WORKFORCE STRATEGY FOR CONTINUING CARE IN ALBERTA

2012 TO 2017

FEBRUARY 2012
Numerous individuals and organizations shared their expertise, firsthand experience and gave substantial time in supporting the development of the Workforce Strategy for Continuing Care through their participation on the Steering Committee and in responding to the Workforce Survey. Sincere appreciation and thank you is extended to Alberta Employment and Immigration for funding the project through the Labour Market Partnerships Grant Program.
EXECUTIVE SUMMARY

The continuing care sector is in a state of flux: the needs of clients are increasingly complex, service models are adapting, and the service offering is evolving. Effective staffing is integral to the success of this dynamic and diverse environment. Staffing must align with the needs of the three interdependent streams in continuing care, dozens of employers, hundreds of facilities, impacting thousands of health workers who serve tens of thousands of Albertans.

The Workforce Strategy for Continuing Care (CC) considers the current workforce situation, the forces and sources of change, and future demands to address workforce challenges and develop reasonable and attainable strategies to deal with current and future labour shortages in the growing continuing care sector.

The diagram above provides a high level summary of the Continuing Care Workforce Strategy. The following sections provide a detailed explanation of its components.

WHAT IS THE CONTINUING CARE SYSTEM IN ALBERTA?

Alberta’s continuing care system is the union of health, personal care, accommodation, and hospitality services that support Albertans’
independence, well-being, and quality of life. The system is made up of many players: two ministries (Alberta Health and Wellness and Alberta Seniors), Alberta Health Services, Post-Secondary Institutions, various unions and lobbying groups, stakeholder organizations and hundreds of operators who hire workers and deliver services.

Continuing care services are delivered in three streams:

- **Home living** for people who live in their own house, apartment or condominium. Services are provided at the home and include: assessment, case management, professional nursing, rehabilitation therapy, social work and personal care. Services are available for all ages with health-related problems that can be managed in a community setting.

- **Supportive living** provides accommodation and hospitality services in addition to the health and personal care services provided in the home living stream. Supportive living is organized into four levels, ranging from fairly independent residents who need minimal health services in level one settings up to residents who need many health services in level four settings. Although four levels exist, some or all levels may be housed in a single Continuing Care Centre including a long term care component, allowing clients to age in place.

- **Facility living** (long term care) provides accommodation and health services in nursing homes and auxiliary hospitals. Facility living is for those individuals whose needs cannot be safely met in a home living or supportive living situation. Individuals in the facility living stream usually have medical conditions that are serious, chronic and/or unpredictable requiring the presence of a registered nurse on a 24-hour basis.

**Who is at the “Heart” of Health services in Continuing Care?**

The staff in continuing care are at the heart of the system. They provide services in health, personal services and hospitality. This Strategy focuses on the health care aides (HCAs), licensed practical nurses (LPNs) and registered nurses (RNs) who provide health and personal care services to Albertans:
- **HEALTH CARE AIDES**: Work under the supervision of a nurse or health professional. They provide basic health services, both physical and emotional, personal assistance and support services for elderly, disabled, acute or chronically ill people who require short term assistance or ongoing support.

- **LICENSED PRACTICAL NURSES**: Carry out many nursing responsibilities independently, depending on the nature and complexity of the client care required and the environment in which they work. They have a variety of nursing care responsibilities and collaborate with other health care professionals.

- **REGISTERED NURSES & REGISTERED PSYCHIATRIC NURSES**: May work independently or as members of a health care team. They provide professional nursing services; deliver health education programs; promote, maintain and restore patient health; supervise staff; and conduct research.

**WHAT IS THE WORKFORCE STRATEGY FOR CONTINUING CARE?**

The Strategy is about health workers in continuing care; it considers the implications of the sources and forces of change, identifies current challenges and describes six strategies that address these challenges to positively impact the workforce.

**THE VISION**

*STRONG & ENGAGED WORKFORCE SUPPORTING A HIGH QUALITY OF LIVING FOR ALBERTANS IN CONTINUING CARE*

**THE OUTCOME**

*RIGHT PEOPLE ... RIGHT PLACE ... RIGHT NUMBERS ... RIGHT TIME*

**WHAT MAJOR FORCES ARE IMPACTING CONTINUING CARE?**

Actions always have consequences, either positive or negative, and may have far-reaching implications. Whenever a change occurs in one of the
following drivers or influencers, the effect ripples throughout the continuing care system, with more or less impact on the continuing care stakeholders.

- **POLITICAL ENVIRONMENT**: Provincial action plans target increases in continuing care options ... growth will require additional health workers
- **ECONOMY**: Global, federal and provincial economies are being challenged... the sustainability of the health care system is high on policy agendas
- **SOCIO-DEMOGRAPHICS**: Growing, aging and diverse seniors population... increasing expectations about preferred lifestyles impact choices of accommodation, supports and services
- **TECHNOLOGY**: Rapid and costly advances in technology... make it difficult for continuing care to keep up and optimize use of such technologies
- **MEDIA AND PUBLIC OPINION**: Negative media adversely affects public opinion... eroding the image of continuing care and its appeal to health care workers

**What Major Challenges are Impacting the Continuing Care Workforce?**

**Challenges with the Image of Continuing Care**

The public, professionals and politicians are viewed as giving little attention to continuing care in favour of the more visible, vocal and pressing demands in the acute care sector. When attention is given to continuing care, it is often negative.

**Challenges in the Employee Life Cycle**

At the heart of the Strategy are the health care workers, and surrounding them is the employee life cycle that outlines their journey from the point of entry into the continuing care sector to their leaving it. The following table describes the challenges associated with each stage in the continuing care employee life cycle.
| Stage 1: Attraction and Education | For employers, the Alberta job market is competitive across sectors for entry level positions with transferable skills. The Alberta healthcare job market is similarly competing for the same health workers. Continuing care’s public image discourages eligible workers from seeking a continuing care career. A lack of accurate workforce forecasts and a reactive methodology for opening new education seats can result in long time lags between employer demands and student supply for new workers. Some students who enter into nursing education during demand times cannot find jobs when the economy or the health system changes. The forecasting model developed for the Strategy estimates that current capacity is sufficient to meet the current needs of the entire continuing care system across Alberta; however, significant shortages of LPNs, RNs and HCAs are predicted for 2015. A greater number of health care workers must be attracted into continuing care. For HCAs, some of the initial shortages may also be addressed by decreasing the headcount to FTE ratio. |
| Stage 2: Recruitment or bringing individuals into the continuing care health workforce | Work in continuing care is emotionally and physically challenging, and wages (especially for HCAs) are not seen as being appropriate compensation; this is especially apparent when workers are comparing wages in continuing care to other sectors. The work expectations of employers may also be overwhelming; leadership roles are expected of RNs and LPNs whose education and experience in leadership is limited; HCAs may also be requested to work independently and in challenging and variable work environments. |
| Stage 3: Retention or keeping individuals in the continuing care health workforce | Workers are finding themselves employed in challenging situations with shortages of staff, and outdated equipment and infrastructure; increasing client needs further exacerbate the resulting stress. Limited educational opportunities make it difficult for workers to keep their skills and knowledge current and to seek new approaches to address these issues. Workers may feel undervalued and their work underappreciated. |
| Stage 4: Retirement or exit from the continuing workforce | Clients are not the only ones aging in place, workers are as well. An aging population and older workforce are contributing significantly to the widening gap between the supply and demand for workers. A large proportion of workers are over the age of 45. Although mature workers may experience difficulties with the physical and emotional demands of the job, relating to younger generations, and the use of technology, they possess a wealth of experience, corporate memory, and may have suitable leadership and mentorship skills. Yet these workers are slated to be exiting the health continuing care system in coming years. |
Specific information on the current supply and demands for RNs, LPNs and HCAs is lacking in the health system. The lack of information affects workforce planning and forecasting for continuing care and results in confusion on two fronts: for employers over the number and mix of staff they will need in the future, and for post-secondary institution over the number of students they should be educating.

**How does the strategy address the challenges?**

Six strategies address the challenges facing the continuing care sector, its image, the employee life cycle, and forecasting. Nineteen continuing care system actions and 33 individual employer actions help to achieve each strategy.

### System Actions

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Objective</th>
<th>Continuing Care System Actions</th>
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<tbody>
<tr>
<td><strong>Strategy 1:</strong> Enhance Continuing Care Image</td>
<td>Continuing care is positively perceived and valued by Albertans and is viewed by healthcare workers as a rewarding sector in which to work</td>
<td>1.1 Develop and implement a branding strategy for the continuing care sector 1.2 Develop, coordinate, and implement an awareness campaign promoting the continuing care sector as a workplace of choice in Alberta 1.3 Develop, coordinate, and implement an awareness campaign promoting the options in continuing care. 1.4 Advocate for consistent and positive continuing care experiences and messaging across all organizations.</td>
</tr>
<tr>
<td><strong>Strategy 2:</strong> Enhance Continuing Care Attraction and Education</td>
<td>More people attracted to and enrolled in appropriate educational programs for registered nurses, licensed practical nurses, and health care aides resulting in</td>
<td>2.1 Enhance the alignment of post-secondary institutions’ educational practicums for RNs, LPNs and HCAs with continuing care workforce priorities and needs 2.2 Develop and implement learning opportunities for junior and high school students in continuing</td>
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*Workforce Strategy for Continuing Care in Alberta*
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<th>Strategy</th>
<th>Objective</th>
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<tr>
<td></td>
<td>employment in the continuing care sector.</td>
<td>2.3 Promote the HCA designation as a bridging step</td>
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<td>2.4 Advocate for the reduction/removal of barriers to foreign and out-of-province recruitment, recognition, and certification of HCAs</td>
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<td>2.4 Advocate for the reduction/removal of barriers to foreign and out-of-province recruitment, recognition, and certification of HCAs</td>
<td>2.5 Review and harmonize professional credentialing for foreign and out-of-province RNs and LPNs</td>
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<td><strong>Strategy 3:</strong> Strengthen Continuing Care Recruitment &amp; Onboarding</td>
<td>New recruits with required technical and soft skills are hired into continuing care and provided with the necessary mentoring and orientation required for succeeding in their jobs.</td>
<td>3.1 Collaborate, develop and implement a strategic industry staffing plan</td>
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<td></td>
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<td>3.2 Develop and support industry leading practice in recruitment</td>
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<td>3.3 Promote and advocate enhancements to HCA position such as appropriate compensation, flexible benefits, reduction of casual and fractional FTEs, etc.</td>
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<td></td>
<td>3.3 Promote and advocate enhancements to HCA position such as appropriate compensation, flexible benefits, reduction of casual and fractional FTEs, etc.</td>
<td>3.4 Promote and advocate funding for the development of programs to support English proficiency</td>
</tr>
<tr>
<td><strong>Strategy 4:</strong> Increase Continuing Care Employee Engagement and Retention</td>
<td>Employees are satisfied with their jobs; they are recognized for their contributions, mentored and allowed to develop their skills, they work in an open and communicative environment and use their skills efficiently by leveraging technology.</td>
<td>4.1 Build a business case and advocate for increased funding to support continuing care client needs</td>
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<td></td>
<td>4.1 Build a business case and advocate for increased funding to support continuing care client needs</td>
<td>4.2 Collaborate on the development and implementation of plans to modernize infrastructure and advance use of enabling resident care technology in continuing care settings</td>
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<tr>
<td></td>
<td>4.2 Collaborate on the development and implementation of plans to modernize infrastructure and advance use of enabling resident care technology in continuing care settings</td>
<td>4.3 Develop and support industry leading practice in retention, recognition, mentorship and leadership</td>
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<tr>
<td><strong>Strategy 5:</strong> Engage Continuing Care Mature Workers</td>
<td>Employers engage mature workers according to their acquired knowledge and skill sets, and provide</td>
<td>5.1 Develop industry leading practice in engaging mature workers and retirement planning; develop an online community and tools to support employers in engaging <strong>mature</strong> workers</td>
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<td>Strategy</td>
<td>Objective</td>
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| **Strategy 6:**                   | A workforce forecasting model based on a single source of detailed and continuously updated data on population health and continuing care staffing is available to the continuing care sector. | **6.1** Collaborate, develop and share a workforce forecasting model based on modeling best practices  
**6.2** Develop and maintain a common database to collect and compile information required by the model |

**Employer Actions**

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<thead>
<tr>
<th>Strategy</th>
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| **Strategy 1:**                  | Continuing care is positively perceived and valued by Albertans and is viewed by healthcare workers as a rewarding sector in which to work | **1.1** Work collaboratively to champion the brand and awareness of continuing care  
**1.2** Encourage current employees who are leaders to champion working within continuing care |

