Comprehensive Health Workforce Plan: Appendices

Comprehensive Health Workforce Planning Committee
July 2003

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Appendix A: Background Information

In 1998, **A Framework for Managing Provincial Health Workforce Planning in Alberta** was published. This report introduced a provincial framework for creating an integrated, service-sector driven health workforce planning and management approach in Alberta. A provincial Health Workforce Steering Committee proposed processes and strategies to address identified objectives to optimize health workforce resources through the strategic management of collaborative planning practices and activities. In 1999, this committee released a report, **Health Workforce Planning in Alberta: Optimizing Health Workforce Resources to Support Health System Performance** presenting the work it had embarked on. The accountability framework for provincial health workforce management can be found in Appendix B)

In January 2000, Premier Klein announced the formation of the PACH. The council was assigned the task of determining the challenges we all face with the current health care system and providing recommendations and advice on how Alberta's health care system can be more responsive for all Albertans. In January 2002, the council released its report, **A Framework for Reform** (i.e. the Mazankowski report http://www.gov.ab.ca/home/health_first/pach.cfm). The report presents a comprehensive package of recommendations designed to put the health system on a sustainable foundation for the future.

The report identifies better ways of staying healthy, providing more choice and more competition, freeing up the system to introduce new approaches, and getting rid of barriers that stand in the way of getting the needed health services. The council talks about the need to:

- Give health providers more opportunities to deliver services to Albertans,
- Give Regional Health Authorities more authority to make decisions and more options for delivering the health services their community members want and need,
- Set rigorous targets and standards and hold people accountable for the results they achieve,
- Abandon some of our old ideas about how health systems work and be willing to say, "Let's give this a try".

With these factors in mind, the council recommended that Alberta Health and Wellness work with regions, professions/providers, post-secondary institutions and other stakeholders to develop a comprehensive health workforce plan that includes all aspects of the health care system including acute care institutions, community health, long-term care and home care. A planning committee was formed with membership from Alberta Health and Wellness, regional health authorities and Provincial Health Authorities of Alberta.

Background papers were commissioned by the committee on current strategies and studies that addressed the key health workforce issues (i.e. **The Supply and Demand of Heath Care Workers, Trends and Issues Affecting Health Workforce Planning, and Current Strategies to Address Health Workforce Shortages**). Stakeholder feedback and input on these reports was solicited in September 2002. Based on discussions on health workforce issues and health workforce strategies (see Appendices C and D), the stakeholders confirmed that the following health workforce issues continue to be the relevant issues for the comprehensive health workforce plan:

Comprehensive health workforce planning	There are basic requirements for long-term, comprehensive health workforce planning
Supply	There are basic shortages of health providers, which affects service delivery
Retention	Those who work in the system are frustrated and demoralized
Utilization	Change is needed in the way health care services are organized for delivery to bring the health care system into the 21st century and to make the best use of the full spectrum of healthcare workers.
Distribution	It is difficult to recruit to rural and remote areas. Private health care services influences distribution.
Resources	The lack of stable, predictable funding is jeopardizing long-term planning and eroding public confidence. The instability is making it difficult to attract and retain a health workforce.
Collaboration	Relationships between unions and employers have suffered through the period of fiscal restraint and restructuring. Current functional bargaining units established by the Labour Relations Board impede integration across facilities and the community.
Other	The invisible nature of public health (health promotion/illness prevention) in human resource planning. Communication mechanisms related to health workforce planning strategies must be established.

The committee collapsed these issues into the following four categories:

- Adequate supply,
- Effective Utilization,
- Healthy workplaces, and
- Planning capacity.

In September 2002, the committee on Collaboration and Innovation produced a report **Going Further: Building on a Framework for Reform.** This report indicates that the current shortages of health professionals provides the incentive and opportunity to explore the potential benefits of changing the scope of services that a variety of professionals provide. The report recommends that:

- Regional Health Authorities pool resources in the area of human resources,
- Legislative changes occur to ensure that the staffing mix can change as care needs change,
- Regional Health Authorities jointly develop an overall human resources plan that is proactive, forward looking and sustainable, and
- The human resources plans of the Regional Health Authorities will complement and underpin the provincial workforce planning initiative and will include the means to share information on supply and demand, establish clear recruitment objectives and facilitate collaboration on professional development and training.

Over time, stakeholders have provided feedback on the many challenges regarding health human resource planning that are summarized in Appendix E. Similarly, the Romanow Report (i.e. **Building on Values, the Future of Health Care in Canada,** http://www.hc-sc.gc.ca/english/pdf/care/romanow_e.pdf) and the Kirby Report (i.e. **The Health of Canadians – The Federal Role**, www.parl.gc.ca, Committee Business – Senate – Recent Reports, 37th Parliament – 2nd Session) made many recommendations on strategies for addressing health human resources shortages specifically and improving health workforce planning generally. Many of the recommendations have already been implemented in Alberta. Some of the recommendations have been captured in Appendix G.

Other reports reviewed in the preparation of this report included the 2002 final report of the Canadian Nursing Advisory Committee **Our Health, Our Future Creating Quality Workplaces for Canadian Nurses** and The Broda report **Healthy Aging: New Directions for Care** released in November 1999.

Consideration was given to all the mentioned reports and feedback in designing the comprehensive health workforce plan outlined in this report.

Appendix B: Accountability Framework for Provincial Health Workforce Management

(Note: as identified in Part 1 of the report, the information in this table will be updated to reflect current the current environment)

Stakeholders	Roles and Responsibilities	Processes Utilized to Fulfill Responsibilities and Related Accountability Mechanisms
Health Authorities	The ***Regional Health Authorities Act*** defines the responsibilities of a regional health authority. Responsibilities which relate directly to health workforce planning include: ▪ Determine priorities in the provision of health services in the health regional and allocate resources accordingly. ▪ Ensure that reasonable access to quality health services is provided in and through the health region. Accountability Relationships Health Authorities are accountable to the Minister of Health and Wellness.	1) Determine staff mix (taking into consideration population health needs, service delivery models, health profession legislation, availability of required health workers, etc.). 2) Develop and implement, at the local level, strategies which will ensure cost-effective utilization of staff. 3) Work collaboratively with other health workforce partners at the provincial level to develop and implement strategies which will ensure the optimal number, mix and distribution of health service personnel (such as: recruitment and retention strategies, and education and development strategies to ensure an adequate supply of health workers with specified skill sets). Accountability Mechanisms – Health Authority Annual Health Workforce Plans and Annual Reports (for Items 1 and 2 above). – Provincial Health Workforce Steering Committee Health Workforce Plans and Reports (for Items 1, 2 and 3 above).
Provincial Health Authorities of Alberta	▪ The Provincial Health Authorities of Alberta (PHAA) is a service-provider organization which provides various services for the Health Authorities. Accountability Relationships PHAA is a self-governing association, accountable only to its members	1) Represent members in discussions and negotiations with various organizations. 2) Provide labour market information. 3) Coordinate collaborative ventures undertaken by Health Authorities. Accountability Mechanisms – Client satisfaction surveys (for Items 1, 2 and 3 above).

