FLAOHT Frontenac Lennox & Addington Ontario Health Team | ÉSOFLA Équipe Santé Ontario de Frontenac, Lennox et Addington

POLICY BRIEF

KEY FINDINGS

1. **Regional health workforce data is highly variable, inconsistent, difficult to access and not organized by Ontario Health Team (OHT).**
2. **It is a challenge to understand the population's current and future health service needs with data that is out of date and not bounded by OHT.**
3. **Health human resource (HHR) planning is largely conducted off the side of a desk, with few resources and a lack of regional focus.**
4. **Currently there is little infrastructure in the OHT to support health human resource data or regional planning.**

Regional Health Human Resource Planning

The Frontenac Lennox and Addington Ontario Health Team (FLA-OHT) is working together with their partners and community to support the needs of their local populations to deliver seamless and coordinated care across all sectors. A regional workforce that can meet these needs is core to this vision and one of the key strategic directions of the FLA-OHT.

The policy brief provides a set of proposed policy options to support the FLA-OHT in their HHR planning.

Why is this important right now?

We are experiencing a health human resource crisis. In the FLA-OHT, 15% of the population do not have a family physician, approximately 50% do not have access to a primary care team and our hospitals are relying on contracted nursing services. Without the effective and optimal utilization of knowledge, skills and expertise, people cannot access the health services they need[1]. At a regional level, HHR planning ensures that the unique realities of local health systems are considered along with community priorities and population health needs.

Many approaches to HHR planning are siloed, focused on one profession, one sector or population. *To address local population health needs we need to ensure FLA-OHT workforce planning aligns with the goal of integrated and coordinated care across sector.*

Methods

A scoping review was conducted to identify HHR planning frameworks that: i) considered multiple professions, ii) adopted a population-based approach, iii) were designed for regional HHR planning, and iv) were developed for a Canadian context.

A deliberative dialogue was held to obtain input from diverse voices of the FLA-OHT and provincial and federal decision makers to inform final policy recommendations.

Four Phases

1.The Integrated Primary Care Workforce Planning Toolkit[2,3] was identified and applied to the FLA-OHT. Multiple regional, provincial and federal data sources were used to describe the FLA-OHT population, their health needs, and the service providers.

2.Interviews with FLA-OHT leaders and community members provided insights into the regional context.

3. A review of publicly facing HHR documents of 54 OHTs was conducted.

What we learned

From the literature: A total of 113 articles were found and five primary approaches to HHR planning were found, including needs-, supply-, demand-, competency- and scenario-based. The needs-based approach aligned best with the principles of integrated care models with the identification of a population's need for health services, expected future needs, and provider requirements for multiple professions.[6,7] The Integrated Primary Care Workforce Planning Toolkit[2,3] met all criteria.

The Toolkit[2,3], co-developed using an action research approach, incorporates data related to demography, socioeconomic and cultural diversity, health status, health services utilization and needs, and metrics of unmet healthcare need. The Toolkit includes a workforce planning model[3] (Figure 1) that identifies a series of data modules to consider in HHR planning. The authors assessed the availability, comprehensiveness, and quality of the needed data. Importantly, population variables, such as gender, language, race, Indigenous identity, and disability, are included which facilitate a health equity dimension to workforce planning.

