authorized by the regulations.

10. Speech Language Pathologist (SLP) – Proclaimed 2002

In their practice, SLPs do one or more of the following:

(a) assess, diagnose, rehabilitate and prevent communication and oral motor and pharyngeal dysfunctions and disorders;
(b) teach, manage and conduct research in the science and practice of speech-language pathology; and
(c) provide restricted activities authorized by the regulations.

11. Audiologist – Proclaimed 2002

In their practice, audiologists do one or more of the following:

(a) assess auditory and vestibular function and diagnose, rehabilitate, prevent and provide appropriate devices and treatment for auditory and vestibular dysfunction;
(b) teach, manage and conduct research in the science and practice of audiology; and
(c) provide restricted activities authorized by the regulations.

TAB 13

Definitions: Unregulated Occupations

The following is a list of definitions approved by the HRSC, but is not intended to be a comprehensive listing of all unregulated occupations.

UNREGULATED OCCUPATIONS

Perform restricted activities only with the consent of, and under the supervision, of a regulated member, in accordance with the regulations of the regulated member's college.

1. Diagnostic Medical Sonographer (DMS)

In their practice DMSs do one or more of the following:

(a) operate diagnostic ultrasound imaging equipment that transmits high frequency sound waves through the body to produce images;
(b) optimize the ultrasound equipment during the examination to ensure quality and consistency of diagnostic images;
(c) observe and care for patients throughout examinations to ensure patient safety and comfort;
(d) prepare interpretative reports for physicians to aid in the diagnosis of cardiac, obstetrics/gynecological, abdominal, vascular, ophthalmic and other disease states; and
(e) routinely perform quality assurance to ensure proper system performance.

2. Health Care Aide (HCA)

(a) HCAs is the generic term for non-professional, entry-level, direct service providers in the health industry who provide personal support and basic health services to clients of the continuing care sector.
(b) The defining characteristic of HCAs is the job requirement that they provide basic health services as well as support with activities of daily living, mobility and grooming for clients who medical conditions or major functional limitations.
(c) Thus, unregulated support workers whose primary job responsibilities are to provide meal planning and preparation services or leisure and recreation services are not HCAs.
(d) The distinction between health care aides and other support workers is important because the services provided by health care aides pose a greater risk to the patient than the services provided by other support workers. HCAs provide services for Albertans with diverse health needs including:
    (i) individuals with acute illnesses;
    (ii) individuals requiring end-of-life (palliative) care;
    (iii) individuals with complex, chronic medical conditions; and

(iv) individuals with physical/cognitive disabilities or functional deficits (in the activities of daily living).

3. Orthopotic

A paramedical profession recognized by its education and training to provide a wide range of activities within Ophthalmology. Specializes in:

(a) the detection and management of strabismus (crooked eyes);
(b) pediatric vision screening and assessment; and
(c) management in stable glaucoma/ocular hypertension.

4. Pharmacy Technician

In their practice, pharmacy technicians under a pharmacist's supervision, do one or more of the following:

(a) compounding, preparing and dispensing medications;
(b) managing drug acquisition and distribution systems;
(c) participating in drug-related research and health-related programs; and
(d) providing restricted activities in accordance with the regulation.

5. Perfusionist

In their practice, perfusionists do one or more of the following:

(a) manage the heart/lung equipment:
  (i) extracorporeal circulation, cardiopulmonary bypass, and blood conservation; and
  (ii) extracorporeal life support, and orthopedic and vascular surgery.

6. Recreation Therapist (RT)

In their practice, RTs do one or more of the following:

(a) develop programs to assist person with disabilities plan and manage their leisure activities; and
(b) schedule specific activities and coordinate programs with existing community resources.

TAB 14

Getting Started on Health Human Resources Planning

Build Support

Gaining and maintaining management and staff commitment to the HHR planning process is key to developing an effective HHR plan. Health authorities can use the following techniques to build support for the HHR process:

- Automate the process so data can be easily stored and retrieved, thereby simplifying the process. The more simple the process is, the more participation and acceptance health authorities will have from those who are participating in the process.
- Obtain support from senior leaders within the health authority. It is important that senior leaders understand the value of health HHR; their commitment can determine its success or failure. Understanding the factors that affect the health authorities future operations will help convince senior leaders of the need for HHR planning.
- Communicate benefits and results of HHR planning to managers and workers. Management should be involved in understanding the link between health human resources plans and the budget, and workers need to understand how HHR planning affects them and the health authority.
- Establish a HHR planning team consisting of dedicated and knowledgeable employees from different functional areas and organizational levels. Trust for the HHR plan can be achieved by involving employees in the planning process.
- Develop and implement a plan to ensure accountability throughout the health authority. This will help ensure success of the strategies within the plan and identify accountabilities of those participating.
- Solicit continuous feedback for improvements to the process. The HHR planning process should be continually reviewed and refined to ensure effectiveness and continuous improvement.