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| **Strategy 2:**                  | More people attracted to and enrolled in appropriate educational programs for registered nurses, licensed practical nurses, and health care aides resulting in employment in the continuing care sector. | **2.1** Review the organization’s website to ensure it promotes the organization as a great place to work  
**2.2** Brand and promote the organization’s unique features and benefits of working in continuing care  
**2.3** Consider incentives that use employee networks to attract prospective employees  
**2.4** Forge alliances with local colleges and schools to promote continuing care and health care workers. Attend career fairs and provide practicums and summer placements  
**2.5** Keep door open to employees who left the |
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<td>Strategy 3:</td>
<td>New recruits with required technical and soft skills are hired into continuing care and provided with the necessary mentoring and orientation required for succeeding in their jobs.</td>
<td>2.6 Network to learn about industry trends and meet qualified people looking for new opportunities&lt;br&gt; 2.7 Create an internal talent pool and develop organizational talent at all levels&lt;br&gt; 3.1 Provide recruitment resources and collaborate with other employers by contributing to a provincial open online leading practice community/weblog&lt;br&gt; 3.2 Create targeted employment advertising that “sells” the organization and the job&lt;br&gt; 3.3 Develop a professional selection process that includes communicating professionally with candidates through all stages of the process&lt;br&gt; 3.4 Review selection criteria to ensure that it includes factors clearly linked to the occupational requirements, the needs of the job and organization&lt;br&gt; 3.5 Develop a strong behaviorally based interview process that helps to determine fit between the candidate, the requirements of the job and the organizational culture and include a tour of the facilities&lt;br&gt; 3.6 Develop leadership and supervisor training that focuses on effective onboarding of new employees&lt;br&gt; 3.7 Develop a strong orientation process that may include a buddy system to introduce new employees to the organization and its culture&lt;br&gt; 3.8 Follow up with new employees after three, six and 12 months to see if they are well-oriented and engaged; take action on areas identified for improvement</td>
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**Strategy 4:**<br> Increase Continuing Care Employee Engagement and Retention<br> Employees are satisfied with their jobs; they are recognized for their contributions, mentored and allowed to develop their skills, they work in<br> 4.1 Strengthen recognition programs<br> 4.2 Enhance training and mentorship programs<br> 4.3 Enhance engagement<br> 4.4 Improve communication
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|          | an open and communicative environment and use their skills efficiently by leveraging technology. | 4.5 Leverage technology  
4.6 Improve total compensation |
| **Strategy 5:** Engage Continuing Care Mature Workers | Employers engage mature workers according to their acquired knowledge and skill sets, and provide flexible work options that best meet the needs of mature workers and employers. | 5.1 Develop strategies to meet future organizational talent needs  
5.2 Provide opportunities for employees approaching retirement such as part-time work after retirement or change roles to mentorship and coaching positions  
5.3 Offer transition to retirement programs  
5.4 Develop a pool of talent for future succession opportunities  
5.5 Encourage good workers to return to the organization should their circumstances allow it  
5.6 Conduct exit interviews through a neutral party to gather information on how the employee who is leaving felt about the organization and then utilize the data for organizational improvement  
5.7 Reinforce a concept of graceful exits |
| **Strategy 6:** Strengthen Continuing Care Workforce Data | A workforce forecasting model based on a single source of detailed and continuously updated data on population health and continuing care staffing is available to the continuing care sector. | 6.1 Continuously share detailed current information on client needs/acuity  
6.2 Continuously share detailed current information on staffing  
6.3 Use the workforce forecasting model as a benchmark for staffing best practices |

**LET'S WORK TOGETHER TO DEVELOP A WORKFORCE THAT PLACES THE RIGHT NUMBER OF WORKERS WITH THE RIGHT SKILLS INTO THE RIGHT SETTINGS AS THEY ARE NEEDED.**
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**Introduction**

The Alberta Continuing Care Association (ACCA) represents owners and operators of facility living and designated assisted living facilities and providers of publicly funded home care and home support services. ACCA is a non-profit voluntary organization that advocates for the private, voluntary and public sector providers in the continuing care system in Alberta. One of ACCA’s Strategic Priorities is to ensure a sustainable workforce in continuing care health services. Assisted with a grant from Employment and Immigration, ACCA undertook the development of a Workforce Strategy for Continuing Care in collaboration with stakeholders. The project was overseen and guided by a broad-based stakeholder Steering Committee.

The major deliverable was the development of a practically oriented but high quality strategy for the continuing care sector in Alberta. This document provides the Workforce Strategy for Continuing Care in Alberta.

**Purpose of the Workforce Strategy**

The purpose of the Workforce Strategy for Continuing Care is to:

- Determine the current situation and future demands and address the workforce challenges to help update and/or develop strategies to fill potential shortages.
- Develop reasonable and attainable strategies to deal with current and future labour shortages in the growing Continuing Care workforce.

The Strategy includes the three streams of the Continuing Care system – home care, supportive living, and facility living, focusing on health care aides (HCAs), licensed practical nurses (LPNs), and registered nurses (RNs). Please note that Registered Psychiatric Nurses are also employed in Long Term Care. References to RNs also include RPNs when appropriate.

The Strategy focuses on the publicly funded continuing care system, with appreciation that there are also workforce pressures from the parallel private continuing care system that includes home care and supportive
living. Similar needs for HCAs, LPNs and RNs are also experienced in the acute and primary care sectors.

The two major audiences for the Workforce Strategy are expected to implement the actions identified in this Strategy:

- **Continuing Care System Stakeholders**: all the players who, together, have a collaborative role and stake in the outcomes expected of the continuing care system as a whole.
- **Continuing Care Employers**: all the employers who own and operate continuing care settings who are responsible for the attraction, recruitment, retention and retirement of the targeted health care workers.

**Organization of the Strategy**

The remainder of the Workforce Strategy for Continuing Care in Alberta is organized into six sections:

- **Framework for Developing the Workforce Strategy for Continuing Care**: describes the framework for developing the Workforce Strategy, gives an overview of the Workforce Strategy, the methodologies used in developing the Workforce Strategy and the acronyms used throughout the Workforce Strategy.
- **Understanding Alberta’s Continuing Care System**: describes the three continuing care streams that make up Alberta’s continuing care system and provides a description of the health care workers targeted for this Strategy.
- **Current Situation in the Continuing Care System**: describes the four stages of the employee lifecycle that underpin the Workforce Strategy.
- **Understanding the Environmental Context for Continuing Care in Alberta**: describes the major forces and sources of change having an impact on the environment in which continuing care operates in Alberta.
- **The Workforce Strategy for Continuing Care**: gives the details on the Workforce Strategy, highlighting the objectives and actions to be taken for six identified strategies.
- **Appendices**: contains four appendices: list of the Steering Committee members, executive summary of the literature review,
detailed information on the Continuing Care Operator Survey and the Workforce Model; overview of Registered Psychiatric Nurses.

Acknowledgements

Numerous individuals and organizations shared their expertise, first hand experience and gave substantial time in supporting the development of the Workforce Strategy for Continuing Care through their participation on the Steering Committee and in responding to the Workforce Survey. Sincere appreciation and thank you is extended to all individuals and organizations for their commitment and diligence in developing, reviewing and providing recommendations to the Alberta Continuing Care Association for the Workforce Strategy in Continuing Care. A list of the Steering Committee members is given in Appendix A.
FRAMEWORK FOR DEVELOPING THE WORKFORCE STRATEGY

The framework for the Workforce Strategy for Continuing Care shows all of the elements that went into the development of the Workforce Strategy for Continuing Care.

The Strategy addresses the three streams of home living, supportive living, and facility living in continuing care.

The Strategy focuses on three types of health care workers: HCAs, LPNs and RNs.

The Strategy revolves around the employee life cycle with a focus on attraction, recruitment, retention and retirement.

The Strategy is developed in the context of environmental drivers and influencers in key areas: political environment, economy, socio-demographics, technology and media/public opinion.

Information for the Strategy was drawn from four key sources: environmental factors, literature review, workforce survey and the stakeholder consultations.

The Strategy consists of a vision, guiding principles and strategic goals. Each strategic goal gives the issue, objective, continuing care (CC) system priority actions, Continuing Care employer actions, performance indicators and background information.

The Strategy provides a summary of the strategic goals and actions by the Continuing Care system and Continuing Care employers.
PARAMETERS OF THE WORKFORCE STRATEGY FOR CONTINUING CARE

The Workforce Strategy for Continuing Care addresses:

• **Three continuing care streams**: of home living, supportive living and facility living.

• **Three health care workers**: RNs, LPNs and HCAs. It notes that RNs working as Community Case Managers are found in the home living and supportive living streams while RNs are on site 24/7 in the facility living stream.

• **Employee lifecycle**: attraction, recruitment, retention and retirement.

• **Environmental context** in which continuing care operates: political environment, economy, socio-demographics, technology and media/public opinion.

METHODOLOGY

The methodology to develop the Workforce Strategy for Continuing Care involved several components:

• **A literature review**. The literature review was limited to online documents available in the public domain that were published or developed between 2006 and 2012 in order to access the most current information. The executive summary of the literature review is available in Appendix B.

• **A workforce survey** of continuing care employers in the home care, supportive living and facility living streams. As part of developing the workforce strategy, an accurate picture was needed of the current staffing situation as it relates to three key health care roles: RNs, LPNs and unregulated health care workers (Health Care Aides, Personal Care Aides, Home Care Aides, Health Support Worker and Nursing Attendants). A survey was developed to look at these staff positions in home care (HC), supportive living (SL) and facility living (LTC) settings. Using this information as a baseline, the future needs for these staff positions were determined. The gap between the current staffing situation and the future staffing needs provided information to help identify the actions to be taken in the Workforce Strategy.
**Stakeholder Consultations.** Forty-four stakeholders were identified for interviews. Thirty-two interviews, involving 56 people, were completed. Two provincial forums were held in the fall 2011; one in Calgary on September 27 and the other in Edmonton on September 29, to review the workforce survey process, findings from the literature review and to consult on the proposed strategy.

**Listing of Acronyms**

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<th>Name</th>
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<tr>
<td>ACCA</td>
<td>Alberta Continuing Care Association</td>
<td>DSL</td>
<td>Designated Supportive Living</td>
</tr>
<tr>
<td>AE</td>
<td>Alberta Education</td>
<td>GOA</td>
<td>Government of Alberta</td>
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<tr>
<td>AET</td>
<td>Advanced Education and Technology</td>
<td>HC</td>
<td>Home Care</td>
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<tr>
<td>AHS</td>
<td>Alberta Health Services</td>
<td>HS (EI)</td>
<td>Human Services (Employment &amp; Immigration)</td>
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<td>AHW</td>
<td>Alberta Health and Wellness</td>
<td>LTC</td>
<td>Long Term Care</td>
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<td>AS</td>
<td>Alberta Seniors</td>
<td>NFP</td>
<td>Not For Profit</td>
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<td>ASCHA</td>
<td>Alberta Senior Citizens’ Housing Association</td>
<td>PSI</td>
<td>Post-Secondary Institutions</td>
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Understanding Alberta’s Continuing Care System

In this section, a brief overview is given of the continuing care system in Alberta. An understanding of the continuing care system, its components, the characteristics of the individuals being served and the type of health services required is critical to the development of the workforce strategy. Information on each of the health care workers is also necessary for the strategy. Key findings of the literature review and stakeholder consultations conclude this section.

Three Continuing Care Streams

Alberta’s continuing care system provides health and personal care, accommodation and hospitality services to support Albertans’ independence, well-being and quality of life. The continuing care system is a joint responsibility of two government ministries: Alberta Health and Wellness (AHW) for health and personal care services and Alberta Seniors (AS) for accommodation and hospitality services. Continuing care services are delivered in three streams. A brief description of each continuing care stream follows:

Home Living Stream

Home living is for people who live in their own house, apartment, condominium and in other independent living options. Home Care Program services include: assessment, case management, professional nursing, rehabilitation therapy, social work and personal care. Services are available for all ages with health-related problems that can be managed in a community setting.

Services are based on assessed unmet need for short term or long-term care, and include palliative or end-of-life care. Home care also provides assessments for Alberta Aids to Daily Living (AADL) benefits to support independence, applications to continuing care centres, supportive living, and facility respite care.
Supportive living is gaining increasing prominence in Alberta. The terminology used in supportive living varies. However, the Supportive Living Framework (2007) names and describes four levels of supportive living. The framework illustrates how the resident’s needs change from one level to the next, requiring more services as their dependencies increase:

- **Level 1: Residential care**: individuals can arrange, manage and direct their own care, make decisions about their day-to-day activities and can manage most daily tasks independently. Some supports/services are required and personal assistance can be scheduled. Their primary needs are for safety, security and socialization.

- **Level 2: Lodge Living**: individuals can arrange, manage and direct their own care, make decisions about their day-to-day activities and can manage most daily tasks independently. A basic set of supports/services is required and all or most personal assistance can be scheduled. Residents may require some assistance/encouragement to participate in social, recreational and rehabilitation programs.

- **Level 3: Assisted Living**: individuals have choices but may need assistance in making some decisions about day-to-day activities and require assistance with many daily tasks. Most personal assistance can be scheduled. The need for unscheduled personal assistance is infrequent. May require increased assistance to participate in social, recreational and rehabilitation programs.

- **Level 4: Enhanced Assisted Living**: individuals need assistance in making decisions about day-to-day activities, but should still be given as many choices as possible. Requires assistance with most/all daily tasks. The need for unscheduled personal assistance is frequent. Requires enhanced assistance to participate in social recreational and rehabilitation programs.

**Designated Supportive Living (DSL)**. Alberta Health Services contracted arrangements are referred to as Designated Supportive Living. DSL refers to spaces contracted from an operator (or operated by AHS) for sole
access of Alberta Health Services within a congregate living setting. The spaces are used for individuals assessed as requiring continuing care health services in a congregate living environment.

**Facility Living Stream**

Facility living (FL) includes nursing homes and auxiliary hospitals. Facility living provides facility living for those individuals whose needs cannot be safely met in a home living or supportive living situation. Individuals in the facility living stream usually have medical conditions that are serious, chronic and/or unpredictable, requiring the presence of a registered nurse on a 24-hour basis.