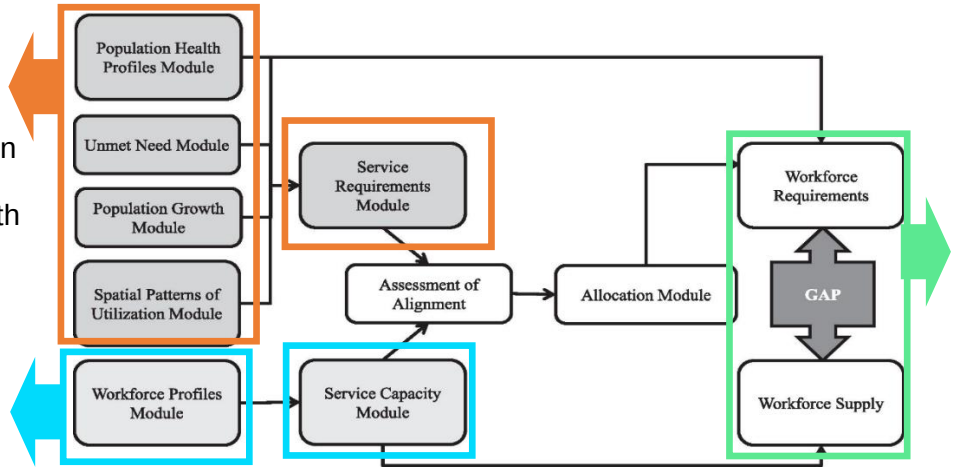
HHR Defined

HHR planning is defined as the process of estimating the number of persons and the right mix of providers with the knowledge, skills, and expertise to provide high-quality care when and where people need it in a given population[4,5]

"Although this framework was developed for a pan-Canadian approach to health workforce planning, as a guiding framework it emphasizes some of the key principles of high-quality HWP that can be incorporated at a regional level" (p2.)[2,3]

Integrated Primary Care Workforce Planning Toolkit

Identifies data related to the FLA-OHT service requirements including population demographics, health status, health use



Determines the gap between the requirements of the FLA-OHT community and the available health workforce

Identifies data related to the FLA-OHT health workforce

Figure 1: Health Workforce Planning Model [3]

Using the Health Workforce Planning Model[3], we attempted to capture data related to service requirements (including population data demographics, health status, and health services utilization) and service capacity (health workforce) to determine the fit between the two and identify if gaps existed. Data were gathered at the provincial, regional, hospital/clinic and educational institution levels.

Understanding the FLA-OHT Populations Needs: Challenges and Data Gaps

- Data was collected from six different sources from **2016-2022**: Canadian Community Health Survey (CCHS), 2017-2018; City of Kingston, 2016 and 2021 Canadian Census; Public Health Ontario, INSPIRE-PHC Primary Care Reports 2022; and the Ontario Community Health Profiles Partnership.
- Most data was specific to the Kingston, Frontenac, Lennox and Addington (KFLA) region while other data was only available for the city of Kingston, the previous Local Health Integration Network (LHIN) and all of Ontario.
- Community services in the region reported different boundaries than the FLA-OHT.
- The three hospitals reported a patient catchment area outside the FLA-OHT boundaries. Therefore, populations needing these services differ from the population within the FLA-OHT.
- Data gaps were identified in two areas. For Social Assistance, data was pulled for Ontario Disability Support Program + Ontario Works. Data regarding other welfare programs was not found. Data pertaining to eye exams for people with diabetes was not publicly available.
- Most data was available related to the population health profiles module while limited data was located on unmet needs, population growth and spatial patterns of utilization.
- Data was available on current - not future service requirements.

Contextual Realities in the FLA-OHT

Regional key informant interviews highlighted that an assessment of population need was often not completed – people were "flying blind" as data was not available, and agencies did not have the skills, time or resources to adequately "do" HHR planning effectively.

"And I don't know that there's any specific tools or data that we use, other than somebody's leaving, it's time to replace. Or there's a whole bunch of people who don't have family doctors… It's more there are hundreds of people calling the office every day. There must be a shortage kind of thing."

"And beyond that we haven't as far as I know done the numbers. Like I'm not sure that we know how much of our practice of our X patients require that type of service and support… I'm not sure we've broken down the population to understand exactly how much of the program we need to be providing."

Understanding the FLA-OHT Workforce: Challenges and Data Gaps

Health workforce data was collected from seven different sources:

1. An online survey was sent to all FLA-OHT partners to obtain workforce description– including volunteers and unpaid caregivers, sick time/absenteeism, the ability to provide English and French language services and services to our Indigenous populations.
2. Family Health Team, Family Health Organization clinic websites.
3. Public Health primary care data.
4. FLA-OHT – primary care roster data.
5. Professional colleges - 30 colleges in total were reviewed (note PSW's do not have a College).
6. South Eastern Ontario Medical Organization Physician Specialist data.
7. Ontario Health Data Branch.

Surveys sent to all OHT partners

Completed surveys

Data sources provided current workforce numbers only. Without the ability to accurately determine the current workforce we cannot make accurate projections of future capacity.