Take Some Important First Steps

The capacity to perform effective HHR planning will take time to develop. Regardless of how complex or simple, a health authority decides the HHR planning process should be, HHR planning will require a variety of input from cross-functional areas and levels within the organization. It is critical to begin carefully and not take on too much too soon. Health authorities might find it helpful to begin planning for a subset of the health human resources and then extend HHR planning through the remainder of the organization.

Before starting HHR planning, it is necessary to:

- clearly understand the purpose of HHR planning;
- determine the timeframe;
- identify the resources available;
- adapt models, strategies, tools, and processes specific to the health authority's culture and needs; and
- identify planning outputs that are meaningful to the organization and that support health authority objectives, budget requests, staffing requests, and strategic plans.

It is recommended the **HHR Planning Questionnaire (see Tab 16, page 54)** be utilized in the annual planning process. Health authorities can, of course, supplement this questionnaire with more detailed plans.

Sample HHR Plan Outline - (See Tab 15 for Diagram of this Outline)

Phase I

1. Organizational Strategic Direction.
   - (a) Introduction
   - (b) Organizational goal
   - (c) Other

Phase II

2. Analyze supply: determine current workforce profile.
   - (a) Demographics:
     - (i) Age
     - (ii) Gender
     - (iii) Other
   - (b) As of March 31
   - (c) Status of employment:
     - (i) Full-time/part-time/casual/temporary
   - (d) By location
   - (e) By unit
   - (f) Other

(g) Potential supply information:

(i) Alberta graduates

(ii) Immigration

(iii) Other

3. Analyze demand: develop future workforce profile.

(a) Where are we going:

(i) Business plans

(ii) Data collection template

(iii) Long-range capital expansion plan

(iv) Other

(b) Health goals:

(i) Strategic

(ii) Operational

(iii) AHW

(iv) Population health

(v) Other

4. Analyze gap: Identify discrepancy between supply and demand analyses.

(a) By occupational group as per Health Workforce Template:

(i) Unionized

(ii) Non-unionized

(iii) Out of scope

(b) Indicators:

(i) Retirement age

(ii) Separations

(iii) Other

(c) Trends:

(i) Demographics

(ii) New hires

(iii) Separations

(iv) Other

(d) Time span:

(i) Past (subject to availability of data)

(ii) Present

(iii) Projected (e.g., 1,3,5,10 yrs.)

5. Develop strategy: recommend solutions to reduce shortages and surpluses in the number of staff and needed skills.

(a) Local/Provincial:

(i) Bursaries

(ii) Relocation bonus

(iii) Supernumerary positions

(iv) Increase post-secondary seats

(v) Promote health careers

(vi) Develop partnerships with educational institutions

(vii) Other

Phase III

6. Implement HHR plan

(a) Communicate HHR plan

(b) Implement strategies to reduce gaps and surpluses

Phase IV

7. Monitor, Evaluate and Revise

(a) Measure

(b) Local/provincial:

(i) Analyze strategy effectiveness

(c) Revisit Phase I-III:

(i) Assess what's working and what's not working.

(ii) Make adjustments to the plan

(iii) Address new organizational issues that affect the workforce

(d) Linking the HHR plan to the Health Authority Business Plan

TAB 15

The Health Human Resources Planning Model

Many organizations have developed models for HHR planning. Except for variations in terminology and the order of the processes, all models are very much alike. Health HHR planning can be conducted in many ways depending on the requirements of a health authority; therefore, the order and phases used may vary.

Human Resources Planning Model

Phase I
Set Organization Strategic Direction

Determine the future functional requirements of the workforce through the program's strategic planning and budgeting process.

Phase II
Conduct Workforce Analysis

- Analyze supply: determine current workforce profile.
- Analyze demand: develop future workforce profile.
- Analyze gap: Identify discrepancy between supply and demand analyses.
- Develop strategy: recommend solutions to reduce shortages and surpluses in the number of staff and needed skills.

Phase III
Implement Human Resources Plan

- Communicate HHR plan.
- Implement strategies to reduce gaps and surpluses.

Phase IV
Monitor, Evaluate and Revise

- Assess what's working and what's not working.
- Make adjustments to the plan.
- Address new organizational issues that affect the workforce.

Phase I: Determine Health Authority Strategic Plan

Workforce planning is integral to and compliments strategic planning. Just as strategic planning helps health authorities map where they are, where they are going, and how they plan to get there, a HHR plan lays out the specific tasks and actions needed to inform the health authority about the human resources required to accomplish its mission.

One of the main purposes of HHR planning is to inform the health authority about the required human resources to support its mission and strategic plan. In Phase I, those responsible for HHR planning should identify the health authority's mission and the key goals and objectives of its strategic plan.