Stakeholders	Roles and Responsibilities	Processes Utilized to Fulfill Responsibilities and Related Accountability Mechanisms)
Employer's Associations	▪ Represent their members' interests in a comprehensive manner.	1) Provide leadership on issues pertinent to their membership through research, education and training, advocacy and policy development and liaison with government, consumers, and other organizations at the local, provincial and national levels.
Ministry of Health and Wellness	Responsibilities of the Ministry of Health and Wellness for health workforce planning and management include: ▪ Set Direction, Policies and Provincial Standards for provincial health workforce planning and management. ▪ Promote and support the development and implementation of practices and strategies, which will ensure the optimal number, mix, and distribution of health service personnel and the cost-effective utilization of the health workforce. Accountability Relationships The Minister of Health and Wellness is accountable to the Legislative Assembly and the Government of Alberta.	1) Develop policy for various health statutes which affect the demand for and utilization of health workers, such as the **Health Professions Act,** the ***Restricted Activities Regulation.*** And other regulations pursuant to the ***Health Professions Act***. External stakeholders are consulted on policy principles and draft legislation. 2) Develop and implement the Provincial Health Workforce Strategic Plan in collaboration with Health Authorities, other Government Departments, and other health workforce partners as required. 3) Work collaboratively with other provinces and the federal government, (through mechanisms such as the Conference of the Deputy Ministers of Health) to develop national policy, legislation and regulations which affect the production and utilization of the health workforce. 4) Work with health workforce partners within the province to generate, collect and disseminate research and other information related to health workforce planning and management. Accountability Mechanisms – Ministry of Health and Wellness Business Plan and Annual Reports (Items 1, 2 and 4 above). – Provincial Health Workforce Steering Committee Annual Health Workforce Plans and Reports (for Item 2 and 4 above). – Project Reports (for Items 2, 3 and 4 above).
Regulatory Bodies of the Health Professions	Responsibilities of Colleges of Regulatory Bodies of Health Professions include: ▪ Carry out its activities and govern its regulated members in a manner that protects and serves the public interest. ▪ Provide direction to and regulate the practice of the regulated profession. ▪ Establish, maintain and enforce standards of practice, ethics, registration and continuing competence for the practice of the regulated profession. Accountability Relationships As self-governing organizations, regulatory bodies of the health professions are answerable to the Minister of Health and Wellness and the Legislative Assembly.	1) Define scope of practice of members in regulations. 2) Establish and implement mechanisms and processes for: (i) initial and ongoing registration of members; (ii) ensuring entry-level and continuing competence of members; (iii) issuance of practice permits; and (iv) hearing and resolution of complaints. 3) Work with post-secondary educators and employers to ensure that new graduates have the competencies required by employers. Accountability Mechanisms – Annual Reports to the Minister of Health (for Item 2 above). – Reports submitted by post-secondary educators (for Item 3 above).

Stakeholders	Roles and Responsibilities	Processes Utilized to Fulfill Responsibilities and Related Accountability Mechanisms
Ministry of Advanced Education and Career Development (AECD)	Major Responsibilities of the Minister of Learning include: ▪ Ensure that individual public institutions and programs are coordinated to form an overall system of adult learning that is responsive to the needs of Albertans. This includes: (i) providing a diverse array of quality learning opportunities for Albertans; (ii) providing a reasonable level of access to programs throughout the province; (iii) avoiding unnecessary duplication of programming; (iv) promoting transferability and career-laddering opportunities for learners; and (v) orienting the system to respond to changing public priorities. Accountability Relationships The Minister of Learning is accountable to the Legislative Assembly and the Government of Alberta.	1) Approve or refuse new programs, changes to the length of or enrolment in existing programs, and program suspensions or terminations for public post-secondary institutions. 2) Develop and implement program funding policy. In general, the Depatment of Learning does not provide additional funding for minimal program changes made by post-secondary institutions and expects that post-secondary institutions to keep their educational programs current. When funds are available, the Department of Learning provides conditional funding for new programs. At present, funding is available though the new ACCESS fund. Currently, the priority for this new funding is Innovation, Communication and Technology programs. Accountability Mechanisms – Ministry of Health and Wellness Business Plan and Annual Reports (for Items 1 and 2 above)
Post-secondary Institutions	▪ Work in partnership with regulatory bodies, employers and government to ensure an adequate supply of health workers with requisite mix of skills to provide defined health services to clients. ▪ Manage resources appropriately. This includes ongoing review and realignment of educational programs to ensure programs remain responsive to the communities they serve. ▪ Ensure proposed programs meet appropriate standards of academic quality and legislated competencies. ▪ Set policy respecting student applications, admissions, selection, enrolment, dismissal, withdrawal and other such matters. ▪ Certify graduates of educational programs. Accountability Relationships Post-secondary institutions are accountable to the Minister of Learning.	1) Work in collaboration with employers to determine competencies needed by health workers to meet health needs of Albertans. 2) Consult with employers and other relevant stakeholders to assess student and economic demand for programs. 3) Design and deliver educational programs to meet identified needs. 4) Conduct research on best practices for the delivery of educational programs. Accountability Mechanisms – Reports on Key Performance Indicators such as: student numbers, employment rate of graduates and student satisfaction ratings, and employer satisfaction ratings (for Items 1, 2, 3 and 4 above). – The Program Approval Process of the Ministry of Learning requires evidence of consultation with employers and other relevant stakeholders (for Item 2 above). – Funding relates directly to student enrollment (for Items 1, 2, 3 and 4 above) – Annual Business Plans and Reports (for Items 2 and 4 above).
Federal Government	▪ Ensure the development of a national network of information about health, health services and the health workforce. ▪ Develop and implement Immigration Policy in consultation with provinces. Immigration is a constitutionally shared jurisdiction with federal paramountcy in decision and policy-making. The Minister of Learning has lead responsibility for immigration matters in Alberta.	1) Information: The Canadian Institute for Health Information (CIHI) collects and disseminates information on health professionals. It also develops standards for the collection of health and health–related data. 2) Immigration Policy: Processes utilized by the province to consult with the federal government on immigration policy include: (i) multilateral discussions between federal and provincial/ territorial ministers responsible for immigration matters, and with the Forum of Labour Market Ministers (on labour market related issues such as skilled workers and temporary foreign workers); (iii) correspondence between the Minister of Learning and the Minister of CIC; (iii) meetings between provincial and federal officials, as required.