Inconsistency in operational definitions

FTE, full-time, part-time, sick time and absenteeism

12 reported full-time equivalent (FTE) & body count, 5/12 reported incomplete FTE / body count, 6 reported only body count, and 1 reported only FTE. Four reported both sick time and absenteeism;15 reported a mix of sick time/absenteeism or none.

Specific sectors to note:

Hospitals	Hospitals were well represented in the data due to reporting requirements and clear identification of staff who are responsible for obtaining and reporting the data.
Primary Care	Primary care is core to the FLA-OHT, with the vision of a Health Home for every person. The high value placed on primary care resulted in robust primary care data, with FLA-OHT partners and staff providing dedicated resources to collect primary care data.
Community Support Services	Least represented in the data were Community Support Services, with little staffing infrastructure to compile data, no HHR reporting and a workforce that relies heavily on volunteers that are difficult to quantify. PSWs heavily work in this sector and do not have a College to identify workforce data.
Caregivers and Volunteers	The survey highlighted the importance of informal caregivers and volunteers, comprising 8.6% and 1.9% of total care providers. However, this data significantly underestimates the reliance on unpaid individuals to fill gaps in the workforce. There is currently no formal way volunteers or caregivers are identified, reported or factored into HHR planning.
Private	Many private health care providers (pharmacy, psychology, psychotherapy and physiotherapy) were not formal OHT partners and did not receive the survey. Private providers were identified by handsearching College websites. Consideration needs to be made for the private providers in regional HHR planning.

Contextual Realities in the FLA-OHT – Service Capacity Data

Regional participants reported a lack of comprehensive and up to date data on the available workforce, including total numbers as well as an understanding of the services provided and to whom.

"And in the absence of current information we're flying blind. We don't know who to recruit, we don't know what characteristics we need."

"So I think the biggest constraints are, number one, data and number two capacity. So, in terms of data constraints, we really – there are a lot of data out there, but especially for medicine and nursing. But the data are not comprehensive, so we're missing huge parts of our workforce – like PSWs – we know nothing about PSWs – where they work, who they are, how they work."

Participants also spoke about the need for data related to the future workforce and the impact of workforce trends on future staffing. Others expressed concerns as to whether information on workforce gaps was being fed back to educational institutions to prepare for the future.

"As an example, we have an aging workforce here within Kingston, we ..we're going to be needing more people in the future.

"We need to have something better than numbers written on the back of an envelope or on a napkin. And I fear that when we talk about regional HHR planning, that's where we are right now, we don't have a good understanding and an appreciation of human resources that are in place, what the needs are, what the needs are today, let alone what the needs will be one, three, five years from now. And as a result, we can then ask questions about how can do our jobs differently"

Participants spoke about the lack of qualified people to fill positions and the resultant culture of competition.

"But from a regional perspective, if we can buy into the greater – the region makes sense. What we do best for the region will serve all corners of it better, then that competition factor goes away. But it doesn't exist now at the moment. It's a competition from everything from locums to primary care providers to nurses and hospitals."

Assessment of the FLA-OHT Population and Workforce - How to Minimize Gaps?

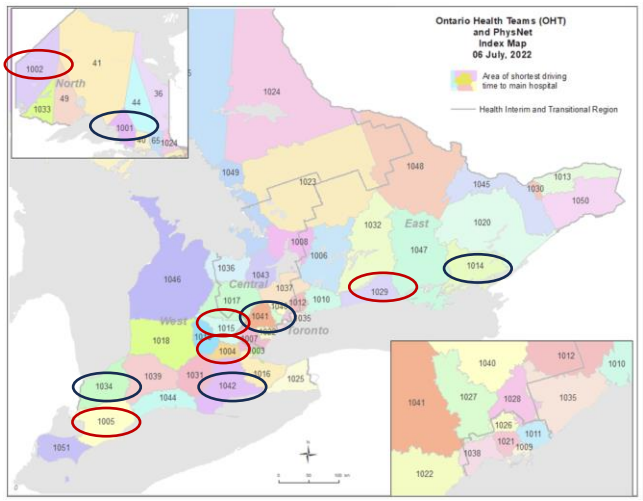
The final steps in the workforce planning model are to assess for alignment - looking at the FLA-OHT population and the capacity of the FLA-OHT providers.