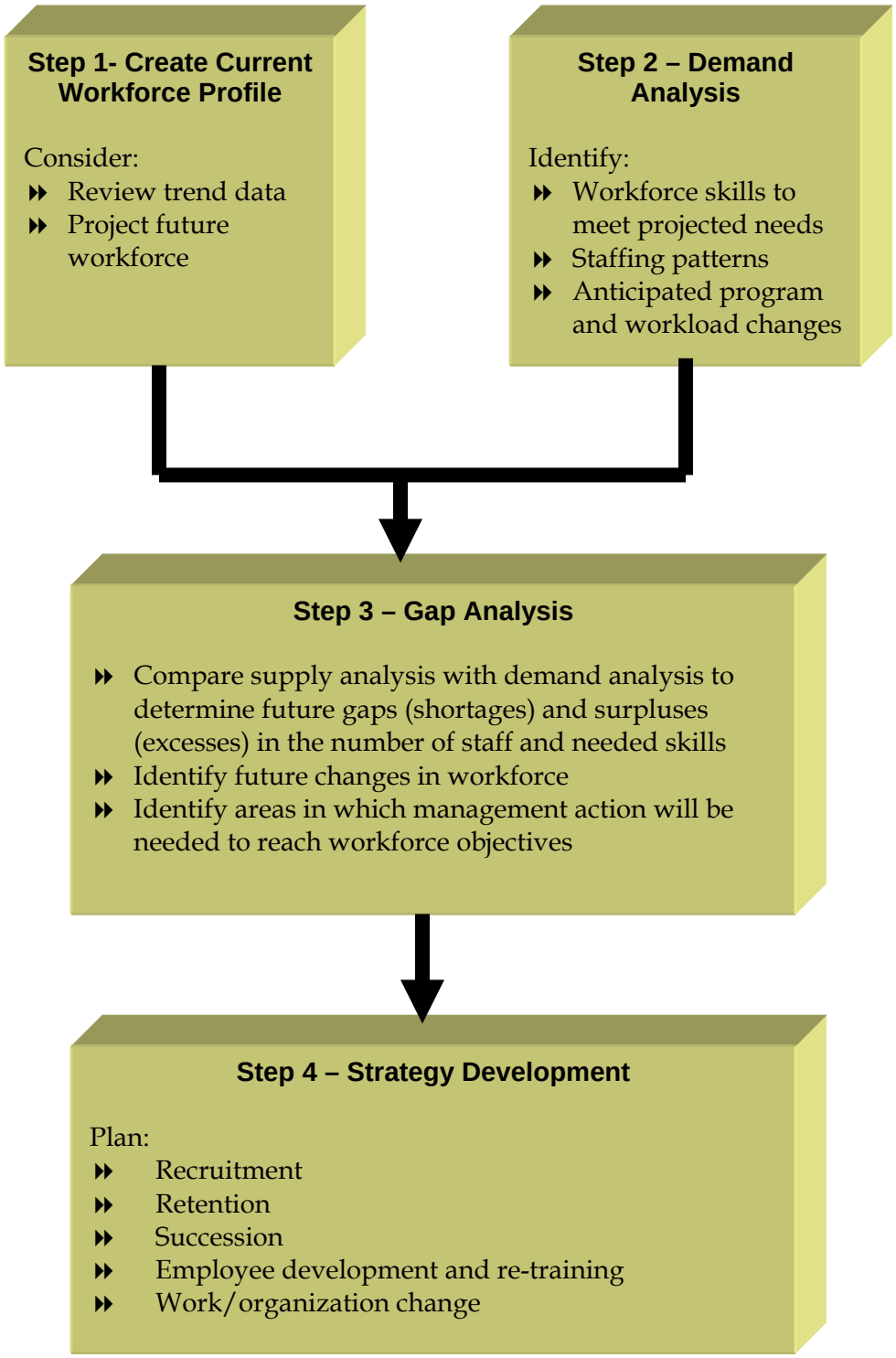
A strategic plan charts the future with broad mission-related targets and milestones. A health authority's vision, mission, and measurable goals and objectives drive the identification of what type of work needs to be accomplished. A HHR plan translates strategic thinking into concrete action in the area of staffing and training needs. It attempts to answer the following questions:

- How many and what types of jobs are needed in order to meet the performance objectives of the health authority?
- How will the health authority develop worker skills?
- What strategies should the health authority use to retain these skills?
- How will fluctuations in the workforce affect your health authority's ability to get the work done?

Phase II: Conduct Workforce Analysis

Analysis of workforce data is the key element in the HHR planning process. Workforce analysis frequently considers information such as occupations, skills and experience, retirement eligibility, diversity, turnover rates, and trend data.