Stakeholders	Roles and Responsibilities	Processes Utilized to Fulfill Responsibilities and Related Accountability Mechanisms
Federal/ Provincial/ Territorial Advisory Committee on Health Human Resources (ACHHR)	▪ Provide proactive policy advice to the Conference of Deputy Ministers of Health which will lead to national direction and intergovernmental cooperation on health human resources production and utilization. ▪ Support and advise the Labour Mobility Coordinating Group (LMCG) in the implementation of the Labour Mobility Chapter of the Agreement on Internal Trade. <u>Accountability Relationship</u> ACHHR is accountable to the Conference of Deputy Ministers of Health.	Specific activities carried out by ACCHR or its sub-committees include the following: 1) Monitor trends in health human resources. 2) Review and comment on proposals for changes in national legislation and regulations, which have an effect upon the production, credentialling and deployment of health personnel and provide, appropriate policy direction. 3) Undertake studies on health human resource issues and opportunities for interprovincial/ federal cooperation particularly in: the preparation of definitions and classifications; the elaboration of planning methods; the development of a collaborative database; and review and recommendations of research. 4) Assist with the LMCG to implement the Labour Mobility Chapter of the Agreement on Internal Trade by: (i) providing information on health occupations, (ii) dealing with issues regarding health occupations. <u>Accountability Mechanisms</u> – Annual Reports and Project Reports (for all activities). – The Province of Alberta assesses its financial support for ACHHR on an annual basis (for all activities).
Forum of Labour Market Ministers	▪ The Forum of Labour Market Ministers (Labor Mobility Coordinating Group – LMCG) and the Conference of Deputy Ministers of Health (Advisory Committee on Health Human Resources –ACHHR) share responsibility for the coordination of implementation activities of the Labor Mobility Chapter of the Agreement on Internal Trade (Chapter 7). ▪ The major obligation set forth under Chapter 7 of the AIT is an agreement to recognize the qualifications of workers from other provinces or territories. Governments have agreed to ensure that occupational regulatory bodes will comply with this and other obligations within a reasonable period of time (by July 1, 2001).	1) Key activities undertaken by the Labor Mobility Coordinating Group (LMCG) to coordinate compliance with federal Labor Mobility policies include: (i) informing regulatory bodies of their obligation to remove provincial/territorial residency requirements; and ensure that their occupation licensing practices and transparent, non-discriminatory and related principally to competence; and (ii) determining whether or not regulatory bodies have met these obligations. <u>Accountability Mechanism</u> – Annual Reports.
Unions	▪ Unions are systems of employee representation whose primary functions are to negotiate the substantive content of working conditions, and the procedural aspects of labour management relations. <u>Accountability Relationship</u> Unions are accountable to their members.	1) Negotiate collective agreements. 2) Represent members in resolving issues arising from the employment relationship. <u>Accountability Mechanisms</u>: – Members elect union executive (for Items 1 and 2 above). – Members vote on various decisions reached by union executive and negotiators (for Item 1 above). – Alberta Labor Code requires unions to file collective agreements (for Item 1 above). – Unions have a duty to fair representation and union members can file complaints to the Alberta Labour Board (for Items 1 and 2 above).

Stakeholders	Roles and Responsibilities	Processes Utilized to Fulfill Responsibilities and Related Accountability Mechanisms
Health Professionals	▪ Provide advice, care and treatment to clients. ▪ Advocate for clients. ▪ Health professionals in private practice have a primary responsibility to their clients/patients for the provision of quality services. <u>Accountability Relationship</u> Health professionals are accountable to their respective regulatory bodies for their ongoing practice, including competence and conduct; and to their employers for the quality of services they deliver.	1) Develop and implement client service plans in accordance with professional standards. 2) Participate in continued competence programs. 3) Participate in planning/policy-development/evaluative committees at various organizational levels. <u>Accountability Mechanisms</u> – Professional standards, and employer performance standards (for Item 1 above). – Peer review, practice audits (for Item 1 above). – Registration requirements (for Item 2 above). – Competency assessment processes (for Item 2 above).

Appendix C: HEALTH WORKFORCE ISSUES

(Report prepared for discussion with stakeholders at September 2002 forum as identified in Appendix A)

Issue	Example/Comment
I. Comprehensive Health Workforce Planning There are inadequacies in the basic requirements for long-term comprehensive health workforce planning:	
1. Absence of national long-term, comprehensive health workforce strategies which provide the context for provincial planning.	-The federal government has important roles in healthcare including: transfer of funds; research and evaluation; infrastructure; population health and direct service to specific groups (e.g. military and aboriginals). -RHAs recruit healthcare professionals nationally and internationally. Federal involvement is needed to facilitate immigration and collaborate in addressing problems related to supply and distribution of healthcare workers across the country.
2. Information systems may not be in place. Existing systems are not integrated.	Data which is collected (e.g. provider information) is not standardized or stored consistently, resulting in the inability to form direct relationships between inputs and outputs, as a basis for evidence–based planning.
3. Projection models have not been developed for most professions.	Projection models require good data and evidence-based policies.
4. Research is lacking in key policy/practice areas.	E.g. -What data to collect and how to collect it and analyze it, -Optimum skill mixes, -Workload measurements, -Optimum deployment patterns.
5. Effective, timely methods of research dissemination are not in place.	

II. Supply	
"There are serious shortages of health providers … The most pressing immediate factor limiting the ability of health authorities to bring new service capacity and programs on line in response to public demand for access to service is availability of…personnel" (Framework for Reform).	E.g. -Over the next 5 years, Alberta needs 610 general practitioners. Family physicians are now working an average of 80/hours/week. 55.2% have closed their practices. -There are 210.5 vacant pharmacy positions in the province.
A. Education Seats	
1. Fiscal restraint and restructuring in the 1990s resulted in decreased health care funding and reduced education spending to the extent that the number of new graduates in the health care professions is not keeping pace with the needs of an aging population, advances in health care and the rate of retirement of an aging workforce.	E.g. -The number of education seats in nursing across Canada dropped from 12, 170 in 1990 to 8, 790 in 2000. -40–60% of laboratory technologists are expected to retire over the next 10 years. Only 9% of their workforce is 20-25 years of age.
2. Education programs face challenges associated with expanding the number of seats:	
2a. The number of applications to some schools are decreasing. Some groups are under-represented. *There is a need to consider pre and post-secondary education.*	E.g. -Occupational therapy, laboratory technology: -Careers in healthcare became less attractive in the 1990s; the number of career choices has expanded; tuition fees are rising; safety concerns have arisen (e.g. HIV). -Aboriginal groups are under-represented.
2b. Physical space is limited.	
2c. There are shortages of educators.	
2d. Downsizing of healthcare institutions has resulted in a shortage of clinical placements. *Clinical placements are not funded.*	E.g. Dietary and laboratory settings.
3. Education levels required to gain employment, often driven by the increased complexity of work, are resulting in longer, more costly periods of training.	E.g. -Occupational therapists and physiotherapists are considering a Masters level as entry to practice. -RHAs experience difficulty recruiting specialists in medical, nursing and technical areas.