- We were unable to obtain accurate data for population health and growth, unmet need and spatial patterns of utilization as well as the workforce - as a result, an objective assessment of the gap between service requirements and service capacity could not be done.

What is happening across the province?

A review of 54 OHT websites found only 12 OHTs had documents mentioning HHR, including strategic plans (66.7%) and other reports (year-end reports, CQIP reports, Integrated Care Reports and Primary Care Reports). The FLA-OHT stands out as one of the few OHT's with HHR planning specifically highlighted within a publicly facing Strategic Plan. It should be noted that 3 of the 12 Accelerated OHTs were included in the 12 OHTs with HHR documentation.

OHTs with HHR Planning



Code	OHT	Attributed Population
1001	Algoma	98 142
1002***	All Nations Health Partners*	27 741
1004	Cambridge North Dumfries	149 993
1005	Chatham-Kent	98 601
1009	Downtown East Toronto	139 248
1014***	FLA-OHT**	214 766
1015	Guelph Wellington	221 713
1026***	North York Toronto**	503 291
1029	Northumberland	52 656
1034	Sarnia Lambton	114 269
1041	Central West	879 144
1042	Brantford Brant	191 303

Red=First Wave; Black = 2nd Wave; ** = Accelerated OHT

What do we need to move forward?

Very few participants spoke about having resources or supports for HHR planning, with most planning happening off the side of the desk. In addition to a lack of data, many reported limited tools and policies to assist with the HHR planning process.

"And a lot of the planning is responsive, right. A lot of what we do now is kind of filling the gaps and back tracking as opposed to anticipating needs. So, I think ideally we would be anticipating need well in advance so we're able to provide the support, the HHR support when its needed as opposed to waiting until a crisis."

"And so not every hospital or health service provider has the same level of human resource expertise. And many of them are hard pressed to do their own work, let alone work on the side of their desk, for the region"

"And then having strong leadership as well to, you know, build consensus, build up the idea of like, consistent and local equity, determine local priorities"

They spoke about potential solutions to minimize the current and future gap between the service requirements and capacity as well as some of the limitations in implementing creative solutions.

"If we had a flat rate and integrated labour, whatever the union would be, or even without a union, it would be a lot easier for people to carry portability and staff as an organization and move people kind of where you need to. Right now we're in silos"

"Do we all kind of as a community decide that we're going to share resources between us? And maybe there's some surplus of like a point one or a point two in one FHT and a surplus of a point one and a point two in another FHT, and that funding doesn't get used until you combine it together by providing a community-based resource. I think those are the discussions that we need to have at the health home support structure to understand how we can promote team-based care without influx or more money or influx of more funding."

Conclusion

The alignment of HHR planning across the province and regional OHTs is central to achieving the quintuple aim outcomes. However, our review of HHR planning with the FLA-OHT has illustrated that HHR planning is complex with many significant challenges including lack of time, lack of resources, lack of standardized data, data siloed either by profession or sector, and increased competition between healthcare facilities. Comprehensive data and HHR initiatives are essential to ensure more efficient HHR planning. Representation of HHR at leadership tables is crucial if the FLA-OHT is to be a regional leader in bringing sectors and organizations together for a unified workforce that supports the population needs.