There are four key steps to the workforce analysis phase of the planning model:



Step 1: Create Current Workforce Profile (Supply Analysis)

Supply (as defined in the LPN Supply Forecasting Model) is the number of individuals within a particular health discipline who are actively involved in the provision of health services to clients/patients. Hours worked per time period (full-time, part-time, casual hours) varies among those active in the provision of health care. The FTE supply (i.e., the supply expressed in terms of FTEs) can be derived by dividing total hours of care provided by individuals active in the provision of health care during a particular time period by the known or assumed standard full-time hours.

Supply analysis focuses on the specifics of a health authority's existing workforce **and** projects future workforce supply. This step involves:

- creating a current workforce profile;
- reviewing trend data; and
- projecting future workforce supply.

Creating a current workforce profile of its existing workforce helps a health authority understand where it is in terms of the right number of people with the right skills. Analysis of the current workforce could include:

- number of employees and contracted workers by headcount and FTE.
- skill assessment of employees.
- salary and contract workforce expenditure data.
- workforce diversity (age, gender).
- retirement eligibility statistics; and
- location.

- Do you want need additional definitions?
- Example of a monthly profile?
- Best Practices

Next, health authorities should look at indicators, which provide a picture of what occurred in the past. It can also help a health authority predict the supply of skills that may be available in the future. Examples of indicators include:

- hiring patterns (time required to fill vacancies, average number of vacancies in a year, etc.).
- retirement patterns. and
- employee turnover statistics.

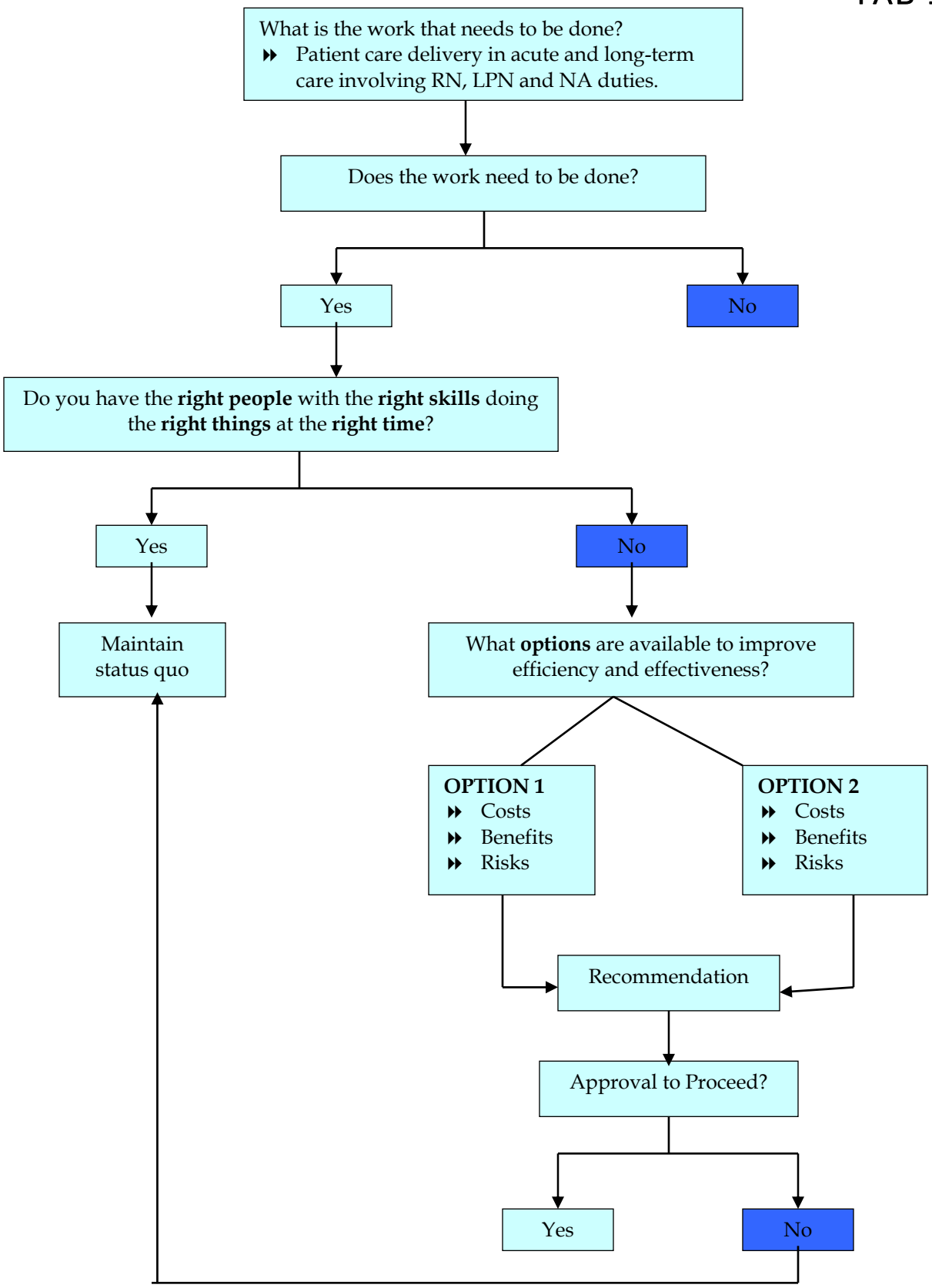
It may be helpful to break down the indicator analysis by health authority divisions or by occupational groups. Looking at indicators will help a health authority project future workforce supply. It will also help a health authority apply assumptions about how the variables such as those listed above will influence the future workforce. Indicator information combined with the current workforce profile is an essential building block for projecting future health authority workforce supply.