B. Immigration **1.** World-wide shortages of health care professionals is raising concerns about countries "poaching" workers from countries that are more in need. **2**. Need to assess and integrate health care workers from other countries.	E.g. South African ambassador expressed concern that physicians from his country are coming to Canada when they are needed to deal with the HIV/AIDS crisis in South Africa.
C. Repatriation/Return to Profession **1**. During the period of fiscal restraint and restructuring in the 1990s, many young professionals left the country or their profession, resulting in an older workforce and a lack of leaders to assume positions when the current cohort retires.	E.g. -21% of nurses graduating in Canada between 1990 and 2000 are not practicing in the profession or in Canada. -Laboratory technologists express concerns related to "a lost generation".
III. Retention "…those who work in the system are frustrated, demoralized and pessimistic about the future of their profession in the current environment" (Framework for Reform)	
1. Part-time/casual work and lack of availability of mentors hinders integration of new graduates into the profession.	E.g. An estimated 3 in 10 nurses leave the profession within 5 years of graduation.
2. Poor working conditions are the main reason that healthcare workers leave the profession.	E.g. -Occupational therapists have a high rate of attrition after the age of 45 years. -Quality of Worklife surveys of nurses and health professionals in Alberta indicate that the increasing complexity of work, increasing workloads leading to burnout and emotional and mental fatigue; patient care becoming more task oriented and less holistic, and lack of support for ongoing education to meet day to day work needs, are key factors causing dissatisfaction in the workplace. -Other factors include lack of professional leadership and clinical support; lack of communication and consultation; risk of disease/abuse; lack of flexible scheduling and deployment; lack of recognition for expertise and experience. *Shift work is of concern as is the personal distress inherent in constant change*.

IV. Utilization	
1. "Change is needed in the way healthcare services are organized for delivery to bring the healthcare system into the 21st century and to make the best use of the full spectrum of healthcare workers. The first and essential step in organizational change must be primary care reform." (Kirby)	E.g. Pharmacists and licensed practical nurses feel their skills are seriously underutilized.
1a. There is not a clear picture of how primary healthcare reform translates into concrete, practical realities.	E.g. RHAs ask: How will multidisciplinary teams work? Who will be included (mix)? What will members do (scopes of practice)? Where? How do we prepare? What are the steps to getting there?
1b.Obstacles to primary healthcare reform: **1bi.** Fee for service as main method of paying physicians. **1bii**. Scope of practice rules. **1biii.** Challenging the current distribution of decision-making power. **1biv**. Encouraging the public to embrace a new model.	
2. Human resource management practices which do not maximize the use of available resources	E.g. High rates of absenteeism in nursing (9000 full time equivalents/year in Canada – 80% higher than Canadian average). Overtime is highly predictive of lost days to injury. The cost of overtime and absenteeism is $902 million – 1.5 billion/year.

V. Distribution	
1. Difficult to recruit to rural and remote areas.	Workload ("on call"), isolation, lifestyle, need for specific skills etc. are contributing factors.
2. Private healthcare services influences**.**	E.g. -Calgary lost 14 sonographers to private clinics. -Lower wages, lack of security, and difficult working conditions of homecare staff are a barrier in the shift from institutional to community care. **-**Pharmacists and psychologists earn more in private **practice**.
3. *Movement within the workforce is disruptive -*	*E.g. Managers may be placed in areas not within their expertise*.
VI. Resources	
1. "Lack of stable, predictable funding is jeopardizing long-term planning and eroding public confidence." (Romanow)	E.g. Health Sciences Association of Alberta website notes recent layoffs of staff in areas and professions of supply shortages.
2. *Time for budget process is lengthy.*	
3*. Budget plan is only 3 years.*	
VII. Collaboration	
1. Relationships between unions and employers have suffered through the period of fiscal restraint and restructuring. Current functional bargaining units established by the Labour Relations Board impede integration across facilities and the community. *Union approach of uniformity does not meet the unique needs of the regions.*	
VIII. Other	
1. The invisible nature of public health in workforce planning.	Despite the trend to health promotion/illness prevention strategies, these currently receive 2.9% of the health budget.

Appendix D: Health Workforce Strategies

(Report prepared for discussion with stakeholders at September 2002 forum [and restructured following the stakeholder review] as identified in Appendix A)

Issues **and Strategies**	**Strategy Implemented by**
I. Comprehensive Health Workforce Planning	
1. Absence of national long-term, comprehensive health workforce strategies which provide the context for provincial planning.	
Nursing Strategy for Canada / Final Report of the Canadian Nursing Advisory Committee.	ACHHR – Federal Government
Allied Health Working Group Initiatives	"
Sector Studies – Physicians	Human Resources Development Council – Federal Government
Nurses	
Home Care	
Dental	
Pharmacy	
Social Workers (complete)	
Task Force II	Canadian Medical Forum
Postgraduate Medical Education Coordinating Committee	ACHHR – Federal Federal Government
Office of Nursing Policy	
Canadian Resident Matching Service	
Canadian Association of Medical Colleges	
Canadian Association of Schools of Nursing	
2. Information systems may not be in place. Existing systems are not integrated.	
Canadian Health Infoway	Federal Government
Canadian Health Information Partnership Program	"
Health Workforce Information Network	Alberta Government Professional/Licensing Bodies Regional Health Authorities
3. Projection models have not been developed for most professions.	
"Setting a Direction for Alberta's Physician Workforce"	Physicians Resource Planning Working Group Postgraduate Medical Education Working Group

4. *Research is lacking in key policy/practice areas.*	
Canadian Institute of Health Research (CIHR)	Federal Government
Canadian Health Services Research Foundation (CHSRF)	"
Canadian Institute of Health Information (CIHI)	
Data Collection – "What?"	
Health Workforce Information Network	Alberta Government
Data Collection – Supply & Demand	
Background Paper "Supply and Demand"	Alberta Government
"Canada's Health Care Providers"	Canadian Institute of Health Information
"Supply and Distribution of RNs in Rural and Small Town Canada"	"
Supply and Distribution of RNs in Canada – 2001"	"
"What Happened to Canada's Physician Workforce in the 1990s"	"
"Planning for the Future"	Canadian Nurses Association
"2001 National Family Physician Health Workforce Survey"	College of Family Physicians
"Report on the Education, Supply and Distribution of Occupational Therapists in Canada 2001"	Canadian Association of Occupational Therapists
"Physiotherapy Human Resources Background Paper"	Canadian Physiotherapy Assn.
"Medical Laboratory Technologist Human Resources Review 2002 Update"	Canadian Association of Medical Laboratory Sciences
"Survey of Employers of Emergency Response Personnel"	AB College of Paramedics
"Environmental Scan of Pharmacy Technicians"	Canadian Pharmacy Assn
" Alberta International Medical Graduate Program – Who are They?"	Alberta Family Physicians Research Network
" The Nature of Nursing Practice in Rural and Remote Canada"	Can. Health Services Research Fund
" Student Nurses Perspectives on the Recruitment and Retention of Nurses"	University of Victoria
Policy/Practice	
Staff/patient Ratio; workload measurement	Can. Assn. Of Speech Pathologists and Audiologists
Commitment and Care – a Policy Synthesis	Can. Health Services
Creating High Quality Healthcare Workplaces	Research Foundation