**Continuing Care Centres.** Some, or all, levels of supportive living and a long term care (facility living) component may be housed in a single location. These Continuing Care Centres provide an integrated approach to the provision of services and care allowing services to be adjusted as care needs change rather than the client having to move to another setting;

**Three Targeted Health Care Workers**

The Workforce Strategy for Continuing Care targets three types of health care workers: health care aides (HCAs), licensed practical nurses (LPNs) and registered nurses (RNs). An overview of each of these positions follows with pertinent information taken from the Alberta Occupational Profiles and the professional bodies responsible for registration: LPN (College of Licensed Practical Nurses of Alberta) and RN (College and Association of Registered Nurses of Alberta). Demographic information is taken from the workforce strategy survey.
HEALTH CARE AIDES (HCAs)

Demographics

TABLE 1) REPORTED HCAS BY AGE COHORT BY CONTINUING CARE STREAM, FEBRUARY 2011

![Chart showing reported HCAs by age cohort and continuing care stream]

<table>
<thead>
<tr>
<th>Age Cohort</th>
<th>Supportive Living Setting(s)</th>
<th>Home Care</th>
<th>Long Term Care Settings(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>19 to 24</td>
<td>3%</td>
<td>4%</td>
<td>7%</td>
</tr>
<tr>
<td>25 to 29</td>
<td>12%</td>
<td>8%</td>
<td>7%</td>
</tr>
<tr>
<td>30 to 34</td>
<td>12%</td>
<td>9%</td>
<td>8%</td>
</tr>
<tr>
<td>35 to 39</td>
<td>13%</td>
<td>12%</td>
<td>13%</td>
</tr>
<tr>
<td>40 to 44</td>
<td>13%</td>
<td>15%</td>
<td>12%</td>
</tr>
<tr>
<td>45 to 49</td>
<td>15%</td>
<td>17%</td>
<td>15%</td>
</tr>
<tr>
<td>50 to 54</td>
<td>8%</td>
<td>9%</td>
<td>10%</td>
</tr>
<tr>
<td>55 to 59</td>
<td>2%</td>
<td>4%</td>
<td>8%</td>
</tr>
<tr>
<td>60 to 64</td>
<td>0%</td>
<td>1%</td>
<td>2%</td>
</tr>
<tr>
<td>65 to 69</td>
<td>5%</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>70 to 100</td>
<td>10%</td>
<td>0%</td>
<td>1%</td>
</tr>
</tbody>
</table>

The 2011 survey of Alberta continuing care providers (Appendix C) showed that the largest reported HCA age cohort is between the ages of 45 and 60 (31%).

<table>
<thead>
<tr>
<th>Which Stream</th>
<th>Role Summary</th>
<th>Duties</th>
<th>Educational Requirements</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

- Work across all continuing care streams.
- Provide personal assistance and support services for elderly, disabled, acute or chronically ill people who require short term assistance or ongoing support

- Work under the supervision of a nurse or health professional.
- Provide basic health services for clients who have medical conditions or major functional limitations. Provide the physical and emotional support clients need to be as independent as possible.

- HCAs in Alberta must complete a recognized HCA program (standardized curriculum) to be certified in Alberta. An HCA can participate in a competency assessment process if they have not been trained through a certified program.
- Eighteen private (10) and public post-secondary institutions (8) in Alberta are licensed to provide health care aide training programs. Other programs exist but are not part of the Government of Alberta certification.
- Employer organizations with a valid licensing agreement with Alberta Health and Wellness may use the curriculum for in-service training of their employees at their place of employment.
- Program length and delivery options vary and include fulltime, part-time, distance, and in-service options.
Some colleges also offer HCA Prior Learning Assessment and Recognition (PLAR), or Prior Learning Assessment (PLA), which is a certification program for individuals with related work experience.

### Salary

- Salaries may vary widely by employee and employee responsibilities.
- HCAs are included in the National Occupational Classification 3413: Nurse Aides, Orderlies and Patient Service Associates. The 2011 Alberta Wage and Salary Survey indicated the wage for this classification ranged from $16.25 to $21.15 per hour with the average wage being $19.13 per hour. Average starting wage was $17.32 per hour and the top average wage was $21.48 per hour.
- The Alberta Union of Public Employees negotiated 2012 wage rates vary by contract, however they generally start at approximately $18 per hour and increase up to approximately $22 per hour for year seven.

### Advancement

- NorQuest and Bow Valley Colleges in Alberta offer a HCA Bridging Program to Practical Nurse Diploma Program, which can be taken on a fulltime basis, part-time or through distance education.
- HCAs may move into supervisory or management positions. However, additional education is usually required for such advancement.

A 2011 survey of Alberta continuing care providers showed that LPNs are evenly distributed across all age groups, with the exception of a large spike in LPNs aged between 55 and 70 and working in SL.

### Which Stream
- Work across all continuing care streams, but work in greatest number in supportive living and facility living. Generally, work in a wide range of health care roles such as: acute care, facility living, community and primary health clinics, education, occupational health, public health and leadership.

### Role Summary
- Provide care for individuals, families and groups in a variety of health care settings. They may practice independently or as part of a health care team.

### Duties
- May have a variety of nursing care responsibilities and collaborate with registered nurses, psychiatric nurses, physicians, physiotherapists or other health care professionals.
- Carry out many nursing responsibilities independently, depending on the nature and complexity of the client care required and the environment in which they work.
- In many settings, LPNs are in leadership roles, assigning care to HCAs and managing client and family concerns.

### Educational and Registration Requirements
- Two year diploma in practical nursing offered at the college level. The program provides instructional hours, theoretical instruction and clinical/lab experience.
- Eleven post-secondary institutions in Alberta offer fulltime LPN
programs.

- Under Alberta's Health Professions Act and Licensed Practical Nurses Profession Regulation, registration with the College of Licensed Practical Nurses of Alberta (CLPNA) is mandatory.
- Registered members who are authorized by the College may perform restricted activities specified in the Regulation. Only registered members may call themselves LPNs.

### Salary
- According to the 2011 Alberta Wage and Salary Survey, Albertans in the Licensed Practical Nurses occupational group (3233) earned from $24.34 to $27.17 an hour. The average wage was $26.45 an hour. Average starting wage was $22.85 per hour and the top average wage was $29.90 per hour.
- The Alberta Union of Public Employees negotiated wage rates vary by contract, in general 2011 wages start at approximately $24 per hour and increase to approximately $31 for year seven.

### Advancement
- LPNs may move into supervisory or management positions.
- LPNs may take additional education to provide expanded services and be registered for those services.


A 2011 survey of Alberta continuing care providers showed that most RNs are over the age of 50. A third (34%) of RNs are between 50 and 60 years old. However, in SL, a large number of RNs are 30 to 35 (21%), with a large gap before a second set of RNs who are aged between 60 and 65.

**Which Stream**
- Work across all continuing care streams, but work in greatest number in facility living.

**Role Summary**
- Provide professional nursing services, deliver health education programs and provide consultative nursing services to promote, maintain and restore patient health.

**Duties**
- May work independently or as members of a health care team. Key roles include:
  - Assessing and monitoring the sick or injured.
  - Providing direct care.
  - Promoting wellness.
  - Supporting nursing practice through research.
  - Offering education and counseling.
  - Managing health-care services and supervising staff.

**Educational Requirements**
- Require a baccalaureate degree in nursing.
- Eleven post-secondary institutions offer collaborative degree programs in nursing.
- Under Alberta's Health Professions Act and Registered Nurses Profession Regulation registration with the College and
Association of Registered Nurses of Alberta (CARNA) is mandatory.

- Registered members, who are authorized by the College, provide restricted activities specified in the Regulation. Only registered members may call themselves registered nurses or nurses.
- RNs may obtain advanced education in specialized areas. One such area is psychiatry. Registered Psychiatric Nurses (RPNs) provide professional nursing and mental health nursing services in mental health care facilities and in the community. They promote and help people restore and maintain good mental health. Detailed information on RPNs is available in Appendix C.

### Salary

- According to the 2011 Alberta Wage and Salary Survey, Albertans in the Registered Nurses group (3152) earned from $40.25 to $40.77 an hour. The average wage was $40.20 an hour. Average starting wage was $33.54 per hour and the top average wage was $44.34 per hour.
- The United Nurses of Alberta shows salaries for April 1, 2011, starting at $32.99 for year one and increasing to $43.30 for year nine. Additional compensation is given for long service.

### Advancement

- Advancement to supervisory or administrative positions may require a master’s degree in nursing.

College and Association of Registered Nurses of Alberta. Stepping up to the Plate. Annual Report 2009-2010. [http://www.nurses.ab.ca](http://www.nurses.ab.ca)

HCAs, LPNs and RNs, including RPNs, are all significant members of the health care team in continuing care, each with their respective scope of practice, which is legislated and mandated by professional bodies and provincial governments. The expectations and practice for each position may vary by employer and employment situations.
CURRENT SITUATION IN THE CONTINUING CARE SYSTEM

CHALLENGES TO ATTRACTION, RECRUITMENT AND RETENTION

Numerous challenges have been identified in providing high quality and cost-effective aged care services over the next few decades and the continuing care sector is a high priority area of special need. Workers are at the heart of the continuing care system and factors such as an aging population and worker shortages contribute to the need for change. Some of the most common issues identified in the literature affecting HCAs, LPNs and RNs follow.

HEALTH CARE AIDES

Factors that enhance and detract from HCA job satisfaction

- Constant short staffing results in heavy workloads and does not allow for individualized interaction with residents to enhance quality of life
- Pressure to come to work when ill or to work extra hours
- Low salaries and benefits
- Valuable role of HCA not recognized or respected, work is heavy
- Little or no input into scheduling in facility settings
- Lack of, or poor equipment
- Skills and training not being fully utilized
- Poor communication from supervisors
- Short shifts, frequent weekend work
- Being seen as a source of "cheap labour"
- Lack of respect for skills and training, especially from RNs and LPNs - not considered part of the care team

**LICENSED PRACTICAL NURSES**

Factors influencing recruitment and retention of LPNs in continuing care include:

- Increasing workload and little time to build relationships with clients
- Skills not being utilized to full capacity (*Commitment to Care, 2009, p.44*).
- Perception that the opportunity to use clinical skills is more available in acute care (*Effectively Utilizing BC’s Licensed Practical Nurses and Care Aides, 2008*).
- Being seen as a source of "cheaper labour" than an RN, not being recognized as a skilled member of the nursing and continuing care team (*Effectively Utilizing BC’s Licensed Practical Nurses and Care Aides, 2008*).
- Turnover related to casual employment and unmet job expectations (*Planning, Attracting, Engaging and Sharing Knowledge: An HR Strategy for Seniors Care, January 2011*).
- Perception that working in continuing care is routine-based and not exciting (*Myth Busting: Proven Dynamics in Geriatric Care, Winter 2009*).

**REGISTERED NURSES**

Factors Influencing Recruitment and Retention of RNs in continuing care include (*Workforce Innovation and Reform: Caring for Older People, National Health Workforce Taskforce, Government of Australia, December 2008*):

- Performing duties for which RNs were not trained, e.g., human resources and financial management.
- Heavy workloads that are emotionally and physically challenging.
- Employer expectations for RNs to work additional and consecutive shifts.
- Employer expectations for RNs to multi-task as mentors, administrators and carers.
• Staff shortages
• Unsupportive colleagues and management
• Low morale – A lack of respect from colleagues and/or employers, heavy and demanding workloads and staff shortages lead to low morale (*Commitment to Care: Nurse Recruitment and Retention in Saskatchewan, 2009*)
• Nurses feel undervalued by employers, as well as peers in other sectors (*The Long-Term Care Environment: Improving Outcomes through Staffing Decisions, January 2008*).

**BEST/PROMISING PRACTICES FOR ATTRACTION, RECRUITMENT AND RETENTION**

The section below summarizes best/promising practices developed provincially, nationally and internationally as identified in the literature reviewed and through stakeholder consultations (italicized text).

**WHAT CAN STAKEHOLDERS IN CONTINUING CARE DO?**

Collaboration among industry, labour, government, education and public sector partners - effective management and leadership who can work together across sectors and communities to drive change

Implementing successful strategies to meet staffing needs cannot be done in isolation by individual employers, or even by one health or industry sector. Successful recruitment and retention programs will require collaboration and cooperation among all stakeholders including government departments, employers, labour unions, educational institutions, communities, etc.

*A part of collaboration is the funding relationship between government, labour, industry, and education. Interviewees identified funding as a challenge facing the whole sector. As funding levels are determined by government but implemented by industry and education, fluctuations at the government level impact services offered to clients, staff attraction, staff education, staff compensation, and modernization of infrastructure. Interviewees stressed the importance of funding stability and the need that changes be communicated or more predictable to ensure that all*
stakeholders in continuing care can provide appropriate services and programs.

**ENCOURAGE INNOVATION AND CREATIVITY IN ATTRACTION AND EDUCATION**

A lack of general public awareness of continuing care and a negative opinion of the sector in potential employees, especially when compared to the acute care sector, is a concern shared by many continuing care stakeholders.

Attracting people to a career in continuing care requires creativity and innovation. Considerable time and money have already been spent on recruitment initiatives with minimal success, particularly in recruitment of HCAs. While academic institutions have been licensed to provide HCA education programs, there are limited applicants and in some instances, programs have been cancelled. Continually doing the same types of initiatives will not produce different results.

*Interviewees highlighted the need for positive promotion of the continuing care sector that builds awareness in the general public and confidence and pride in the staff currently working in the sector.*

Creativity and innovation will be required in promoting the continuing care sector as a workplace of choice and developing viable and exciting career paths to attract and retain staff. Targeted, rather than general initiatives may be more successful.

**SELF-SUFFICIENCY IN ALBERTA’S HEALTH HUMAN RESOURCES NEEDS MORE ATTENTION MOVING FORWARD... IT’S MORE THAN NUMBERS**

Self-sufficiency is defined as the ability to attract, develop and retain the right supply and mix of skilled health care providers working within each jurisdiction’s service delivery models to provide high quality, timely, safe care that meets the population’s changing health needs. However, faced with a global shortage of skilled health providers, all countries are struggling, and often competing, to develop and maintain a stable, appropriate health workforce.
In order to become self-sufficient, Alberta will need to create skilled health providers. Interviewees stressed the importance of available seats in post-secondary institutions reflecting the number of applicable students who wish to enter a profession. In addition to available seats, the need for promoting and creating practicums in continuing care was highlighted. Interviewees identified the high cost of education as the greatest barrier for entering into a career in continuing care. Funding, scholarships and bursaries, especially for HCAs, were recommended. Additionally:

- HCA Certification was overwhelmingly seen as a positive change that improved HCA self-worth and encouraged consistency in the system. Alternate methods of delivery (such as on-site training) were recommended.
- Continuous learning and continuing education were identified as methods for retaining staff. The importance of education focused on mental health and behavioural issues, to respond to increasing resident/client needs was stressed.