Step 2: Demand Analysis

Demand analysis identifies the human resources needed to carry out the mission of a health authority. The focus of this step should be on the *skill sets of employees, job responsibilities and service delivery model.* This step may provide one of the greatest benefits in HHR planning because it offers the chance for a health authority to re-examine long-standing assumptions about the purpose and direction of its programs in light of changes that are taking place in the external and internal environment. Results include a future projected demand of the numbers of employees needed in the future (for example, 1 to 5 years out) and the skills workers will need.

The chart on the next page provides you with a patient care delivery flowchart that may assist you in making appropriate staff determinations.

TAB 15



TAB 15

Two ways to determine future requirements are through *environmental scanning* and *organizational analysis*.

Environmental scanning is the process of examining external trends to obtain a better understanding of what is happening in the environment in which the health authority operates. There are several approaches to environmental scanning. The scan should include population-based trends and issues in the economic, social, technological, geographical and political areas.

An ***organizational analysis*** considers the changing composition of the workforce and shifting work patterns including demographics, diversity, outsourcing, and growing and vanishing occupations. It should also include internal factors such as strategic objectives, service and program delivery changes and technology.

A Demand Analysis Template may assist you in gathering this information from your organization. The template on the next page provides you with a sample for reference.

TAB 15

Sample Demand Analysis Template

Human Resource Forecast April 1, 2006 - March 31, 2009. Service &/or Physical Space Changes

Factors Having Human Resource Implications	Dept/ Site	Target Date	Details	Classification Impacted	FTE Impact	Position Break Down	
						FT	PT
Expansion or reconfiguration of existing services or new services/new beds							
De-emphasis or discontinuance of services							
Additional coverage/hours							
Change in skill mix or new roles							
Staff to Patient Ratios							
New Wing/Facilities							
Other							
Comments							

TAB 15

Internal Analysis

Pressures Due to Staffing Changes With Existing FTE's	Area	Est. Date	Details	Classification Impacted	FTE Impacted		
Employees eligible for retirement (55+) in current year							
Maternity Leaves							
Long Term Disability							
Personal LOA & Educational LOA							
Secondments							
Comments:							

TAB 15

Recruitment

	Area	Est. Date	Details	Classification Impacted	FTE Impacted		
Current Vacancies							
Upcoming Recruitment opportunities							
Comments:							

Once the "what" and "how" of future work are determined, the next step is to identify the skills employees need to carry out that work. The future workforce profile shows the number of workers and the set of worker skills needed for the health authority's future workforce.

Supply forecast (i.e., the size of the pool from which you can recruit) for a certain type of worker in the year 2008 is 2000.	⟷ Gap is an under-supply of 400 of these workers. How can/will the gap be closed?	Demand projection (i.e., the number of workers required to do the work) is that the health system in 2008, will require 2400 of these workers.

The role of AHW in supply and demand forecasting is to determine the provincial HHR supply, match that against the provincial demand forecast, outline the provincial gap and formulate recommendations for closing the provincial gap.

Step 3: Gap Analysis

Gap analysis is the process of comparing the workforce supply projection to the workforce demand projection. An analysis should consider the composition of the workforce, including skill sets of employees, job responsibilities and service delivery model. The health authority will establish workforce strategies based on the results of this analysis. Analysis results will show one of the following:

- A **gap** (when projected supply is less than projection), which indicates a future shortage of needed health human resources or skills.
- A **surplus** (when projected supply is greater than projection), which indicates a future excess in some categories of workers and may require action. The surplus data may represent occupations or skills that will not be needed in the future or at least not needed to the same extent.

Step 4: Strategy Development

The final step in the workforce analysis phase involves the development of strategies to address future gaps and surpluses. Strategies include the programs, policies, and practices that assist health authorities in recruiting, developing, and retaining the critical staff needed to achieve program goals. A wide range of strategies exists for attracting and/or developing staff with needed skills and dealing with human resources or skills no longer needed in a health authority.