Quality of Worklife/Career Satisfaction: - Nurses - Health Professionals - Support Staff "What Family Physicians Want and Don't Want" Pharmacist Perception Survey Monitoring the Health of Nurses in Canada	Alberta Quality of Worklife Planning Group AB of Family Physicians Research Network Pharmacy Assn. of AB Can. Health Research Found
5. *Effective, timely methods of research dissemination are not in place.* Electronic Update Research Net	 Office of Nursing Policy CIHR
6. Provincial Planning	
"A Framework for Managing Provincial Health Workforce Planning in Alberta" "Health Workforce Planning in Alberta: Optimizing Health Workforce Resources to Support Health System Performance." "A Framework of Provincial Human Resource Objectives, Strategies & Action Plans for the Future Continuing Care Sector" Ongoing Health Workforce working group activities eg. Education Diagnostic Imaging Steering Committee MLA Review of Ambulance Services Regional Health Authorities Business Plans	Provincial Health Workforce Steering Committee " Continuing Care Working Group Regional Health Authorities
II. Supply "*There are serious shortages of health providers*" …	
A. Education Seats	
1.The number of new graduates in the health care professions is not keeping pace with the needs of an aging population/advances in health care & the rate of retirement of an aging workforce. ACCESS Fund provided increased number of seats over 3 years.	 Alberta Learning consulting with Education Working Group, Education Institutions
2. Education programs face challenges associated with expanding the number of seats:	

2a. The number of applications to some schools are decreasing. Some groups are under-represented.	
Careers the Next Generation Recruitment Video Career Marketing Plan for Continuing Support Workers	PHAA – HR Leaders Council Can. Nursing Students Assn. Continuing Care Working Gr.
Return for Service Bursaries/Northern Student Practicum Bursaries Rural Student Practicum Bursaries Endowment Fund Matching Education Grants	Northern Alberta Development Council/RHAs Rural Physician Action Plan AB Government/AARN RHAs/AARN
Task Force on the Recruitment and Retention of Aboriginal Persons into Nursing	Federal Government (First Nations & Inuit Health Branch)
2b. *Physical space is limited*.	
2c. *There are shortages of educators.* ACCESS seats	
2d. *Downsizing of healthcare institutions has resulted in a shortage of clinical placements*. A Review of Clinical Placement Requirements Rural Student Practicum Bursaries	 Education Working Group Northern Alberta Development Council/RHAs
3. Education levels required to gain employment, often driven by the increased complexity of work, are resulting in longer, more costly periods of training. Demand for specialists increasing ACCESS seats Funding support for specialization courses as in 2a Geriatric Inservice Mentoring Program Provincial Curriculum for Health Support Workers.	 Continuing Care Working Group

B. Immigration	
1. *World-wide shortages of health care professionals is raising concerns about countries "poaching" workers from countries that are more in need.* Ethical Recruitment Guidelines	World Medical Association International Council of Nurses
2. *Need to assess and integrate health care workers from other countries.* International Medical Graduates Provincial Nominee Program	Working Group on Trade Agreements/Physicians AB Government – Workforce
C. Repatriation/Return to Profession	
1. *During the period of fiscal restraint & restructuring in the 1990s, many young professionals left the country or their profession, resulting in an older workforce and a lack of leaders to assume positions when the current cohort retires* RHA Refresher Programs	Eg. Capital Health
III. Retention	
1*. Part-time/casual work & lack of availability of mentors hinders integration of new graduates into the profession.* Support programs for new graduates	RHAs

2. *Poor working conditions are the main reason that healthcare workers leave the profession.*	
Physician Compensation	Alberta Government
Specialist "On Call"	"
Alternate Payment Plans	"
Midwives - Insurance	"
Position Paper: Principals for Physician "On Call" Services	AB Family Physicians Research Network
Collective Bargaining	PHAA, AB Health, AMA, UNA. HSAA, CUPE, AUPE
Healthy Workplace Standards	Can. Council Health Services Accreditation
Healthy Workplace Guidelines for Nurses	Office of Nursing Policy
Position Paper: Quality Professional Environments	Canadian Nurses Association
Bibliography: Healthy Workplaces	Alberta Association of Registered Nurses
Newsletter Column: Healthy Solutions	
Geriatric Inservice Mentoring Program	Continuing Care Working Gr.
Dementia Caregivers Educational Program	
Endowment Fund	AB Government/AARN
Matching Educational Grants	RHA/AARN
General retention strategies include: • Wellness Committees and programs, including workplace safety, immunization; • Disability Management; • Communication via newsletters**;** • Support for education upgrading eg. LPN to RN in hard to recruit areas	RHAs
Continuing education eg. upgrading skills of managers; • Succession planning when individuals are retiring; • Job sharing: amalgamating smaller jobs; • Converting overtime expenses to a full-time position; • Recognition programs/events; • Working with unions for employee/employer benefit.	
Some specific RHA Strategies:	
Annual Wellness Conference	Crossroads
"Respectful Workplaces"	Health Authority #5
Management and Employee Enhancement Team" (MEET)	Headwaters

IV. Utilization	
1. "Change is needed in the way healthcare services are organized for delivery to bring the healthcare system into the 21st century & to make the best use of the full spectrum of healthcare workers. The first & essential step in organizational change must be primary care reform." (Kirby)	
"The Health of Canadians – The Federal Role" – Kirby "The Commission on the Future of Healthcare in Canada" – Romanow "A Framework for Reform" – Mazankowski	Federal Government Federal Government Alberta Government
1a. *There is not a clear picture of how primary healthcare reform translates into concrete, practical realities.*	
Primary Healthcare Transition Fund Projects Professional Practice Model Position Paper: Primary Care & Family Physicians Can Meds 2000 Position Paper: Primary Care Reform in Alberta Position Paper – Nurse Practitioners Study of Cardiovascular Risk Intervention by Pharmacists Specialization Certification, Fee for Cognitive Services, Economic Model for Consultative Services etc. Health Link	Federal Government/ RHAs Mental Health Board College of Family Physicians of Canada Royal College of Physicians AB College of Family Physicians Canadian Nurses Association Pharmacy Association of AB Canadian/AB Pharmacy Assn. Federal/Alberta Government/RHAs
1b.*Obstacles to primary healthcare reform:* *1bi. Fee for service as main method of paying physicians.*	
Alternate Compensation Plans Research: The Process, Particulars& Players involved in the Taber Alternate Payment Plan Agreement	Alberta Government Alberta College of Family Physicians
1bii. Scope of Practice rules.	
Health Professions Act Public Health Act – Nurse Practitioners Integration of Midwifery Services Evaluation Roles for Clinical Nurse Specialists & Nurse Practitioners Paper: Integration of LPN Scope of Practice	Alberta Government " " Continuing Care Working Group PHAA – Council of CEOs