**Consider Recruitment and Retention Together**

The goal of health workforce planning is to ensure that projected population demand for health care services is matched by workforce supply and to take necessary steps to ensure that populations most in need receive essential services. Recruitment and retention strategies must be considered together, recognizing that it is not enough to bring people into the workforce; they must also be encouraged to stay in the workforce and develop their careers.

**Use a Holistic Approach to Workforce Issues: Balance Immediate Workforce Needs with Long Term Issues**

Current staffing and service provision models are not sustainable in the long term. The continuing care sector is not alone in experiencing a workforce shortage. As baby boomers age and retire, the next generation is significantly fewer in numbers; there will not be enough people to fill currently existing jobs, not only in seniors care or the health system, but across the entire workforce spectrum. Not only will there be
competition between continuing care providers and health providers for workers, there will also be competition with all other industries and employers.

**TRADITIONAL WORKFORCE PLANNING MODELS NEED ADJUSTMENT**

Models for projecting workforce shortages and needs exist. However, workforce planning has occurred largely in isolation of, or separately from, other aspects of health planning. The general approach has tended to focus exclusively on particular provider groups and consists of estimating shortfalls or surpluses in those groups or calculating changes in the size of training programs required to eliminate those imbalances. However, these models do not take into account rates of economic growth, the extent to which governments, taxpayers and seniors are willing or able to pay, changes in the range of services (e.g., changing expectations and demands of seniors, government policy and strategies, funding limitations), population health status changes (e.g., healthier and longer living seniors than 20 years ago), potential technological advances, or other health and societal changes.

**WHAT CAN INDIVIDUAL EMPLOYERS DO?**

**STAFF IN A MANNER THAT FOCUSES ON CLIENT QUALITY OF LIFE**

Clients are the main priority of all operators in continuing care. Interviewees from SL and LTC settings stressed the importance of a home-like environment for clients. Furthermore, services should be outcome driven and focus on the clients. The interviewees valued services that considered the whole client’s health, empowering clients to live to their full potential, and building relationships between clients and staff.

Implementing home-like and independent environments that enable clients was recognized as being time-consuming, which adds pressures on staffing.
A key issue facing providers is having the right number of staff to provide services, the solution may be retaining and recruiting the right staff in the right number. The importance of having the right people working in continuing care was stressed by a number of interviewees (84 times). Interviewees highlighted the need for staff who are both technically skilled and have appropriate soft skills (e.g., compassion, ethics, teamwork, and enthusiasm).

The literature notes fundamental differences between the younger generation of workers and their older colleagues regarding their expectations and attitudes toward work and their values. As organizations become more multi-generational, it is important to understand these differences and implement recruiting and retention practices that leverage them.

Other considerations were also identified in the workforce literature and in the consultations held with continuing care stakeholders.

**Employee Life Cycle**

<table>
<thead>
<tr>
<th>Attraction &amp; Education</th>
<th>Best/Promising Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Attract</strong></td>
<td>Promote and market continuing care as an workplace of choice</td>
</tr>
<tr>
<td></td>
<td>Develop a profile of &quot;What Makes a Great HCA&quot; and target people or groups who meet the profile for employment, education and awareness/attraction campaigns</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td>Develop a Continuing Care apprenticeship program</td>
</tr>
<tr>
<td></td>
<td>Support HCAs in completing certification through bursaries and scholarships</td>
</tr>
<tr>
<td></td>
<td>Develop training recognition/tracking to eliminate duplication of training as employees move between</td>
</tr>
</tbody>
</table>

**Health Care Worker Specific Best/Promising Practices**
employers
- Evaluate HCA programs to determine if graduates are appropriately prepared to work in continuing care settings

<table>
<thead>
<tr>
<th>Recruitment</th>
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</thead>
<tbody>
<tr>
<td>• Use recruitment campaigns targeted to under-represented segments of the workforce (e.g., men, some cultural groups, parents re-entering the workforce, new retirees, volunteers or other staff who would like a formal HCA career)</td>
</tr>
<tr>
<td>• Use media campaigns that highlight the relationships built between HCAs and residents</td>
</tr>
<tr>
<td>• Provide education incentives, relocation incentives, and competitive compensation packages</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Retention</th>
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</thead>
<tbody>
<tr>
<td>• Provide additional training and education, e.g., workplace English language and literacy, medication management</td>
</tr>
<tr>
<td>• Structure organizations to appeal to different generations and cultures</td>
</tr>
<tr>
<td>• Create safe and positive work environments</td>
</tr>
<tr>
<td>• Create FTEs and schedules that appeal to employees and allow for work/life balance</td>
</tr>
<tr>
<td>• Reduce understaffing situations to reduce staff stress and allow for time to build relationships between staff and residents</td>
</tr>
</tbody>
</table>

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**LICENSED PRACTICAL NURSES (LPNs)**

**Employee Life Cycle**

**Best/Promising Practice**

<table>
<thead>
<tr>
<th>Attraction &amp; Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Promote and market continuing care as a workplace of choice</td>
</tr>
<tr>
<td>• Develop a profile of &quot;What Makes a Great LPN&quot; and target people or groups who meet the profile for employment, education and awareness/attraction campaigns</td>
</tr>
<tr>
<td>• Evaluate the LPN program to determine if graduates are appropriately prepared to work in continuing care settings</td>
</tr>
<tr>
<td>• Collaborate with educational institutions to include more gerontology education in the curriculum</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Recruitment</th>
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</thead>
<tbody>
<tr>
<td>• Structure organizations to appeal to different generations</td>
</tr>
</tbody>
</table>
and cultures
- Create FTEs and schedules that appeal to employees and allow for work/life balance
- Offer competitive compensation packages to match the level or responsibility and work done

| Retention | • Use responsive shift scheduling that matches resident needs with employee scheduling preferences
  • When providing home care, ensure LPNs and health care aides are assigned a cluster of clients who live in close proximity to each other; LPNs and HCAs move freely among the clients as necessary
  • Budget time for LPNs to build relationships with residents
  • Implement role enhancements as appropriate and provide the required training

| Retirement | • Dedicate a portion of experienced LPNs’ time to mentoring new LPNs

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**Registered Nurses (RNs)**

**Employee Life Cycle**

**Best/Promising Practice**

| Attraction & Education | • Develop a profile of "What Makes a Great RN" and target people or groups who meet the profile
  • Examine RN program options, e.g., accelerating programming, virtual campus education and rural mentoring programs
  • Provide bursaries for nurses wanting to re-enter the profession or to upgrade training, e.g., internationally trained nurses
  • Collaborate with educational institutions to include more gerontology education in the curriculum
  • Develop a targeted rural workforce strategy

| Recruitment | • Promote and market continuing care as a workplace of choice, e.g., HealthForceOntario website for health professionals [http://www.healthforceontario.ca/](http://www.healthforceontario.ca/)
  • Provide financial incentives for relocation
  • Offset tuition costs for RNs to receive training in skill areas that are most needed

| Retention | • Structure work and initiatives to appeal to different
generations and cultures

- Reduce administrative functions, e.g., budget and HR management, and allow RNs more time with residents and care planning
UNDERSTANDING THE ENVIRONMENTAL CONTEXT FOR CONTINUING CARE IN ALBERTA

CONTINUING CARE DRIVERS AND INFLUENCERS

Many factors drive and influence the continuing care environment in Alberta. These factors are summarized into five areas: political environment, economy, socio-demographics, technology and media/public opinion. The following section summarizes the key influences in each of these five areas. These influences will place demands on each continuing care stream and the health care workforce.

POLITICAL ENVIRONMENT: PROVINCIAL ACTION PLANS TARGET INCREASES IN CONTINUING CARE OPTIONS ... GROWTH WILL REQUIRE ADDITIONAL HEALTH WORKERS

The public and operators pressure the provincial government and Alberta Health Services (the delivery arm of Alberta’s health system) for more services, supports and funding for each of the three continuing care streams. In response, Alberta Health Services’ 2011-2015 Health Plan, includes an increased number of and range of living options to meet the growing needs of the aging population by 2015. Additionally, over the past 25 years, the provincial government has examined and made recommendations for Alberta’s continuing care system. Recent reports focus on:

- Investing in more community supports such as home care (Continuing Care Strategy, Aging in the Right Place, 2008);
- Adding and refurbishing facility living beds and supportive living spaces while expanding available home care capacity (Becoming the Best: Alberta’s 5-Year Health Action Plan, 2010-2015);
- Enabling Alberta seniors to reside in an environment that is appropriate to their circumstances (Alberta’s Aging Population Policy Framework, 2010).
- Encouraging the integration of services in a single location (integrated supportive living and long term care settings) (Continuing Care Centres Concept Paper, 2012)

Changes to provincial continuing care policy (whether through AHW or AHS) affect the structure and capacity of the continuing care system,
staffing patterns, and scopes of practice, attraction, education requirements and recruitment into continuing care.

Changes to provincial legislation, associated regulations and professional policies may impact scopes of practice and the resulting needs for adjustments in educational and upgrading programs.

Advanced education programs are challenged to respond quickly to increasing or decreasing demands for educational programs brought on by these policy and legislation changes.

**ECONOMY: GLOBAL, FEDERAL AND PROVINCIAL ECONOMIES ARE BEING CHALLENGED... THE SUSTAINABILITY OF THE HEALTH CARE SYSTEM IS HIGH ON POLICY AGENDAS**

Federal and provincial economies are being adversely affected by global events. Health, a major consumer of public funds, is under increasing scrutiny for effectiveness, efficiency and accountability. Over 38% of public funds in Alberta are spent on the health system.

Financial concerns lead to increased examinations of public funding policies for services and supports and different ways of providing services to assure greater value in use of taxpayer dollars. Continuing care is subjected to the same scrutiny, which can result in new structures and processes that impact the health care workforce.

Continuing care operators feel the “budget pinch” in the contracted situations they manage, which has an impact on their workforce planning and flexibility in budgeting/staffing to meet client needs.

Alberta’s economy affects the supply of health care workers. Anecdotally, when the economy is in a “boom” cycle, demands for unregulated workers are high; often creating competitive employment scenarios in the service sector that cannot be matched in the continuing care sector. This can adversely affect the supply of HCAs. The converse is true when the economy is in a “bust” cycle.
SOCIO-DEMOGRAPHICS: GROWING, AGING AND DIVERSE SENIORS POPULATION... INCREASING EXPECTATIONS ABOUT PREFERRED LIFESTYLES AND CHOICES OF ACCOMMODATION, SUPPORTS AND SERVICES

Seniors are one of the fastest growing segments in Alberta’s population. By 2021, 15% of the total population will be aged 65 and older and by 2030, about 19% (about one in five Albertans or 923,000) will be a senior (Alberta Finance).

- Seniors’ needs for social supports and health care are higher and are increasing:
- Over 90% of Alberta seniors reported having at least one chronic condition (Statistics Canada, Canadian Community Health Survey, Healthy Aging, 2008-2009)
- In 2008, 39,645 Albertans were estimated to have dementia; in 2038 this is projected to increase to 101,698, which is expected to increase the demand for LTC beds by over 11 times the current demand (Rising Tide: The Impact of Dementia in Alberta, 2008 to 2038)
- Individuals being served or requiring continuing care are showing increasingly complex diagnoses and increased demands for services. Conditions include: dementias, cognitive decline, mental illness, incontinence, medication administration, developmental disabilities and needs for special diets.

Increasing seniors’ preferences place increasing demands on continuing care and the health care workers. Seniors want options for where they live as they age, with many preferring to live at home and be as independent as possible for as long as possible. Seniors want services that help them to participate in and feel part of the community while assuring their safety and security. Furthermore, seniors want health and personal care services that focus on their “whole” being and help them to live with as much dignity and respect as possible, keeping them as healthy as possible.

Aging, multigenerational and increasingly diverse workforce. Alberta’s health workforce is also aging with significant levels of retirement anticipated in the next few years. Continuing care is challenged to replace mature workers as well as adding new recruits to allow for
growth. Additionally, the diversity and multi-generational nature of the health workforce requires increased attention to differing generational needs/expectations, varying cultural norms and language issues.

**TECHNOLOGY: RAPID AND COSTLY ADVANCES IN TECHNOLOGY... MAKE IT DIFFICULT FOR CONTINUING CARE TO KEEP UP AND OPTIMIZE USE OF SUCH TECHNOLOGIES**

Limited access to IT technology, both hardware and software, and the use of physical health records reduce potential efficiency in clinical support work. The use of multiple, non-integrated information systems across employers and settings compound the problem.

Demands on buildings and infrastructure such as aging buildings, barrier-free access and movement within (bathroom, hallways, dining rooms that can accommodate mobility aids), security/emergency call systems, resident/tenant lifts, etc. are increasing. Some funding is being made available to support needs in this area: $49M allocated in Alberta’s Capital Plan for Health and Wellness for health information systems and equipment (GOA Health and Wellness Website, accessed Nov 29 2011).

**MEDIA AND PUBLIC OPINION: NEGATIVE MEDIA ADVERSELY AFFECTS PUBLIC OPINION... MINIMIZING THE IMAGE OF CONTINUING CARE AND ITS APPEAL TO HEALTH CARE WORKERS**

Publicity surrounding negative incidents that occur in the continuing care system often outweighs success stories and adversely affects the image of continuing care which, in turn, affects the attraction of health care workers.