Identify outcome measures to evaluate?

Once a health authority identifies a workforce gap, it needs to develop and implement effective strategies to fill the gap. Such strategies may include recruitment, contract workers, staff training, and succession planning. Critical gaps should be analyzed with care to ensure that timely action is taken before these gaps become a problem for the organization.

Several factors influence which strategy or, more likely, which combination of strategies should be used. Some of these factors include, but are not limited to, the following:

- **Time** - Is there enough time to develop staff internally for anticipated vacancies or new skill needs, or is special, fast-paced recruitment the best approach?
- **Resources** - What resources (e.g., technology, Web sites, structured templates, and sample plans) are currently available to provide assistance, or must resources be developed?
- **Internal depth** - Does existing staff demonstrate the potential or interest to develop new skills and assume new or modified positions, or is external recruitment needed?
- **"In-demand" skills** - What competition exists for future skills that are needed? Will the health authority need to recruit for these skills or develop them internally?
- **Job classification** - Do presently used job classifications and position descriptions reflect future responsibility requirements and skills?
- **Reorganization -** Will some services need to be reorganized to meet business needs and strategic objectives?

Phase III: Implement Human Resources Plan

Implementation brings your HHR plan to life. You may need a separate action plan to address the implementation of each strategy in the HHR plan. Before implementing the plan, workforce planners should:

- Ensure that there is executive support for the plan.
- Allocate necessary resources to carry out workforce strategies.
- Clarify roles and responsibilities in implementing strategies. This includes identifying who is involved in implementing what and identifying the need for coordination among different parts of the health authority.
- Establish time lines.
- Define performance outcome measures and expected deliverables.
- Communicate the plan.

The HHR plan should be implemented in connection with the requirements of the health authority's strategic plan.

Phase IV: Monitor, Evaluate and Revise

Ongoing evaluation and adjustments are imperative in HHR planning and are keys to continuous improvement. The HHR plan should be reviewed at least annually. If the strategic plan changes due to unanticipated service delivery changes, etc., adjustments to workforce plan strategies may be necessary.

If a health authority does not review its HHR planning efforts, it runs the risk of failing to respond to unanticipated changes. Consequently, health authorities should establish a process that allows for a regular review of HHR planning efforts in order to:

- review performance measurement information;
- assess what's working and what's not working;
- adjust the plan and strategies as necessary;
- address new workforce and organizational issues that occur.

Health authorities should ask themselves the following questions to determine whether or not the plan needs revisions:

- Have health authority strategies changed?
- Is the analysis used in both the demand and supply models still valid?
- Have there been changes that would cause the strategies to need revision?

The following sources of information have been found to be helpful in determining whether or not the HHR plan is achieving results:

- satisfaction surveys;
- reports (e.g., quarterly performance reports);
- questionnaires (e.g., exit interviews); and
- information available in accordance with accreditation standards, see www.cchsa.ca

By simply completing the attached questionnaire (See Tab 16, page 54) a health authority will have a HHR plan upon which it can build in subsequent years. Health authorities should expand on this minimized format as time and needs dictate. Health authorities can also create much more detailed HHR plans using this Guide and available tools.

Future iterations of a health authority's HHR plan could measure and analyze trends to predict future effects of risk factors such as:

- the aging workforce;
- worker satisfaction;

- use of high-growth occupations;
- use of shrinking occupations;
- increases or decreases in headcount (or FTEs);
- increases or decreases in employee tenure within the health authority;
- contract dollars spent;
- overtime worked;
- decreasing budget;
- increasing retirement;
- skills shortage; and
- other.

TAB 16

Recommended Health Human Resources Planning Questionnaire

The questionnaire, when completed, is recommended for use as a baseline HHR plan for each health authority's strategic plan.

By completing this questionnaire, a health authority will have a basic HHR plan upon which it can build in subsequent years. Health authorities should expand on this minimized format as time and health authority needs dictate. Health authorities can create much more detailed HHR plans using this Guide and available tools.

Phase I

Overview Describe the mission, strategic goals, objectives, and business functions of the health authority. Discuss what changes, if any, may take place over the business planning cycle that could affect the mission, objectives, and strategies.	
Recommended Information to Include in the Human Resources Plan	**Additional Considerations**
▸▸ Mission ▸▸ Strategic goals and objectives ▸▸ Business functions ▸▸ Anticipated changes to the mission, strategies, and goals over the next five years	▸▸ What are the key economic and environmental factors facing the health authority? ▸▸ What are the key issues and challenges facing the health authority that will affect the health authority's mission, strategies, or goals? ▸▸ What are current demands compared with demands predicted for the future? ▸▸ What are the long-range business plans? ▸▸ How is the health authority currently organized and structured? ▸▸ How will the health authority's structure look in five years, and how will the current structure evolve? ▸▸ Others as appropriate.