1biii. Challenging the current distribution of decision-making power.	
1biv. Encouraging the public to embrace a new model.	
2. Human resource management practices which do not maximize the use of available resources	
V. Distribution	
Difficult to recruit to rural & remote areas.	
Office of Rural Health	Federal Government
Innovations in Rural & Community Health Initiatives Fund	Office of Rural Health
Framework for Rurality	"
Research: The Nature of Nursing Practice in Rural and Remote Canada	CHSRF
Task Force on the Recruitment and Retention of Aboriginal Persons into Nursing	Federal Government (First Nations & Inuit Health Branch
First Nations & Inuit Health Branch National Nursing Recruitment & Retention Strategy	
Northern Student Practicum Bursaries/ Return for Service Bursaries	Northern Alberta Development Council/RHAs
Careers the Next Generation	PHAA – HR Leaders Council
Rural Physicians Action Plan	
Rural Nursing Program	Grant MacEwan College
Telehealth	
Website: Healthjob.ca	PHAA – HR Leaders Council
Opportunities North	Northern Development Council
Ambassador Program	RHAs
Providing relocation assistance and housing allowances	RHA - East Central
Student Road Trip	RHA - Northernlights
Host Program	RHA - Mistahia
Staff bonus for attracting new employees	
Other Recruitment Initiatives:	Working Group on Trade
Mutual Recognition Agreements	Capital Health
Supernumerary positions	Regional Health Authorities
General initiatives • Advertising on websites – their own; healthjobs.ab.ca; professional associations: unions; • Advertising in professional journals, college publications, newspapers;	

• Hiring "head hunters"; • Participating in job fairs, school career days etc. (May involve partnering to promote the area); • Hiring students during times of peak absences eg. vacations; • Offering mentors for practicums and "Careers the Next Generation"; • Hiring retired individuals into flexible positions; • Obtaining information from exit and transfer interviews; • Providing bursaries, tuition assistance, subsidizing refresher courses, career laddering for hard to recruit positions; • Forming recruitment committees.	
1. Private healthcare services influences. Calgary sonographers recruitment plan	Calgary Health Authority
VI. Resources	
1. "*Lack of stable, predictable funding is jeopardizing long-term planning & eroding public confidence." (Romanow)*	
VII. Collaboration	
1. *Relationships between unions and employers have suffered through the period of fiscal restraint & restructuring. Current collective bargaining structures impede integration across facilities & the community.* Individual RHA initiatives	
VIII. Other	
1. *The invisible nature of public health in human resource planning.*	

Note:
Additional reports not noted in this report that add value to discussions on health workforce strategies include the following related to medical laboratory technologists:

- A Call to Action,
- Medical Laboratory Technology Clinical Training Cost Issues, and
- Laboratory Human Resources Survey.

Appendix E: Challenges Identified by Stakeholders Regarding Health Workforce Planning

Other detailed challenges regarding health workforce planning identified by stakeholders over time:

1. There is no clear vision of the health system or the key characteristics of the future health workforce to guide health workforce strategy development.
2. It is difficult to develop ten-year health workforce plans in the absence of a RHA Ten-Year Service Plan.
3. Health workforce needs [and issues] are not viewed as integral to the development of the key service delivery strategies outlined in the RHA business plans. Instead, health workforce planning is viewed as a separate, often secondary, policy exercise.
4. Physician resource planning occurs in isolation from non-physician resource planning. These disparate planning processes are a barrier to the successful development and implementation of interdisciplinary care teams comprised of physicians and other health professionals.
5. Health workforce strategies are not always based on research and evidence.
6. It is difficult to implement coordinated health workforce planning processes in the absence of health workforce information.
7. Specific accountabilities of the partners are not always well defined.
8. Although there have been numerous studies and discussion forums on health workforce issues, there is little communication of the results attained by the multiple stakeholders who have implemented health workforce strategies during the past few years.
9. Public policy analysts are now paying considerable attention to health workforce planning, and suggesting, in some cases, that additional stakeholders need to participate in the discussions of health workforce issues and the policy-development process. Expanded participation of other stakeholders will add a further layer of complexity to the health workforce planning process, and heighten the need for a clear vision for health workforce planning and effective planning processes.
10. There is limited data or tools for forecasting.
11. There is limited evaluation of outcomes to assess effectiveness of planning activities.
12. The amount and quality of collaboration that results in synergistic efforts towards actions for the “greater good” of Albertans.
13. There is limited flexibility in allowing for conceptualizing alternatives.
14. Workloads are heavier and position vacancy rate is increased.
15. Employees are not always treated as assets. Sometimes there is a reluctance to acknowledge that health service providers constitute the core elements of the service delivery system since health services are created in the interaction between service providers and the clients.
16. There is a lack of research information available on optimal workload / staff mixes.
17. Collective agreements can limit recruitment and retention strategies.

Appendix F: Definitions of Workforce Planning

In 1999, the Provincial Health Workforce Steering Committee (PHWSC) agreed that the purpose of health workforce planning was to achieve the optimal number, mix and distribution of health service personnel at a cost the health system could afford, based on service delivery models.

The PACH described a comprehensive health workforce plan as one that sorts out the roles of various providers, anticipates future demands and guides decisions on post-secondary education.

The Committee on Collaboration and Innovation stated that health workforce planning is one of the greatest challenges facing the health care system as the workforce ages and Alberta's population grows. The committee identified workforce planning as ensuring an adequate supply of health workers.

The Kirby report states that addressing the shortage of professionals in all health care disciplines, and finding ways to increase their individual and collective productivity are two of the most pressing, yet complex, problems facing health care policy makers.