Societal views on aging and the value of older and disabled persons are largely negative/pessimistic, which affects attraction, recruitment and retention in continuing care.
Actions always have consequences, either positive or negative, and may have far-reaching implications. Understanding the ripple effect of a change in any one of the drivers or influencers is critical to preparing for and adapting to the impact they may have on the continuing care system and its health workforce. Such changes and their impacts can be likened to a pond – when a pebble is tossed in, it causes a ripple across the pond and affects everything in its path for better or worse.

The schematic illustrates the impact of the aforementioned drivers and influencers. The drivers and influencers are the pebbles and the pond is the pool of key players and their interrelationships in the continuing care system. Whenever a change occurs in one of the drivers or influencers, the effect ripples throughout the continuing care system, with more or less impact on the continuing care stakeholders.
**THE WORKFORCE STRATEGY FOR CONTINUING CARE IN ALBERTA**

The framework for the Workforce Strategy for Continuing Care shows all of the elements that went into the making of the Workforce Strategy for Continuing Care. The following diagram shows the components of the strategy that build on each other to achieve the outcome and move towards the vision to build and sustain a strong and engaged workforce for continuing care in Alberta. The following section describes the framework in detail.

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**THE VISION**

**STRONG & ENGAGED WORKFORCE SUPPORTING A HIGH QUALITY OF LIVING FOR ALBERTANS IN CONTINUING CARE**

---

**THE OUTCOME**

**RIGHT PEOPLE ... RIGHT PLACE ... RIGHT NUMBERS ... RIGHT TIME**
Guiding Principles

- **Meaningful & Purposeful Work** - Continuing care health care workers are able to make a positive difference in the lives of the individuals they serve and their families.

- **Quality & Continuous Improvement** - Continuing care health care workers are using their knowledge and skills to the best of their abilities and supported to continually improve and develop their capabilities.

Continuing care employers strive to continually improve their leadership and management practices in continuing care.

- **Respect & Integrity** - Continuing care health care workers’ differing needs, cultures and abilities are respected and valued within the workplace.

- **Value & Reward** - Continuing care health care workers feel valued for their competencies and contributions receiving fair compensation in return.

- **Strategic & Proactive** - Continuing care employers are strategic and innovative in their planning and day-to-day operations, providing quality and productive work environments.

- **Collaboration & Communication** - Alberta’s continuing care stakeholders work together, with openness and transparency in their communications, to address the continuing care workforce needs and implement effective strategies to meet those needs.

Continuing care employers foster open and transparent work environments where employees are engaged in changes that affect them.

Six Strategies

The Alberta Workforce Strategy for Continuing Care is comprised of six strategies as shown in the schematic on the previous page. The six strategies are:

1. Enhance Continuing Care Image
2. Enhance Continuing Care Attraction and Education
3. Strengthen Continuing Care Recruitment and On-Boarding
4. Increase Continuing Care Employee Engagement and Retention
5. Engage Continuing Care Mature Workers
6. Strengthen Continuing Care Workforce Data
Each strategy contains the following information:

- **Issue** - A summary of the key issue leading to the identification of the strategy.
- **Objective** - The outcome expected of the strategy.
- **How Might We Measure Success** - Recommended measures that may help assess whether there has been progress in meeting the objective. The list is not exhaustive and other measures may be used as available.
- **Continuing Care System Actions** - The Continuing Care System Actions refer to all continuing care residents/clients, continuing care employees, continuing care employers, continuing care associations, government ministries, educational institutes, and regulatory bodies in Alberta. Actions to help achieve the objective are proposed for implementation by the continuing care system stakeholders as a whole.
- **What Can Employers Do?** - Employers are the operators who provide continuing care services within the three streams of continuing care. Leading practices are proposed to help employers achieve the objective.
- **Background** - Information related to the strategy; information was gathered through stakeholder consultation and the literature review.
- **Workforce Survey and Model Highlights** - Information on the highlights of pertinent survey findings and application of the workforce model are presented to add further support for the strategy.
Strategy 1: Enhance Continuing Care Image

The Issue

Continuing care does not have a consistent or positive image in the public eye; continuing care does not adequately communicate or portray that it is a desirable sector in which to work.

The Objective

Continuing care is positively perceived and valued by Albertans and is viewed by healthcare workers as a rewarding sector in which to work.

How might we measure success?

- Proportion of Albertans with a positive view of continuing care (by age cohorts)
- Proportion of healthcare workers with a positive view of continuing care (by position and health care stream)

Continuing Care System Actions

1.1 Develop and implement a branding strategy for the continuing care sector; target the strategy to Albertans in general and to existing employees, promote HCAs as key members of the continuing care system. As part of this action, develop and distribute a common industry marketing toolkit to be customized and used by stakeholders in continuing care.

1.2 Develop, coordinate, and implement an awareness campaign promoting the continuing care sector as a workplace of choice in Alberta; target underrepresented groups such as men and certain minority population groups.

1.3 Develop, coordinate, and implement an awareness campaign promoting the options in continuing care; target Albertans in general.

1.4 Advocate for consistent and positive continuing care experiences and messaging across all stakeholder organizations.
### What Can Employers Do?

- Work collaboratively to champion the brand and awareness of continuing care.
- Encourage current employees who are leaders to champion working within continuing care.

### Background

Albertan’s perceptions of continuing care are adversely affected by negative media coverage, images and information. The public, professionals and politicians are viewed as giving little attention to continuing care in favour of the more visible, vocal and pressing demands in the acute care sector. When attention is paid to continuing care, it is often negative. Furthermore, many families, especially younger generations, are not exposed to older persons, so their sense of aging is disproportionally affected by media and public/societal perceptions.

Work in the continuing care sector is physically and emotionally demanding. Adequate hours, total compensation and shift work are concerns. Additionally, employees perceive that few opportunities exist in continuing care for additional education or advancement, especially for the HCAs. This workplace experience reinforces the perception that continuing care is not valued and that care of older or younger disabled persons is not valued. Overall, current and potential employees have a poor perception of continuing care as a viable sector in which to work and progress.

Furthermore, while workers of all ages value pay, benefits and job security, younger workers want to work in an environment that values intellectual stimulation and learning opportunities, provides opportunities to continuously engage their minds and creative capabilities, and emphasizes the social/fun and prestige aspects of their work and work environments. Work/life balance is also important to younger workers so careers and jobs that offer more flexibility are appealing. The branding of continuing care must be modified to promote these values as existing within the sector.
STRATEGY 2: ENHANCE CONTINUING CARE ATTRACTION AND EDUCATION

THE ISSUE

DUE TO LIMITED STUDENT EXPOSURE TO CONTINUING CARE, LIMITED AVAILABILITY OF SEATS IN POST-SECONDARY INSTITUTIONS, AND THE BOOMING ALBERTA ECONOMY, INSUFFICIENT ALBERTANS ARE DRAWN TO A HEALTH CAREER IN CONTINUING CARE.

THE OBJECTIVE

INCREASED ALBERTANS ATTRACTED TO AND ENROLLED IN APPROPRIATE EDUCATIONAL PROGRAMS FOR REGISTERED NURSES, LICENSED PRACTICAL NURSES, AND HEALTH CARE AIDES RESULTING IN EMPLOYMENT IN THE CONTINUING CARE SECTOR.

HOW MIGHT WE MEASURE SUCCESS?

- Number of high school students enrolled in continuing care work experience while in high school
- Number of new graduates hired into continuing care (by position)
- New graduate satisfaction with post-secondary educational preparation for continuing care (by position and continuing care stream)
- Employer satisfaction with post-secondary educational preparation for continuing care (by position and continuing care stream)

CONTINUING CARE SYSTEM ACTIONS

2.1 Enhance the alignment of post-secondary institutions’ educational practicums for RNs, LPNs and HCAs with continuing care workforce priorities and needs; target all three continuing care streams.

2.2 Develop and implement learning opportunities for junior and high school students in continuing care.
2.3  Promote the HCA designation as a bridging step for students who may wish to work in continuing care prior to pursuing a postsecondary degree.

2.4  Advocate for the reduction/removal of barriers to foreign and out-of-province recruitment, recognition, and certification of HCAs.

2.5  Review and harmonize professional credentialing requirements for foreign and out-of-province RNs and LPNs.

**WHAT CAN EMPLOYERS DO?**

- Review the organization’s website, does it promote the organization as a great place to work? Is there a Careers or Employment Section?
- Brand and promote the organization’s unique features and benefits of working in continuing care.
- Consider incentives that use employee networks to attract prospective employees.
- Forge alliances and engage with local colleges and schools to promote continuing care and health care workers. Attend career fairs, hire summer students and provide practicums.
- Keep the door open to employees who have left the organization.
- Network to learn about industry trends and meet qualified people who may be looking for new opportunities.
- Create an internal talent pool and develop organizational talent at all levels. Consider upskilling, cross-training, paying for further education and special assignments.

**BACKGROUND**

Attraction and educational preparation represent the first steps in any employee life cycle; attracting individuals into continuing care health careers or helping current employees bridge to continuing care health careers. Attraction and educational preparation are necessary to building a strong and stable workforce for continuing care. **Attraction** is closely related to recruitment and retention. A continuing care organization known for keeping and engaging staff is more likely to attract new talent.

In addition to the individual’s awareness and perceptions of the sector (Strategy 1: Enhance Continuing Care Image) several factors have an
impact on the sector’s ability to attract individuals to a continuing care career:

**Numerous career options are available to young people graduating from high school.** Continuing care is only one career option amid a plethora of careers and within health care. Consequently, entry into continuing care specific post-secondary nursing programs is affected. Furthermore, emphasis is often placed on pursuing a university/college degree or diploma, rather than certification, which affects HCA program enrollment.

- **Post-secondary institutions are affected by the supply-demand messages** and events in the economy in general and in the health care system specifically. A “boom or bust” economy has a major impact on the number of people seeking admission to post-secondary institutions. Government studies show that enrolments drop during boom economies because potential applicants are working; when the economy slows, these individuals return to school. Adverse media publicity on continuing care or public announcements on changes to workforce staffing also affect public interest in pursuing health care careers.

- **Post-secondary institutions’ funding and available seats are affected by provincial policy and funding.** Due to time lags in creating additional seats, post-secondary institutions are challenged to respond to rapid changes in demand and supply. In some cases, when post-secondary institutions cannot meet the demand for educational seats, adjustments in educational policy may be made to accommodate the immediate needs of employers that may compromise the quality of education in the long term. When enrollment is low, post-secondary institutions may have difficulties filling their seats.

- **High tuition costs** for certification may be a deterrent to HCA applicants, especially when considering the low wages earned after certification.

- **Alberta’s labour market for entry level positions is highly competitive,** a situation that is exacerbated when Alberta is experiencing a “boom”. The skill sets possessed by unregulated
workers such as HCAs are readily transferable to other industries, especially the service and hospitality industries. While some major continuing care facility living providers are able to be competitive in terms of wages and benefits, the attraction of higher wages and benefits, less demanding work requirements and better work/life balance, can deter potential continuing care employees from smaller settings and home care.

- **Competition nationally and internationally** also attracts health care workers out of Alberta.

- **Competition within Alberta’s health care sector is high** for both regulated and unregulated health care workers. Continuing care regularly competes with acute care, which employees perceive as more “glamorous and exciting”, possessing higher wages and benefits, and less strenuous work demands. Major continuing care employers are able to compete with acute care, but smaller facilities and home care may not. Competition also occurs between continuing care streams, in particular home care may compete with designated supportive living and facility-based streams. Competition may also be experienced between public, not for profit and private employers within continuing care.

**Workforce Survey and Model Highlights**

All these factors come together to affect the supply of health workers in continuing care. As part of the ACCA survey results, completed in 2011, a model was created to compare anticipated future demand for continuing care health workers with the anticipated future supply, assuming that rates of graduation do not increase. The following graphs show the difference between anticipated demand, future estimated headcounts of health workers, and the future estimated continuing care system FTEs for health workers (HCAs, LPNs, and RNs) in a status-quo scenario (assumes clients use the same volumes of service, services are supplied by the same ratios of staff, and same rates of graduation occur). More information on the model is available in Appendix C.
The system FTEs of RNs in 2010 was estimated by the model as being sufficient to meet the needs of the entire continuing care system across Alberta. However, the model predicts that unless changes are made to the status quo, the system will begin experiencing unmet RN demand as early as 2015 (985 unmet RN FTEs). The figures follow the dramatic drop in the number of available RN FTEs as RNs retire.

As the system FTEs are high (therefore headcount and FTEs are very similar) minimal improvements would be realized in the system if more RNs worked a full time equivalent. This is significant, as it suggests that the system is experiencing a manpower shortage that must be addressed through attracting additional workers.

**TABLE 4** PROJECTED CLIENT RN NEED (FTEs) AND RN SUPPLY (FTEs AND HEADCOUNT)

<table>
<thead>
<tr>
<th>Year</th>
<th>Non Cum. Shortage</th>
<th>Need (RN System FTEs)</th>
<th>Have (RN System FTEs)</th>
<th>Have (RN Head Count)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>805</td>
<td>985</td>
<td>1,586</td>
<td>1,586</td>
</tr>
<tr>
<td>2015</td>
<td>805</td>
<td>1,586</td>
<td>2,278</td>
<td>2,278</td>
</tr>
<tr>
<td>2020</td>
<td></td>
<td>3,033</td>
<td>3,033</td>
<td>3,033</td>
</tr>
<tr>
<td>2025</td>
<td></td>
<td></td>
<td>4,075</td>
<td>4,075</td>
</tr>
</tbody>
</table>

**TABLE 5** PROJECTED CLIENT LPN NEED (FTEs) AND LPN SUPPLY (FTEs AND HEADCOUNT)

<table>
<thead>
<tr>
<th>Year</th>
<th>Non Cum. Shortage</th>
<th>Need (LPN System FTEs)</th>
<th>Have (LPN Head Count)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>1,370</td>
<td>1,370</td>
<td>1,370</td>
</tr>
<tr>
<td>2015</td>
<td></td>
<td>1,904</td>
<td>1,904</td>
</tr>
<tr>
<td>2020</td>
<td></td>
<td>2,516</td>
<td>2,516</td>
</tr>
<tr>
<td>2025</td>
<td></td>
<td></td>
<td>3,401</td>
</tr>
</tbody>
</table>
The system FTEs of LPNs in 2010 was estimated by the model as being sufficient to meet the needs of the entire continuing care system across Alberta. However, the model predicts that unless changes are made to the status quo, the system will begin experiencing unmet LPN demand as early as 2015 (805 unmet LPN FTEs). The initial shortage occurs due predominantly to retirement of LPNs and an increase demand for LPNs. After 2020, more LPNs are predicted to enter the system but in insufficient quantities to keep up with the rising demand.