Phase II

Step 1: Current Workforce Profile (Supply Analysis)

Describe the health authority's current workforce by assessing whether the people currently with the health authority have the skills needed to address critical business issues in the future.

Recommended Information	Additional Considerations
▸▸ Demographics information to include age, gender, length of service and/or other information as defined in the definition list in Tab 11 of Section B in this document ▸▸ Percentage of workforce eligible to retire within the next five years ▸▸ Turnover ▸▸ Projected employee turnover rate over the next five years ▸▸ Workforce skills critical to the mission and goals of the health authority	▸▸ What will be the skill and experience level of the current workforce five years into the future? ▸▸ How will the health authority's turnover rate affect the health authority's ability to do its work? ▸▸ What challenges affect the health authority's ability to recruit and retain mission critical skills? ▸▸ What did data from the employee exit surveys show? ▸▸ How have retirements, hiring freezes, or layoffs affected your health authority? ▸▸ Others as appropriate

Step 2: Future Workforce Profile (Demand Analysis)

Develop a future business and staffing outlook. Determine trends, future influences, and challenges for the health authority's business functions, new and at-risk business, and workforce composition.

Recommended Information	Additional Considerations
▸▸ Expected workforce changes driven by factors such as changing missions, goals, strategies, technology, work, workloads, and/or work processes ▸▸ Future workforce skills needed ▸▸ Anticipated increase or decrease in the number of employees needed to do the work ▸▸ Critical functions that must be performed to achieve the strategic plan	▸▸ Will new programs be added or old programs deleted? ▸▸ How will jobs and workload change as a result of technological advancements; industry changes; and economic, social, and political conditions? What are the consequences/results of these changes? ▸▸ Do current workers have the necessary skills to do the work? ▸▸ Will the way the work is being done need to change? ▸▸ Others as appropriate

Step 3: Gap Analysis Identify gaps (shortages) and surpluses (excesses) in staffing and skill levels needed to meet future service delivery requirements.	
Recommended Information	**Additional Considerations**
▸▸ Anticipated surplus or shortage in staffing levels ▸▸ Anticipated surplus or shortage of skills	▸▸ What new skills will the health authority need to accomplish its mission and goals? ▸▸ Does the health authority's workforce currently have the anticipated needed skills? ▸▸ What job functions/skills will no longer be required? ▸▸ Others as appropriate.
Step 4: Strategy Development Develop strategies for workforce transition.	
Recommended Information	**Additional Considerations**
Succession Plan **Specific Goals to Address Workforce Competency Gaps or Surpluses (may include the following):** ▸▸ Changes in organizational structure ▸▸ Retention programs ▸▸ Recruitment plans ▸▸ Career development programs ▸▸ Leadership development ▸▸ Organizational training and employee development	▸▸ What will the health authority do about its surplus or shortage? ▸▸ What will the health authority do differently in its recruiting, training, and retention programs to ensure it has, and will continue to have, a high-quality, diverse workforce with the skills vital to accomplishing its mission? ▸▸ How will the health authority address staffing or skill imbalances due to changing programs, turnover, and retirements during the next three to five years? ▸▸ How will individuals for leadership positions be identified, assessed, and developed? ▸▸ Are there any functions or processes that should be outsourced, streamlined, or deleted? ▸▸ How will the human resources plan's success be evaluated? ▸▸ Others as appropriate

TAB 17

Suggested Roles and Responsibilities of Health Human Resources Planning Teams

It is important to remember that when employees are involved in the HHR planning process, they also accept the plan and promote it to other employees. As discussed in the section titled "Getting Started," (Section B Tab 14,) a HHR planning team should consist of dedicated and knowledgeable employees from different occupations, locations, and levels within a health authority. Team members may include:

Senior Leaders	Senior leaders of health authorities are responsible for recognizing the need for HHR planning, demonstrating commitment, and providing the resources to make it happen.
Front-Line Managers	Front-line managers are responsible for using HHR planning as a process for aligning people actions, such as recruitment and training, with strategic goals and objectives.
Human Resource Professionals	Human resource professionals provide expertise in HHR planning. They should also work closely with front-line managers in developing and implementing HHR plans.
Strategic Planners	Strategic planners ensure linkage between the strategic plan and the HHR plan.
Finance Representatives	Finance representatives ensure linkage between the budget and HHR planning.

TAB 18

Factors that Affect Workforce Needs

The following chart illustrates how certain factors can change a health authority's workforce needs.