Appendix G: Building Blocks and Relationship to Multiple Reports

Building Blocks	Mazankowski	Provincial Health Workforce Stakeholders (September 2002)	Committee on Collaboration and Innovation	Kirby	Romanow	Provincial Health Workforce Steering Committee (1998)	Provincial Health Workforce Ongoing Initiatives
Planning Capacity	• Work with regions, professions, providers and post-secondary institutions to develop a comprehensive workforce plan that includes all aspects of the health system including acute care institutions, community health, long term care and home care. • The workforce plan should guide decisions by government, medical and nursing faculties, and other university programs, colleges and technical institutes, on the anticipated numbers of health providers, and the level of funding required to meet future demands.	• Establish a clear vision/plan for health care restructuring, with clearly defined roles, relationships and outcomes. • Provide adequate, stable resources to support restructuring.	• Regional Health Authorities jointly develop an overall human resources plan that is proactive, forward looking and sustainable. • Regional Health Authorities pool resources in the area of human resources.	• The federal government work with other concerned parties to create a permanent National Coordinating Committee for Health Human Resources, to be composed of representatives of key stakeholder groups and of the different levels of government. Its mandate would include coordination of and sharing information on various efforts to deal with health human resource shortages.	• Steps should be taken to bridge current knowledge gaps in applied policy areas, including rural and remote health, health human resources, health promotion, and pharmaceutical policy. (Rec 14) • In the longer term, the proposed Health Council of Canada should provide ongoing advice and coordination in transforming primary health care, developing national strategies for Canada's health workforce, and resolving disputes.	• Establishment of an annual provincial health workforce planning process that is fully integrated into the business planning framework. • RHAs are required to submit regional workforce plans as part of their Regional Business Plans (PHWSC). • The Provincial Workforce Plan will include strategies to address priority areas or issues beyond local level solutions.	• RHAs are required to submit regional workforce plans as part of their Regional Business Plans. • Establishment of an accountability framework to identify the primary provincial health workforce stakeholders, their respective roles, relationships, functions and processes, and associated mechanisms for ensuring accountability. • Development of a Provincial Health Workforce Information Network. • A Provider Directory is under development. This directory will have multiple benefits including the provision of practitioner descriptive information that will be collected from regulatory bodies and used to describe the workforce.

Building Blocks	Mazankowski	Provincial Health Workforce Stakeholders (September 2002)	Committee on Collaboration and Innovation	Kirby	Romanow	Provincial Health Workforce Steering Committee (1998)	Provincial Health Workforce Ongoing Initiatives
Planning Capacity (continued)		• Ensure public education related to the intention, process and outcome of restructuring s in place. • "Take action." (i.e. implement forthcoming research recommendations such as those dealing with quality workplaces). • Establish mechanisms for communication and coordination related to workforce strategies. • Work with unions toward common goals. • Initiate health promotion/illness prevention strategies for the long-term.	• The human resources plans of the Regional Health Authorities will complement and underpin the provincial workforce planning initiative and will include the means to share information on supply and demand, establish clear recruitment objectives and facilitate collaboration on professional development and training.	• The federal government, through the Canadian Institutes of Health Research, Health Canada and the Canadian Health Services Research Foundation, devote additional funding to health services research and clinical research and that it collaborate with the provinces and territories to ensure that the outcomes of such research are broadly diffused to health care providers, managers and policy-makers.	• The Health Council of Canada should systematically collect, analyze and regularly report on relevant and necessary information about the Canadian health workforce, including critical issues related to the recruitment, distribution and remuneration of health care providers. • Governments, regional health authorities, and health care providers should continue their efforts to develop programs and services that recognize the different health care needs of specific population groups (e.g., people with disabilities, new Canadians.).	• Development of a plan for a Provincial Health Workforce Information Network.	• The Physician Resource Planning Committee Terms of Reference was renewed for one year to enable the development of plans for further integration with non-physician planning processes.

Building Blocks	Mazankowski	Provincial Health Workforce Stakeholders	Committee on Collaboration and Innovation	Kirby	Romanow	Provincial Health Workforce Steering Committee (1998)	Provincial Health Workforce Ongoing Initiatives
Adequate Supply	• Alberta should educate sufficient health personnel to more than meet its own needs and not rely on recruitment from other provinces. • Retention programs need to be tailored to the needs of each region • Professional colleges and unions should be challenged to review the respective roles of their members and take a more proactive approach to build better working relationships with other health professions rather than simply "protecting turf".			• Studies be done to determine how the productivity of health care professionals can be improved. These studies should be either undertaken or commissioned by the National Coordinating Committee on Health Human Resources that the Committee recommends be created. • The federal government: -Work with provincial governments to ensure that all medical schools and schools of nursing receive the funding increments required to permit necessary enrolment expansion.	• The Health Council of Canada should review existing education and training programs and provide recommendations to the provinces and territories on more integrated education programs for preparing health care providers, particularly for primary health care settings. • The Health Council of Canada should develop a comprehensive plan for addressing issues related to the supply, distribution, education and training, remuneration, skills and patterns of practice for Canada's health workforce.	• The Education Workforce Working Group of the Provincial Health Workforce Steering Committee identified priority educational needs based on expert opinion, and worked with Alberta Learning to initiate the expansion of post-secondary training spaces • Development of processes and strategies to facilitate communication of health sector expectations to post-secondary educational institutions and private sector training facilities.	• A Provincial Education Workforce Working Group will identify priority educational needs. • The Continuing Care Workforce Working Group (a multi-stakeholder partnership of government, RHAs and private employers) is assisting in the development and implementation of various educational strategies to ensure an adequate supply of health service providers with the competencies required to provide services to seniors and other clients of the continuing care sector. • The PNP recently signed by AHW, will expedite the immigration for 75 foreign-trained health professionals in occupations experiencing chronic shortages. • The RPAP provides support for the recruitment and retention of rural physicians.

Building Blocks	Mazankowski	Provincial Health Workforce Stakeholders	Committee on Collaboration and Innovation	Kirby	Romanow	Provincial Health Workforce Steering Committee (1998)	Provincial Health Workforce Ongoing Initiatives
Adequate Supply (continued)				-Put in place mechanisms by which direct federal funding could be provided to support expanded enrolment in medical and nursing education, and ensure the stability of funding for the training and education of allied health professionals; -Review federal student loan programs available to health care professionals and make modifications to ensure that the impact of inevitable increases in tuition fees does not lead to denial of opportunity to students in lower socio-economic circumstances.	• Provincial, Territorial and Federal governments should reduce their reliance on recruiting health care professionals from developing countries. • The Rural and Remote Access Fund should be used to attract and retain health care providers. • A portion of the Rural and Remote Access Fund should be used to support innovative ways of expanding rural experiences for physicians, nurses and other health care providers as part of their education and training.		

Building Blocks	Mazankowski	Provincial Health Workforce Stakeholders	Committee on Collaboration and Innovation	Kirby	Romanow	Provincial Health Workforce Steering Committee (1998)	Provincial Health Workforce Ongoing Initiatives
Adequate Supply (continued)				-Work with Provincial Governments to ensure that the relative wage levels paid to different categories of health professionals reflect the real level of education and training required of them. -Work with the provinces and medical and nursing faculties to finance places for students from Aboriginal backgrounds over and above those available to the general population. -Work with the provinces and professional associations to inform expatriate Canadian health professionals of emerging job opportunities in Canada, and explore the possibility of adopting short-term tax incentives for those prepared to return to Canada.	• The Rural and Remote Access Fund should be used to support the expansion of telehealth approaches. • Human Resources Development Canada, in conjunction with Health Canada should be directed to develop proposals to provide direct support to informal caregivers to allow them to spend time away from work to provide necessary home care assistance at critical times.		