As the system FTEs are high (therefore headcount and FTEs are very similar) minimal improvements would be realized in the system if more LPNs worked a full time equivalent. This is significant, as it suggests that the system is experiencing a manpower shortage that must be addressed through attracting additional workers.

<table>
<thead>
<tr>
<th>TABLE 6</th>
<th>PROJECTED CLIENT HCA NEED (FTEs) AND HCA SUPPLY (FTEs AND HEADCOUNT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>5,111</td>
</tr>
<tr>
<td>2015</td>
<td>8,238</td>
</tr>
<tr>
<td>2020</td>
<td>11,357</td>
</tr>
<tr>
<td>2025</td>
<td>16,497</td>
</tr>
<tr>
<td>2030</td>
<td>22,261</td>
</tr>
</tbody>
</table>

The system FTEs of HCAs in 2010 was estimated by the model as being sufficient to meet the needs of the entire continuing care system across Alberta. Similarly to LPNs and RNs, the model predicts that the system will experience unmet HCA demand starting in 2015 (5,111 unmet HCA FTEs).

As the system FTEs for HCAs are low, the difference between the number of HCAs in the system and the number of FTEs they represent is very different. Consequently, large improvements can be realized if more HCAs work a greater number of hours (i.e., if each HCA represents a
higher system FTE). The model predicts that an increase in system FTEs would address the shortage issue until 2020, after which more workers would need to be attracted to Alberta’s continuing care system. However, “efficiency” is not the only concern when addressing the FTEs worked by HCAs, other factors need to be considered: HCAs’ preferences for working full time, the availability of employer funding to hire full time HCAs, the feasibility of hiring full time HCAs when work volumes vary greatly (if predictably) each day. Should no solution to these factors be presented, attraction will need to be the main strategy in addressing the predicted shortage.
Strategy 3: Strengthen Continuing Care Recruitment & Onboarding

The Issue

Employees in continuing care are faced with emotionally and physically difficult work, which may be further exacerbated by geographical isolation (especially in home care). New workers, unfamiliar with continuing care, may feel technically unprepared for the advanced scope of work and pace required by the sector; this is exacerbated by the limited staff available to mentor and onboard new hires.

The Objective

New recruits with required technical and soft skills are hired into continuing care and provided with the necessary mentoring and orientation required for succeeding in their jobs.

How might we measure success?

- Average length of time to hire (by position and continuing care stream)
- Retention rates of hires during first three and twelve months (by position and continuing care stream)
- Employee satisfaction rating with hiring process (by position and continuing care stream)
- Employer satisfaction rating with hiring process (by position and continuing care stream)

Continuing Care System Actions

3.1 Collaborate, develop and implement a strategic industry staffing plan; Address differences in urban and rural centres, increasing resident care needs, program redesign (especially home care), job redesign, and staffing models that reflect actual care needs.

3.2 Develop and support industry-leading practice in recruitment. 

Develop and distribute a common industry recruitment leading practice toolkit to be customized and used by stakeholders in
continuing care. Draw on knowledge and experience of employers, health care professionals, and others in the field. Ensure that toolkit addresses cultural differences. Develop an informal open online leading practice community/weblog for sharing recruitment resources and knowledge that can be accessed by all employers.

3.3 Promote and advocate for enhancements to the HCA position; Address: appropriate compensation, adequate hours, flexible benefits, fractional FTEs. Enhance and promote Carework.ca for HCAs.

3.4 Promote and advocate funding for the development of programs to support English proficiency.

**WHAT CAN EMPLOYERS DO?**

- Provide recruitment resources and collaborate with other employers by contributing to a provincial open online leading practice community/weblog.
- Create employment advertising that "sells" the organization and the job, and that is placed in a variety of media (e.g., traditional as well as Facebook, LinkedIn).
- Develop a professional selection process that includes communicating professionally with candidates through all stages of the selection process (including polite rejections and timely updates and communication).
- Review selection criteria to ensure that it includes factors that are clearly linked to the bona fide occupational requirements and the needs of the job and organization.
- Develop a strong behaviourally based interview process that helps to determine fit between the candidate, the requirements of the job and the organizational culture and include a tour of the facilities.
- Develop leadership and supervision training that focuses on effective onboarding of new employees.
- Develop a strong orientation process that may include a buddy system to introduce new employees to the organization and its culture.
- Follow up with new employees after three, six and 12 months to see if they are well-oriented and engaged; take action on areas identified for improvement.
BACKGROUND
Recruitment, or bringing individuals into the continuing care health workforce, is the next step in the employee lifecycle. Once a person is attracted to the continuing care sector strategies and actions are needed to recruit the individual.

A number of challenges were identified for all health care workers; they include:

- Changes in government policy and strategy impact funding and affect recruitment volumes.
- Recruitment of RNs, LPNs and HCAs in rural and remote areas is challenging.
- When compared to other industries in Alberta, especially the energy sector, continuing care has comparatively low wages, no or few benefits and limited number of hours. Hours of demand, such as bathing times, are not consecutive and result in irregular schedules of demand, which is a major work characteristic that leads to split shifts. These concerns are compounded in home care where additional work demands and employee costs may be high.
- Employees to continuing care might not feel technically prepared for a job in a specific continuing care stream. Educational preparation for health workers is predominantly standardized; however, continuing care in general and each continuing care stream require unique technical skills. This is an ongoing challenge as the sector evolves to include innovative new setting types such as Continuing Care Centres.

A number of identified concerns were specific to healthcare worker positions:

**HEALTH CARE AIDES (HCAs)**

- Most HCAs are in casual and part-time positions, have no guaranteed hours, and are expected to be available for work on short notice. Some HCAs may be working scheduled split shifts.
• Wages for HCAs are low but have been improving in recent years. Some variability exists between union and non-unionized environments and between certified and non-certified employees.

• Given the casual nature of the position, many HCAs supplement their income by working several jobs with different employers and in different industries, which may lead to increased fatigue and safety concerns on the job, burnout, decreased job satisfaction, and low workforce retention.

• Work required of HCAs is physically and emotionally demanding, which is a deterrent.

Home Care specific HCA concerns. These home care conditions and challenges will be exacerbated as home care services are expanded in the future:

• Relatively low wages may be exacerbated by minimally compensated travel time and expenses. In some situations HCAs are expected to fund their travel costs and claim those costs as a business expense on income tax. The price of gasoline, vehicle operating costs, winter driving conditions, and locating rural and city clients can be significant travel-related deterrents.

• The home care environment is unpredictable and, at time, unappealing. Working conditions in home care can include: unclean environments, pets, children and poor client attitudes. In some cases, work assignments are juggled to match client preference for type of worker. Such reassignments affect HCA workload, the geographical area they serve, give them fewer residents/clients to serve, and reduce their income potential.

LICENSED PRACTICAL NURSES (LPNs)

• For experienced LPNs, skills and competencies may not be used to full scope of practice; This is magnified by LPNs’ perception that continuing care presents the opportunity to use more clinical skills that in acute care settings.

• Employer expectations of newly graduated LPNs may be too high: expect new LPNs to immediately assume leadership roles,
and take on significant responsibilities with little senior management or mentorship support.

**Registered Nurses (RNs)**

- RNs may be asked to perform duties for which they feel inadequately trained such as hiring and firing the staff they supervise, overseeing budgets for their area of responsibility and other administrative duties.
- The leadership role can be demanding for newly graduated RNs. This is further exacerbated by limited new employee orientation programs, leadership and mentoring programs, and post-secondary education on continuing care work/organizational culture.

**Workforce Survey**

The ACCA workforce survey revealed that across the continuing care system:

- 1.07 to 1.46 people fill each HCA role. This means that each HCA represents approximately 0.7 to 0.9 FTEs for the system as a whole.
- 0.97 to 1.11 people fill each LPN role. This means that each LPN represents approximately 0.9 to 1 FTEs for the system as a whole.
- 0.99 to 1.26 people fill each RN role. This means that each RN represents approximately 1 to 1.2 FTEs for the system as a whole.
STRATEGY 4: INCREASE CONTINUING CARE EMPLOYEE ENGAGEMENT AND RETENTION

THE ISSUE

As client/resident needs and the demand for services increase, staff shortages and outdated equipment/technology result in less time for individualized hands-on care. The challenges are further exacerbated by irregular scheduling and fractional FTEs, which result in less informal supports and mentorship for employees; overall, these reduce job satisfaction.

THE OBJECTIVE

Employees are satisfied with their jobs; they are recognized for their contributions, mentored and allowed to develop their skills, they work in an open and communicative environment and use their skills efficiently by leveraging technology.

HOW MIGHT WE MEASURE SUCCESS?

- Turnover rates (by position and continuing care stream)
- Headcount to FTE ratio (by position and continuing care stream)
- Duration of employment (by position and continuing care stream)

CONTINUING CARE SYSTEM ACTIONS

4.1 Build a business case and advocate for increased funding to support continuing care client/resident needs.

4.2 Collaborate on the development and implementation of plans to modernize infrastructure and to advance use of enabling resident care technology in supportive living and continuing care facilities.

4.3 Develop and support industry leading practice in retention, recognition, mentorship and leadership. Develop and distribute a common industry retention, recognition, mentorship and leadership toolkit to be customized and used by stakeholders in continuing care. Draw on knowledge and experience of employers, health care professionals, and others in the field.
Develop an informal open online leading practice community/weblog for sharing resources and knowledge that can be accessed by all employers.

**WHAT CAN EMPLOYERS DO?**

<table>
<thead>
<tr>
<th>Strengthen Recognition Programs</th>
<th>Enhance Engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Create a recognition culture where employees are recognized for doing their jobs well in both tangible (e.g., recognition program) and intangible (e.g., sincere positive feedback from boss) ways.</td>
<td>• Provide meaningful opportunities for employees to provide input and ideas into decision-making.</td>
</tr>
<tr>
<td>• Help employees to understand the value and importance of their work, to develop a sense of purpose about what they are doing.</td>
<td>• Encourage workplace innovation and creativity to continually challenge positive growth.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enhance Training and Mentorship Programs</th>
<th>Improve Communication</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Develop and offer supervisory, mentoring and coaching programs to give supervisors the tools and skills to be effective as leaders.</td>
<td>• Keep good lines of communication and multiple communication streams open so that employees know what's happening within the organization.</td>
</tr>
<tr>
<td>• Find ways to offer career development opportunities to employees, including: growing within jobs, career bridging, lateral movements and special projects that grow experience. Provide ongoing training, development and education, including technology training.</td>
<td>• Improve communication with residents/clients and their families to ensure appropriate expectations of continuing care sector are communicated.</td>
</tr>
<tr>
<td>• Offer ESL training so foreign employees can function comfortably in an English-speaking environment. Likewise, offer diversity training to help create an inclusive work environment.</td>
<td></td>
</tr>
</tbody>
</table>

**Leverage Technology**

• Update care equipment such as lifts for personal and health care needs.

• Use of innovative technologies for self-scheduling and shift bidding.

• Use client-centered home care technologies.

**Improve Total Compensation**

• Assess adequacy of total compensation from an internal equity and external competitiveness point of view, including benefit flexibility,
BACKGROUND
Retention, or keeping individuals in the continuing care health workforce, is the third phase in the employee lifecycle. Issues related to retention are also intertwined with attraction and recruitment issues. If the attraction and recruitment phases are not well managed, then retention will be a problem.

A number of challenges were identified for all health care workers; they include:

- **Demanding workloads coupled with staff shortages.** Staff work hard to meet the basic physical needs of the individuals but have no time to establish meaningful relationships with individuals, which may have been a major motivation for entering continuing care. Work/life balance is compromised by feelings of failure to meet personal/professional expectations leading to fatigue and burnout.

- **Aging individuals with multiple chronic conditions**, including dementias, often requiring complex and unattractive care regimens. Family expectations may be high resulting in complaints when expectations are not being met. Such interactions can be further demoralizing.

- **Technological supports for resident care, especially lifts, and computerized record keeping systems may be lacking or out-of-date.** For facility care, older buildings and other infrastructure may not be conducive to effective and efficient care. Computer literacy and access may be problematic, especially for HCAs.

A number of identified concerns were specific to healthcare worker positions:

- **Health Care Aides (HCAs)**

  - **Perception that HCAs are viewed as “cheap labour”,** thus causing HCAs to feel devalued in their role, unrecognized for their skills and contributions as an important member of the continuing care team.
• Limited medical knowledge and expertise to deal with unexpected changes in home care client conditions may pose significant challenges for geographically-isolated HCAs.

• Few continuing education and training opportunities are available on the job, especially given many HCAs’ casual status.

**LICENSED PRACTICAL NURSES (LPNs)**

• Perception that LPNs are viewed as “cheap version of RNs”, thus causing LPNs to feel devalued in their role, unrecognized for their skills and contributions as an important member of the continuing care team.

**REGISTERED PRACTICAL NURSES (RNs)**

• Work environment can be demanding with few resources and constant staff shortages increasing concerns about quality of care.