Recommendations

	Provincial Recommendations	Regional Recommendations
Governance	**Establish clear lines of communication and responsibility between the Ministry of Health, Ontario Health and Ontario Health Teams (OHTs) for overseeing all HHR related issues with clearly defined roles, responsibilities, expectations, accountability, and consistency.** a) Implement a Pan Ontario HHR Committee with diversity, equity and OHT representation. b) Create mechanism for OHTs to escalate HHR issues/concerns to Ontario Health, Ministry of Health, and other applicable ministries (e.g., MCU). c) Implement bi-annual opportunities for discussion among OHTs, Ontario Health, and Ministry of Health to create awareness, leverage existing initiatives/resources, and share best practices. d) Develop effective mechanisms and funding to support innovative proposals and continuation of successful initiatives. Scale up ideas that smaller organizations have successfully implemented to support regional planning.	**Establish a structure within the FLA-OHT's governance (e.g. HHR planning) that is directly responsible for regional HHR planning, has a voice at the Transitional Leadership Council (current)/ Board (future) and is a core part of strategic planning, annual retreats and quarterly partner updates.** a) Membership will have cross sectoral and diverse community representation, including regional educational institutions. b) Serve as the point of communication for the Ministry of Health and Ontario Health. c) Be a conduit to provide input to any future Pan Ontario HHR Planning Committee. d) Receive any regional HHR planning issues and use any future provincially created mechanism to report and escalate regional issues from FLA-OHT to OH, MOH and other applicable ministries. e) Support OHT collaboration and communication for HHR planning across OH regions. f) Establish a requirement for regular regional HHR assessment to identify unique barriers that may influence FLA-OHT HHR planning. g) Include equity, representation, cultural awareness, and cultural sensitivity of the health workforce as foundational values for HHR planning and create a standalone policy.
Data	**Provincial support/investment in data systems and data elements that support planning and build capacity for HHR planning within and across OHTs.** a) Working with CIHI, develop/revise a minimum data standard provincially, informed by the OHTs, to identify key indicators of both the health workforce and regional populations that can be	**Establish annual OHT HHR reporting requirements that are consistent with provincial standards along with mechanisms to ensure accessible, up-to date, consistent, regional-level and accurate data is available to all FLA-OHT partners, including HHR projections based on local population data and needs.** a) Identify an individual/structure who is responsible for the workforce data within the OHT and at each partner organization.

	Provincial Recommendations	Regional Recommendations
	used to benchmark progress across sectors within the OHTs. This includes elements identified in the Health Workforce Planning Toolkit as well as attributable populations, and health workforce metrics (turnover, sick time, overtime). b) Establish consistent definitions and methodologies for all core and reported data (e.g. FTE, FT, PT, vacancy rates, overtime) with a publicly available data dictionary and provincial tables that provide transparency for the data methodology. Data must be at a granular level to match OHT catchment areas and the OHT needs. c) Embed equity and representation into all data elements and systems. d) Standardize data collected by regulatory colleges and create one portal with easy searchability. e) Address large data gaps in the health workforce data and determine how to collect this data, including volunteers, caregivers, privatized sectors (e.g. pharmacists, physiotherapists), community services (e.g. community-based outpatient rehab), and unregulated providers (e.g. personal support workers, occupational therapist assistants).	b) Create clear and transparent processes within the OHT and partner organizations to obtain workforce data. c) Establish regional processes (e.g. surveys, annual reporting) to collect local workforce data that is currently not available (e.g. interprofessional providers). d) Develop regional data sharing agreements for metrics not collected centrally or unique regional outcomes/indicators and establish a mechanism to store FLA-OHT specific data. e) Utilize future pan-OHT blanket data sharing agreements or template agreements for OHTs where applicable. **Leverage technology/supports to gather data, address current data gaps and consolidate this data for the FLA-OHT.** **Include HHR data within any FLA-OHT data dashboard.**
Infrastructure	**Provide infrastructure support to OHTs to enhance data collection of HHR data across the province. This support includes funding, human resources, and education**. a) Create more efficient data mechanisms that minimize bureaucratic barriers, reduce duplication and ensure data is more accessible, up-to-date,	**Ensure regional structures have dedicated resources to support HHR planning, including access to personnel, education funding and infrastructure to collect, report and use health workforce data.** a) HHR planning support may include identifying and leveraging current HHR data supports within the FLA-OHT to provide