Examples of Drivers of Change and Their Impact on Future Workforce Needs					
Driver of Change	**Area of Impact on Future Workforce Needs**				
	Employees Needed (Workload)	**Demographics**	**Geographical Location**	**Occupational Competencies**	**General (Core) Competencies**
Demographic trends (e.g., aging workforce, etc.)		X			X
Program strategies that affect staffing (e.g., expanding program coverage)	X		X	X	
Diversity goals		X			X
External mandates (e.g., departmental initiatives and new legislation)	X	X	X	X	X
Special programs (e.g., quality improvement initiatives)	X	X	X	X	X
Cyclical workload factors	X		X	X	X
Evolution of jobs from defined duties and roles (that is, specialists to generalists)					X
New technology, different work process, and workflow	X		X	X	
Budget constraints	X		X	X	X
Growth of team-based organizations					X
New organizational designs to provide better, faster, and cheaper delivery of services	X		X		

Source: National Academy of Public Administration, *Building Successful Organizations: A Guide to Strategic Workforce Planning*, May 2000.

TAB 19

Workforce Analysis Activity Matrix

Four steps are key to conducting a workforce analysis. The table below summarizes the activities, inputs, outputs, and participants in the four steps.

Workforce Analysis Activity Matrix			
Activity	**Input**	**Output**	**Participants**
Supply Analysis	Workforce levels, demographic information, hiring, and turnover trends Workforce skills/experience data collection	Current workforce profile (include relevant information about number of workers, salary, skill assessment, classification, tenure, supervisory ratio, and diversity) Trends/predictors (turnover, retirement rates, and replacement patterns) Workforce skills inventory	Program managers, supervisors, and staff Human resources staff
Demand Analysis	Management assessment of health authority program direction and budget plans Analysis of jobs needed Analysis of skills needed	Future workforce profile (include relevant information about types of jobs needed, number of workers needed, and worker skills needed)	Executive management Planning and budget staff Program managers and supervisors HR staff
Gap Analysis	Supply Analysis and Demand Analysis summaries	Analysis of difference between present workforce and future needs; establish priorities for addressing change	Program managers and supervisors HR staff
Strategy Development	Gap Analysis summary	Develop strategies for workforce transition	Executive management Program managers and supervisors HR staff

Source: U.S. Department of Health and Human Services, *Building Successful Organizations: Workforce Planning in HHS*, November 1999.

TAB 20

Lessons Learned

Lessons learned comes from experiences of workforce planners who have been extensively involved in HHR planning. Lessons include:

- Research, identify, and use best practices
- Keep senior leadership involved and ensure they are involved in the review stages
- Use a HHR planning team representing your organization
- Understand your data requirements
- Set realistic time lines
- Keep it simple
- Communicate, communicate, communicate
- Focus on being helpful
- Follow up and keep up the momentum
- Address difference between "head count" and "head content." In other words, it is not just about "keep the bodies"; it is about keeping and developing quality employees with the right skills.

Lessons Learned in Implementing Human Capital Planning Programs

Following is an outline of situations that create problems during HHR planning and alternatives that provide opportunities for success.

Created Problems	Provided Opportunities
Human resources owning/leading the effort	Line managers owning/leading the effort
Applying a fixed process	Applying general principles in a flexible process
Focus on human resources policy and programs	Focus on strategic business requirements
Presenting completed analyses with suggested solutions	Sharing interim analysis with joint issue identification and ownership
Focus on numbers	Focus on decisions and direction

Source: Q.E.D. Consulting, "Developing and Implementing Human Capital Plans in Government" (paper presented at the Workforce Assessments and Human Capital Planning conference, Washington, D.C., November 2001.)

TAB 21

References

Decision-Making Framework provided by the Calgary Health Region. As of February 2006, Calgary has provided this tool to other health authorities through the Clinical Nursing and Practice Leaders Network for use in other regions (given the regions acknowledge the framework as coming from the Calgary Health Region).

The Workforce Planners Group acknowledges the work of the Texas State Auditor's Office in creating a Workforce Planning Guide [report number 06-704, February, 2006]. Their Guide was used in preparing parts of Section B.

National Academy of Public Administration, *Building Successful Organizations: A Guide to Strategic Workforce Planning*, May 2000.

U.S. Department of Health and Human Services, *Building Successful Organizations: Workforce Planning in HHS*, November 1999.

Q.E.D. Consulting, "Developing and Implementing Human Capital Plans in Government" (paper presented at the Workforce Assessments and Human Capital Planning conference, Washington, D.C., November 2001.)

Regional Health Authority Act found at www.qp.gov.ab.ca/catalogue/

Information on health authority health plans, business plans, capital plans and annual reports on the Alberta Health and Wellness' website:
http://www.health.gov.ab.ca/regions/index.html#accountability

You can contact the Health Workforce Planning branch of AHW (1-780-427-3677) for information on supply and demand issues related to health workforce.