• RNs in a case coordinator role (especially in home care) may experience large client workloads, high acuity residents/clients, and increasing demands for complex interventions. This situation may be exacerbated for contracted home care providers where accountability for client assessments, assignment and supervision of unregulated workers may be unclear.

• Career advancement and continuing education in continuing care may be limited, leading RNs to seek other career options.

**Workforce Survey Highlights**

As shown in the following graph, approximately 27% of respondents to the ACCA workforce survey reported working short staffed (red). LTC showed the greatest proportion of respondents working short staffed.
The challenges culminate in turnover and poor staff retention. The following chart shows the retention of HCAs, RNs and LPNs in continuing care as reported by respondents to the ACCA workforce survey.

**Table 7: Reported Prevalence of Short Staffing by Setting Type, February 2011**

<table>
<thead>
<tr>
<th>Setting Type</th>
<th>0%</th>
<th>20%</th>
<th>40%</th>
<th>60%</th>
<th>80%</th>
<th>100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>HC</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SL</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LTC</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The above graph displays the number of years an individual is with their employer (x axis) as a percentage of employees of that worker type (y axis). The duration of employment was calculated based on the year of most recent employment.

**Table 8: Number of Years with Single Employer by Worker Type, February 2011**

<table>
<thead>
<tr>
<th>Year Range</th>
<th>HCA</th>
<th>LPN</th>
<th>RN</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st to 2nd</td>
<td>28%</td>
<td>32%</td>
<td>36%</td>
</tr>
<tr>
<td>3rd to 4th</td>
<td>24%</td>
<td>24%</td>
<td>15%</td>
</tr>
<tr>
<td>5th to 6th</td>
<td>17%</td>
<td>11%</td>
<td>13%</td>
</tr>
<tr>
<td>7th to 8th</td>
<td>7%</td>
<td>5%</td>
<td>8%</td>
</tr>
<tr>
<td>9th to 10th</td>
<td>5%</td>
<td>6%</td>
<td>6%</td>
</tr>
<tr>
<td>11th to 12th</td>
<td>5%</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td>13th to 14th</td>
<td>3%</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td>15th to 16th</td>
<td>3%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>17th to 18th</td>
<td>1%</td>
<td>3%</td>
<td>2%</td>
</tr>
<tr>
<td>19th to 20th</td>
<td>1%</td>
<td>2%</td>
<td>4%</td>
</tr>
<tr>
<td>21st to 22nd</td>
<td>1%</td>
<td>2%</td>
<td>3%</td>
</tr>
<tr>
<td>23rd to 24th</td>
<td>1%</td>
<td>2%</td>
<td>3%</td>
</tr>
<tr>
<td>25th to 26th</td>
<td>1%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>27th to 28th</td>
<td>1%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>29th to 30th</td>
<td>1%</td>
<td>2%</td>
<td>3%</td>
</tr>
<tr>
<td>31st to 32nd</td>
<td>1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>33rd to 34th</td>
<td>1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>35th to 36th</td>
<td>1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>37th to 38th</td>
<td>1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>39th to 40th</td>
<td>1%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

When comparing employees’ first or second year, we find that:

- Twenty-eight percent (28%) of reported HCAs were in their first or second year with the employer
Thirty-one percent (31%) of reported LPNs were in their first or second year with the employer

Thirty-five percent (35%) of reported RNs were in their first or second year with their employer.

When comparing employees who have been with their employer for four or more years:

- Sixty percent (60%) of HCAs were with their employer for four or more years
- Fifty-three percent (53%) of LPNs were with their employer for four or more years
- Fifty-seven percent (57%) of RNs were with their employer for four or more years

When comparing employees who have been with their employer for over ten years:

- Eighteen percent (18%) of reported HCAs were with their employer for over ten years
- Twenty-four percent (24%) of reported LPNs were with their employer for over ten years
- Twenty-eight percent (28%) of reported RNs were with their employer for over ten years

Overall, RNs have the highest long-term retention rate (28% over 10 years) even though many (35%) are in their first or second year with their employers. The lowest long-term retention is 18% in HCAs. HCAs also have the lowest percentage of staff in their first or second year. A number of factors impact retention of staff; in the case of the demographics, the numbers are subject to job reclassification (some employees may use bridging programs to change from one designation to another), scope of practice changes, and changes in the hiring practices of employers due to changes in funded staffing models.

These trends are reflected in the turnover rates identified by employers (graph below). RNs are shown as having the highest overall turnover rates (16%) compared to LPNs and HCAs between January 2010 and December 2010.
### Table 9: Turnover Rate by Worker Type by Setting Type, February 2011

<table>
<thead>
<tr>
<th>Setting Type</th>
<th>RNs (16%)</th>
<th>LPNs (12%)</th>
<th>HCAs (15%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HC (12%)</td>
<td>14%</td>
<td>10%</td>
<td>11%</td>
</tr>
<tr>
<td>LTC (14%)</td>
<td>20%</td>
<td>11%</td>
<td>12%</td>
</tr>
<tr>
<td>SL (17%)</td>
<td>19%</td>
<td>13%</td>
<td>17%</td>
</tr>
</tbody>
</table>

![Bar chart showing turnover rates by setting type and worker type]
Strategy 5: Engage Continuing Care Mature Workers

The Issue

The continuing care workforce is aging; mature employees are a wealth of knowledge and experience which may be lost if they leave the organization. Conversely, these employees may be less up to date on the latest technical information and may be ready to retire. As mature employees retire the continuing care sector is losing a valuable source of knowledge and labour.

The Objective

Employers engage mature workers according to their acquired knowledge and skill sets, and providing flexible work options that best meet the needs of mature workers and employers.

How might we measure success?

- Percentage of employees age 55+ (by position and continuing care stream)
- Percentage of employees age 55+ in mentorship programs (by position and continuing care stream)
- Average retirement age (by position and continuing care stream)
- Percentage continuing care employers offering mature engagement/late career programs (by position and continuing care stream)

Continuing Care System Actions

5.1 Develop industry-leading practice in engaging mature workers and retirement planning. Develop and distribute a common toolkit to be customized and used by stakeholders in continuing care. Draw on knowledge and experience of employers, health care professionals, and others in the field. Develop an informal open online leading practice community/weblog for sharing resources and knowledge that can be accessed by all employers.
What Can Employers Do?

- Develop strategies to meet future organizational talent needs; Compare current and future organizational service needs and talent needed to increase the likelihood of retaining/hiring this talent.
- Offer employees approaching retirement the opportunity for part-time work after retirement or change their roles to mentorship and coaching positions while they transfer their knowledge to other staff before exiting the organization.
- Offer transition to retirement programs, including supportive retirement programs. Mature workers wanting to participate in the workforce have the support and resources they need which include flexible work arrangements and age friendly work environments.
- Develop a pool of talent for future succession opportunities; combine this with a phased-in retirement program that allows for skill transfer.
- Encourage good workers to return to the organization should their circumstances allow it.
- Conduct exit interviews through a neutral party to gather information on how the employee who is leaving felt about the organization, and then utilize the data for organizational improvement.
- Reinforce a concept of graceful exits where those who are leaving are treated well as they leave the organization.

Background

Retirement or exit from the continuing care workforce is the final stage of the employee lifecycle. The retirement stage looks at maximizing the talent of individuals who are retiring from the continuing care health workforce.

An aging population and older workforce are contributing significantly to the widening gap between the supply and demand for workers. Workers in health related sectors are getting older and a considerable portion of the workforce is already close to retirement age. The number of workers who will be able to replace the retiring Baby Boomers will be less than the number needed to fill existing positions and will further result in increased competition among employers (Health Workforce Action Plan, 2007-2016).
Although aging and mature workers may experience difficulties in productivity due to the physical and emotional demands of the job, risk of injuries, relating to younger generations, and the use of technology; engaging mature workers and early retirees minimizes the loss of experience, corporate memory, leadership, and mentorship that may occur when these workers retire. Mature workers bring a wealth of experience and skill and may be able to serve as mentors to other health workers. Furthermore, as workers retire from other industries, they may be attracted to continuing care. These workers often bring a wealth of life experience and may wish to enter a career that is rewarding, and allows them to feel like they are “giving back” to society.

**Workforce Survey Highlights**

The ACCA workforce survey clearly shows an aging continuing care health workforce. The following graph illustrates the distribution of the continuing care health workforce by age (x axis) by worker type as a proportion of all workers of that type reported. The majority of health workers are shown as being over the age of 45, with most RNs being over the age of 50. LPNs are most evenly distributed across age groups.

**Table 10: Reported Worker Ages by Age Cohort by Proportion of Worker Type, February 2011**

<table>
<thead>
<tr>
<th>Age Cohort</th>
<th>RNs</th>
<th>LPNs</th>
<th>HCAs</th>
</tr>
</thead>
<tbody>
<tr>
<td>19 to 24</td>
<td>2%</td>
<td>5%</td>
<td>6%</td>
</tr>
<tr>
<td>25 to 29</td>
<td>5%</td>
<td>12%</td>
<td>10%</td>
</tr>
<tr>
<td>30 to 34</td>
<td>6%</td>
<td>11%</td>
<td>11%</td>
</tr>
<tr>
<td>35 to 39</td>
<td>11%</td>
<td>11%</td>
<td>9%</td>
</tr>
<tr>
<td>40 to 44</td>
<td>11%</td>
<td>12%</td>
<td>12%</td>
</tr>
<tr>
<td>45 to 49</td>
<td>18%</td>
<td>12%</td>
<td>15%</td>
</tr>
<tr>
<td>50 to 54</td>
<td>15%</td>
<td>18%</td>
<td>15%</td>
</tr>
<tr>
<td>55 to 59</td>
<td>13%</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>60 to 64</td>
<td>6%</td>
<td>12%</td>
<td>8%</td>
</tr>
<tr>
<td>65 to 69</td>
<td>2%</td>
<td>4%</td>
<td>3%</td>
</tr>
<tr>
<td>70 to 100</td>
<td>2%</td>
<td>1%</td>
<td>1%</td>
</tr>
</tbody>
</table>

The following graph looks at the distribution of the continuing care health workforce by age (x axis) by continuing care stream as a proportion of all workers in that stream. In Supportive Living, the reported staff ages shows a large number of individuals poised to retire within the next five years. Long term care settings show a fairly normal distribution of health worker ages. Interestingly, although most staff retire at 65, Home Care
retains the greatest number of staff over the age of 65, and has the greatest proportion of staff over the age of 45 overall (63%).

**Table 11: Reported Worker Ages by Age Cohort by Proportion of Setting Type, February 2011**

<table>
<thead>
<tr>
<th>Age Cohort</th>
<th>Supportive Living Setting(s)</th>
<th>Home Care</th>
<th>Long Term Care Settings(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>19 to 24</td>
<td>3%</td>
<td>3%</td>
<td>6%</td>
</tr>
<tr>
<td>25 to 29</td>
<td>11%</td>
<td>8%</td>
<td>7%</td>
</tr>
<tr>
<td>30 to 34</td>
<td>9%</td>
<td>7%</td>
<td>8%</td>
</tr>
<tr>
<td>35 to 39</td>
<td>12%</td>
<td>9%</td>
<td>13%</td>
</tr>
<tr>
<td>40 to 44</td>
<td>13%</td>
<td>11%</td>
<td>15%</td>
</tr>
<tr>
<td>45 to 49</td>
<td>12%</td>
<td>16%</td>
<td>17%</td>
</tr>
<tr>
<td>50 to 54</td>
<td>11%</td>
<td>11%</td>
<td>15%</td>
</tr>
<tr>
<td>55 to 59</td>
<td>16%</td>
<td>15%</td>
<td>10%</td>
</tr>
<tr>
<td>60 to 64</td>
<td>11%</td>
<td>10%</td>
<td>4%</td>
</tr>
<tr>
<td>65 to 69</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>70 to 100</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>
Strategy 6: Strengthen Continuing Care Workforce Data

The Issue

No single source of consistent data and projections of health status and continuing care staffing volumes is available.

The Objective

A workforce forecasting model based on a single source of detailed and continuously updated data on health status and continuing care staffing is available to the continuing care sector.

How might we measure success?

- Availability of current workforce data and future forecasts (by position and continuing care stream)

Continuing Care System Actions

6.1 Collaborate, develop and share a workforce forecasting model based on modeling best practices; Focus on better assessing future client needs, future demand for student enrollment/graduation from health workforce positions, and determining the impact of retirement

6.2 Develop and maintain a common database to collect and compile information required by the model.

What can employers do?

- Continuously share detailed current information on client needs/acuity.
- Use the workforce forecasting model as a benchmark for staffing best practices.
- Continuously share detailed current information on staffing.
**Background**

Specific information on the current supply and demands for RNs, LPNs and HCAs is generally lacking in the health system, which affects workforce planning for continuing care. Over the years, various workforce models have been developed by Alberta Health and Wellness and used in policy development and strategic planning, signaling the future direction of and priorities for meeting and funding the needs of an aging population. Further workforce models are under development in Alberta Health and Wellness in collaboration with other government departments. Alberta Health Services has also been working on workforce models for continuing care and has initiated employer surveys to collect information on the volume and characteristics of the existing workforce. However, concerns have been raised about the reliability of the workforce modeling as well as the lack of access to developed models so employers may do their own organizational workforce modeling.

The lack of an Alberta workforce forecasting model and the inaccessibility of information have resulted in employer confusion over the number and mix of staff they will need in the future. Employers are implementing their own workforce planning models at varying degrees of sophistication. However, these models do not take into consideration forces and sources outside of the organization or industry and focus exclusively on past hiring practices. Furthermore, employers are left without a method to benchmark their staffing methodologies against best practices or common practices.