Building Blocks	Mazankowski	Provincial Health Workforce Stakeholders	Committee on Collaboration and Innovation	Kirby	Romanow	Provincial Health Workforce Steering Committee (1998)	Provincial Health Workforce Ongoing Initiative
Adequate Supply (continued)				-Contribute $160 million per year, starting immediately, so that Canadian medical colleges can enrol 2,500 first-year students by 2005. -Should contribute financially to increasing the number of post-graduate residency positions in medicine to a ratio of 120 per 100 graduates of Canadian medical schools. -Work with the provinces to establish national standards for the evaluation of international medical graduates, and provide ongoing funding to implement an accelerated program for the licensing of qualified IMGs and their full integration into the Canadian health care delivery system.			

Building Blocks	Mazankowski	Provincial Health Workforce Stakeholders	Committee on Collaboration and Innovation	Kirby	Romanow	Provincial Health Workforce Steering Committee (1998)	Provincial Health Workforce Ongoing Initiatives
Adequate Supply (continued)				-Commit $90 million per year from the additional revenue the Committee has recommended it raise in order to enable Canadian nursing schools to graduate 12,000 nurses by 2008. -Commit $40 million per year from the new revenues that the Committee has recommended it raise in order to assist the provinces in raising the number of allied health professionals who graduate each year. -The exact allocation of these funds be determined by the proposed National Coordinating Committee for Health Human Resources.			

Building Blocks	Mazankowski	Provincial Health Workforce Stakeholders (September 2002)	Committee on Collaboration and Innovation	Kirby	Romanow	Provincial Health Workforce Steering Committee (1998)	Provincial Health Workforce Ongoing Initiatives
Adequate Supply (continued)				-Devote $75 million per year of the new money the Committee recommends be raised to assisting Academic Health Sciences Centres to pay the costs associated with expanding the number of training slots for the full range of health care professionals. • The proposed National Coordinating Committee for Health Human Resources be charged with monitoring the levels of enrolment in Canadian medical schools and make recommendations to the federal government on whether these are appropriate.			

Building Blocks	Mazankowski	Provincial Health Workforce Stakeholders (September 2002)	Committee on Collaboration and Innovation	Kirby	Romanow	Provincial Health Workforce Steering Committee (1998)	Provincial Health Workforce Ongoing Initiatives
Appropriate Utilization	• Encouraging and empowering health providers to explore and implement a number of different approaches in organizing and delivering health care services. • Professional organizations are going to have to be more willing to give and take when examining various scopes of practice rather than simply protecting the "turf" they already have. • Develop incentives for providers in the heath system that will support the kind of integrated health care many providers would like to see. • Implement alternative approaches for paying physicians for their services and providing better alignment between physicians, RHAs and the goals of the health system.		• Legislative changes occur to ensure that the staffing mix can change as care needs change.	• An independent review of scope of practice rules and other regulations affecting what individual health professionals can and cannot do be undertaken for the purpose of developing proposals that would enable the skills and competencies of diverse health care professionals to be utilized to the fullest and enable health care services to be delivered by the most appropriately qualified professionals.	• A portion of the proposed Rural and Remote Access Fund, the Diagnostic Services Fund, the Primary Health Care Transfer and the Home Care Transfer should be used to improve the supply and distribution of health care providers, encourage changes to their scope and patterns of practice, and ensure that the best use is made of the mix of skills of different health care providers.		• The HPA allows for overlapping scopes of practice and removes some of the regulatory barriers to the establishment of multidisciplinary care teams. • The Professional Regulatory Bodies have formed a "federation" to increase communication between health professions. • A new Nurse Practitioner Regulation was enacted in July 2002. • A Nurse Practitioner Supply Working Group comprised of representatives from government, the Alberta Association of Registered Nurses (AARN) and the RHAs, has been established to address barriers to an adequate supply of NPs and their effective utilization.

Building Blocks	Mazankowski	Provincial Health Workforce Stakeholders (September 2002)	Committee on Collaboration and Innovation	Kirby	Romanow	Provincial Health Workforce Steering Committee (1998)	Provincial Health Workforce Ongoing Initiatives
Appropriate utilization (continued)							• The RHAs have initiated the development of nursing sensitive outcome indicators which may assist health authorities during change management processes involving changes in staff mix and scopes of practice. • The Primary Health Capacity-Building Fund will support initiatives that advance and improve the delivery of primary health care services in Alberta.

Building Blocks	Mazankowski	Provincial Health Workforce Stakeholders (September 2002)	Committee on Collaboration and Innovation	Kirby	Romanow	Provincial Health Workforce Steering Committee (1998)	Provincial Health Workforce Ongoing Initiatives
Healthy Workplaces	• Encourage RHAs to develop and implement strategic initiatives to improve workforce morale for all health providers with the long-term goal of increasing work satisfaction and improving retention of the workforce.	• Acknowledge the effects of change on individuals and support change management.				• The RHAs have implemented a wide range of recruitment strategies under the direction of the Human Resource Leaders. Some of these strategies were funded by Alberta Health and Wellness. • Implementation of a uniform Provincial Quality of Worklife Survey which has a career satisfaction and work environment focus. Survey results will support employer development of strategies to improve provincial recruitment. • General retention strategies implemented by RHAs.	• Implementation of a uniform Provincial Quality of Worklife Survey that has a career satisfaction and work environment focus. Survey results will support employer development of strategies to improve provincial recruitment.

Appendix H: Abbreviations

AARN	Alberta Association of Registered Nurses
AB	Alberta
ACHRR	Advisory Council on Health Human Resources
AHW	Alberta Health and Wellness
AMA	Alberta Medical Association
APP	Alternate Payment Plan
ARNET	Alberta Registered Nurses Educational Trust
Assn.	Association
AUPE	Alberta Union of Public Employees
C.	Committee
Can.	Canadian
CEOs	Chief Executive Officers
CIHI	Canadian Institute of Health Information
CIHR	Canadian Institute of Health Research
CUPE	Canadian Union of Public Employees
Gr	Group
HIV	Human Immunodeficiency Virus
AIDS	Acquired Immunodeficiency Syndrome
HPA	*Health Professions Act*
HR	Human Resource
HSAA	Health Science Association of Alberta
HWIN	Health Workforce Information Network
IM/IT	Information Management/Information Technology
LMCG	Labour Mobility Coordinating Group
LPN	Licensed Practical Nurse
MEET	Management and Employee Enhancement Team
NAIT	Northern Alberta Institute of Technology
NP	Nurse Practitioner
PACH	Premier's Advisory Council on Health
PHAA	Provincial Health Authorities of Alberta
PHWSC	Provincial Health Workforce Steering Committee
PNP	Provincial nominee Program
PRPC	Physician Resource Planning Committee
Rec	Recommendation
RHAs	Regional Health Authorities
RN	Registered Nurse
RPAP	Rural Physician Action Plan
SAIT	Southern Alberta Institute of Technology
UNA	United Nurses of Alberta

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