	Provincial Recommendations	Regional Recommendations
	accurate, and applicable to the OHT boundaries with a clear process on whom to contact and how to access the data. This includes Pan-OHT legal data sharing agreements to access databases such as the health professions database.	support for smaller less resourced organizations, including mentorship in health workforce data collection and utilization. b) Ensure equity and representation in all data elements and systems regionally. **Adhere to consistent definitions (e.g. FTE, FT, PT) and methodologies for all core and reported data and ensure all reporting follows these definitions/guidelines. Ensure data dictionary and provincial tables/OHT specific information is publicly available for all regional members to utilize.** **As provincial data infrastructure is developed identify any regionally available data that is available that could address critical gaps in data (e.g. interprofessional providers).**
HHR Planning Framework	**Embed the Health Workforce Planning Toolkit used in this study into the provincial health workforce planning process.** a) Develop interactive and decision-support tools including a dashboard and toolkit using the Health Workforce Planning Toolkit and other resources for OHTs to use. b) Embed equity, representation, cultural awareness, and cultural sensitivity of the health workforce into the HHR planning resources and framework. c) Provide education to all OHTs regarding the tools available and their use.	**Embed the Health Workforce Planning Toolkit consistently across the FLA-OHT in the regional HHR planning process and ensure all necessary data required for the tool is available.** **Facilitate access to/provide training and tools (e.g. provincial developed dashboard/toolkit) to regional personnel across regional organizations to develop skills/capacity for objective HHR planning in a standardized manner/using evidence-based practices.** **Embed equity, representation, cultural awareness, and cultural sensitivity of the health workforce into the health HHR resources and framework for the region.**
Workforce Consolidation	**Primary Care: Prioritize addressing a primary care interprofessional health workforce strategy which will then drive or propel policy recommendations for other sectors and serve as a model.**	**Within the FLA-OHT, begin with the Health Home as the most structurally able to establish a consolidated workforce in the FLA-OHT and begin a phased implementation.**

	Provincial Recommendations	Regional Recommendations
	a) Focus on the Health Home as a starting point of planning then add other priority. b) Enhance a comprehensive primary care environment that is focused on retention, respect, recruitment and return (4 Rs).	a) Identify priority populations (e.g. care pathways) and focus on hiring a workforce that would be jointly recruited and hired, with mobility between health homes. **Establish organizational health workforce policies within Health Homes that support a consolidated workforce, including:** a) Wage harmonization across organizations and sectors for similar job positions and skill requirements, (noted this is unrealistic due to costs and labour relations). b) Hiring for population need and skill requirement versus professional designations. c) Establishment of joint recruitment advertisements. d) Prioritization of workforce recruitment based on FLA-OHT strategic priorities. **Create a code of ethics in hiring and recruitment that reflects the value and goal of an integrated workforce that supports the full FLA-OHT.** **Utilize internationally trained health care providers that are currently not employed in the healthcare sector due to provincial/national policies.** **Invest in retention strategies, including creating positive employment settings.**
Healthcare Professional Education	**Support all educational institutions to address current and anticipated gaps in the healthcare workforce (demand for profession, pipeline for admissions, fill vacancies). This includes funding which aligns with the number of allotted seats.**	**Establish mechanisms to share workforce data with Queen's University, St. Lawrence College and other regional educational systems/institutions to create awareness of HHR needs.**

References

1. World Health Organization. Action towards achieving a sustainable health workforce and strengthening health systems: implementing the WHO Global Code of Practice in the European Region Geneva: WHO (Regional Office for Europe); 2012. No. WHO/EURO: 2012-2220-41975-57689.

2. Bourgeault, I. L., Chamberland-Rowe, C., & Simkin, S. Co-developing an integrated primary care workforce planning approach at a regional level: overarching framework and guiding principles. Hum Resour Health. 2021;19(1), 87.

3. Simkin S, Chamberland-Rowe C, Bourgeault IL. An integrated primary care workforce planning toolkit at the regional level (part 2): quantitative tools compiled for decision-makers in Toronto, Canada. Hum Resour Health. 2021;19(1):86.

4. Mejía A, Fülöp T. Health manpower planning: An overview. In: Hall T, Mejía A, editors. Health manpower planning: Principles, methods, issues. Geneva: WHO; 1978. p. 9–30.

5. Tomblin Murphy G, Birch S, MacKenzie A, Bradish S, Elliott Rose A. A synthesis of recent analyses of human resources for health requirements and labour market dynamics in high-income OECD countries. Hum Resour Health. 2016;14(59):1-16.

6. MacKenzie A, Tomblin Murphy G, Audas R. A dynamic, multi-professional, needs-based simulation model to inform human resources for health planning. Hum Resour Health. 2019;17(1):42.

7. Waddell K, Wilson MG. Rapid synthesis: Exploring models for health workforce planning. Hamilton: McMaster Health Forum. 2019. 16 July.