Across Canada, due to a lack of available data, even provincial workforce planning has occurred largely in isolation of, or separately from, other aspects of health. The general approach has tended to focus exclusively on particular provider groups and estimating demand for providers based on demographic information. Traditional workforce planning models are limited as future workforce needs, are dependent on a multitude of factors including:

- Changes in the range of services (e.g., changing expectations and demands of seniors, government policy and strategies, funding limitations)
- Population health status (e.g., healthier and longer living seniors)
- Potential technological advances
• Other health and societal changes

While not all the listed factors can be quantified, a number of models exist for simulating future population health and the impact of certain changes to the range of services. However, models cannot act in isolation. The lack of shared databases has created challenges for modeling as not every stakeholder holds all the data required. Furthermore, different data collection results in different forecasts, which cause confusion and suspicion of the results available.

A single source of detailed and continuously updated data on population health and continuing care staffing is needed. This information should drive a workforce forecasting model, which takes into account regional variation, operator type and best practices in staffing. Such a model would clearly articulate demand into the future and help educational institutions, employers and government make timely plans for creating supply. Furthermore, the model would act as a benchmark and guideline for operators who wish to know the mix and number of staff they may need and whether their staff utilization is consistent with provincial averages.
APPENDICES
## Appendix A: List of Steering Committee Members

**Members** (with exception of Chair, listed in alphabetical order by first name)

<table>
<thead>
<tr>
<th>Member</th>
<th>Position</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bruce West</td>
<td>Executive Director</td>
<td>Alberta Continuing Care Association</td>
</tr>
<tr>
<td></td>
<td>Chair, Steering Committee</td>
<td></td>
</tr>
<tr>
<td>Anne Forge</td>
<td>Director, Human Resources</td>
<td>CapitalCare</td>
</tr>
<tr>
<td>Belinda Halischuk</td>
<td>Executive Assistant to Michael Harris</td>
<td>Reverta</td>
</tr>
<tr>
<td>Blair Phillips</td>
<td>Director, Human Resources and Facilities</td>
<td>Carewest</td>
</tr>
<tr>
<td>Bernard Anderson</td>
<td>Senior Manager, Research and Planning</td>
<td>Health and Wellness</td>
</tr>
<tr>
<td>Alt: Jacqueline Greenblatt</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Iqbal Ali</td>
<td>Director of Human Resources</td>
<td>AgeCare</td>
</tr>
<tr>
<td>Irene Martin</td>
<td>Executive Director</td>
<td>Alberta Senior Citizens’ Housing Association</td>
</tr>
<tr>
<td>Jayne Degenhardt</td>
<td>Director, Recruitment and Workforce Planning</td>
<td>Covenant Health</td>
</tr>
<tr>
<td>Alt: Shelly Beck</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jodi Wilson</td>
<td>Human Resource Director</td>
<td>CBI Home Health, Calgary</td>
</tr>
<tr>
<td>Jon Steitzer</td>
<td>Senior Advisor, Workforce Planning</td>
<td>Alberta Health Services</td>
</tr>
<tr>
<td>Karen Gayman</td>
<td>Executive Director, Seniors Health</td>
<td>Alberta Health Services</td>
</tr>
<tr>
<td>Laura Schneider</td>
<td>Manager, Health and Social Service Programs, Post-Secondary Programs Branch</td>
<td>Advanced Education and Technology</td>
</tr>
<tr>
<td>Lisa Stebbin</td>
<td>Director of Homecare Operations</td>
<td>Calgary Family Services</td>
</tr>
<tr>
<td>Marie Lyle</td>
<td>Executive Director, Health Policy and Service Standards Development</td>
<td>Health and Wellness</td>
</tr>
<tr>
<td>Sharon Fowler</td>
<td>Project Manager, Human Resources</td>
<td>Alberta Health Services</td>
</tr>
<tr>
<td>Susan Savage</td>
<td>Manager, Policy Development</td>
<td>Alberta Education</td>
</tr>
<tr>
<td>Wayne McKendrick</td>
<td>Vice President, People and Organizational Development</td>
<td>The Good Samaritan Society</td>
</tr>
<tr>
<td>Zarelda Reghelini</td>
<td>Senior Manager, Industry Liaison Coordinator</td>
<td>Human Services (Employment and Immigration)</td>
</tr>
<tr>
<td>Alt: Patricia Sproat</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Project Resources**

<table>
<thead>
<tr>
<th>Resource</th>
<th>Position</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kailey O’Neill</td>
<td>Planning and Research Analyst</td>
<td>Alberta Continuing Care Association</td>
</tr>
<tr>
<td>Carol Blair</td>
<td>Chief Executive Officer</td>
<td>Carol Blair and Associates Inc.</td>
</tr>
<tr>
<td>Dominika Warchol</td>
<td>Consultant</td>
<td>Carol Blair and Associates Inc.</td>
</tr>
<tr>
<td>Cassandra Snider</td>
<td>Analyst</td>
<td>Carol Blair and Associates Inc.</td>
</tr>
<tr>
<td>Claudia Verburgh</td>
<td>Sub-contractor</td>
<td>Carol Blair and Associates Inc.</td>
</tr>
</tbody>
</table>
APPENDIX B: ACCA WORKFORCE STRATEGY FOR CONTINUING CARE LITERATURE REVIEW: EXECUTIVE SUMMARY

Supplying health human resources to meet growing health system demands and increasing population health needs is a challenge in all sectors of the health system. Many of these challenges are exacerbated in continuing care. A literature review was conducted through Internet search engines targeting key government and organizational websites. The documentation was limited to online documents available in the public domain that were published or developed between 2006 and 2011 in order to access the most current information. The literature review consisted of three major parts:

- **Demographic overview for HCAs, LPNs and RNs.** The first part of the literature review provides a demographic overview for HCAs, LPNs and RNs, using information from the most current published sources. This information provides a time-limited snapshot of the graduate and employment circumstances of these healthcare workers, which can be used as a benchmark in assessing the current situation.

- **Attraction, Recruitment, Retention and Retirement Issues.** The second part of the literature review gives an overview of workforce issues and challenges as they relate to the employee lifecycle, focusing on attraction, recruitment, retention and retirement issues generally as well as information that more specifically relates to the three health care worker positions and to continuing care. This information serves to both validate the existing situation in Alberta and inform the development of the workforce strategy.

- **Workforce Strategies.** The third and final part of the literature review provides information on studies and other strategic work completed to develop and promote strategies to address identified workforce issues, some more generally focused strategies as well as strategies that target HCAs, LPNs and RNs. This information is also instructive in developing the workforce strategy as well as providing some evidence-based findings to provide rationale to support specific strategies.

A summary of the key findings in each section follows.

DEMOGRAPHIC OVERVIEW FOR HCAS, LPNS AND RNs

Various studies and reports have been completed over the last few years providing a range of data for each of the three health worker positions. Although this data is dated it provides a snapshot of an assessment in time of the workforce and the projected shortages. As can be seen from the table
below, in 2009, the average age for LPNs, 42.9 years, and RNs, 44.9 years, reflects a middle-aged workforce, with trending information that more and more regulated nurses were nearing retirement.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Health care aides*</td>
<td>NA</td>
<td>20,267</td>
<td>17,834 (88% of total)</td>
<td>21,733</td>
</tr>
<tr>
<td>Licensed Practical Nurses**</td>
<td>42.9</td>
<td>6,669</td>
<td>1,624 (24.4% of total)</td>
<td>NA</td>
</tr>
<tr>
<td>Registered Nurses**</td>
<td>44.6</td>
<td>29,405</td>
<td>1,951 (6.8% of total)</td>
<td>6,200*</td>
</tr>
</tbody>
</table>

**Sources**: * Alberta Health Services. (August 2010). From Forecasting to Planning: Modeling Options for Alberta Nursing and Health Care Aide Workforce, A Discussion Paper.

The proportion of health care workers in long term care (LTC) (defined as nursing homes / long term care by the Canadian Institute of Health Information) was highest for HCAs, at 88% (Alberta Health Services source, which may have all continuing care streams), while that proportion dropped significantly for LPNs (24.4%) and RNs (6.8%). Some of the difference may be explained by the staff-mix ratios, which target higher levels of HCAs than LPNs and RNs, given their respective roles and responsibilities in LTC. The projected staff shortages in the next five years indicated a need for the HCA workforce to double in size and the RN workforce to increase by 21%.

Another tool, *The Alberta Short Term Forecast (STEF) Tool* for 2011-2013 was developed to support short term planning and development of strategies for Alberta Employment and Immigration, the Government of Alberta and the public. The STEF tool approach is evidence based analysis that examines short term labour market trends and conditions and incorporates multiple quantitative and qualitative data from a variety of sources: economic indicators, administrative data and insight from industry sectors. Its results showed that RNs met sufficient indicators to suggest a significant likelihood of shortages in the next three years (2011-2013), while there was a likelihood of shortages for HCAs and LPNs. Note that the likelihood of these shortages reflects the whole health system, including continuing care.
**Attraction, Recruitment, Retention and Retirement Issues**

Numerous challenges have been identified in providing high quality and cost-effective aged care services over the next few decades and the continuing care sector is a high priority area of special need. Workers are at the heart of the continuing care system and factors such as an aging population and worker shortages contribute to the need for change. Some of the most common issues identified in the literature affecting HCAs, LPNs and RNs follow.

### HEALTH CARE AIDES

<table>
<thead>
<tr>
<th>Systemic Barriers</th>
<th>Specific Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Western society does not value the frail, disabled or elderly, resulting in fewer people choosing careers in the sector</td>
<td>Advertising and marketing campaigns are not attracting applicants</td>
</tr>
<tr>
<td>Resources allocated by government to the continuing care sector are limited and may be on the &quot;low end of the scale&quot;</td>
<td>Certification education programs are becoming the responsibility of employers as colleges are unable to attract an adequate number of applicants to run the program</td>
</tr>
<tr>
<td>Funding levels for continuing care are inadequate to meet rising demand and resident expectations, and funding inconsistencies exist across the province</td>
<td>Constant staff shortages, high workloads, increasing expectations and needs of residents, and aging buildings and equipment create unattractive workplaces</td>
</tr>
<tr>
<td>The valuable role of the HCA is not understood or recognized by the public or the broader health system</td>
<td>Competition for workers among employers is significant</td>
</tr>
<tr>
<td></td>
<td>Part time and casual positions</td>
</tr>
<tr>
<td></td>
<td>Shift schedules</td>
</tr>
<tr>
<td></td>
<td>Compensation packages and opportunities for career advancement are lower than in other work sectors</td>
</tr>
</tbody>
</table>

Factors that enhance and detract from HCA job satisfaction

<table>
<thead>
<tr>
<th>Enhance Job Satisfaction</th>
<th>Detract from Job Satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Altruism - helping others, knowing you are making a positive difference in someone's life</td>
<td>• Constant short staffing results in heavy workloads and does not allow for individualized interaction with residents to enhance quality of life, pressure to come to work when ill or to work extra hours</td>
</tr>
<tr>
<td>• Social opportunities - working in a family type environment, positive relationships with residents and colleagues</td>
<td>• Low salaries and benefits</td>
</tr>
<tr>
<td>• Appropriate compensation packages and job security</td>
<td>• Valuable role of HCA not recognized or respected, work is heavy</td>
</tr>
<tr>
<td>• Flexibility in schedules</td>
<td>• Little or no input into scheduling</td>
</tr>
<tr>
<td>• Ongoing education opportunities</td>
<td>• Lack of, or poor equipment</td>
</tr>
<tr>
<td>• Having a variety of challenging work - each day is different</td>
<td>• Skills and training not being fully utilized</td>
</tr>
<tr>
<td>• Recognition of skills and service provided</td>
<td>• Poor communication from supervisors</td>
</tr>
<tr>
<td>• Opportunities to provide input and problem solve as part of a team</td>
<td>• Short shifts, frequent weekend work</td>
</tr>
<tr>
<td>• Positive relationships with supervisors and professional staff</td>
<td>• Being seen as a source of &quot;cheap labour&quot;</td>
</tr>
<tr>
<td>• More full time or higher FTE positions</td>
<td>• Lack of respect for skills and training, especially from RNs and LPNs - not considered part of the care team</td>
</tr>
</tbody>
</table>

**LICENSED PRACTICAL NURSES**

**Factors Influencing Recruitment and Retention**

- Increasing workload and little time to build relationships with clients.
- Turnover related to casual employment and unmet job expectations
- Skills not being utilized to full capacity.
- Perception that the opportunity to use clinical skills is more available in acute care.
- Wages in continuing care are less than that of an equal position in acute care.
- Perception that continuing care is routine-based and not exciting.
- Being seen as a source of "cheaper labour" than an RN, not being recognized as a skilled member of the nursing and continuing care team.


**REGISTERED NURSES**

**Factors Influencing Recruitment and Retention**

- Lack of staff supports such as equipment or technology.
- Heavy workloads that are emotionally and physically challenging.
- Constant staff shortages.
- Inappropriate mix of skill sets due to staff shortages.
- Unsupportive colleagues and management.
- Performing duties for which RNs were not trained, e.g., human resources and financial management.
- Employer expectations for RNs to multi-task.
- Employer expectations for RNs to work additional and consecutive shifts.
- Low morale.
- Perception that continuing care is less challenging and requires fewer skills.
- Nurses feel undervalued by employers and peers in other sectors.

**SUMMARY OF WORKFORCE STRATEGIES FOR HCAs, LPNS AND RNs**

The table below summarizes workforce strategies and best/promising practices developed provincially, nationally and internationally as given in the literature reviewed for the workforce strategy.

### HEALTH CARE AIDES

<table>
<thead>
<tr>
<th>Employee Life Cycle</th>
<th>Strategies</th>
</tr>
</thead>
</table>
| **Attraction & Education** | • Promote and market continuing care as a workplace of choice, e.g., BC Cares website to recruit care aides into the seniors care sector, http://www.bccares.ca/  
• Investigate promoting a career in the sector as an apprenticeship program  
• Develop a profile of "What Makes a Great HCA" and target people or groups who meet the profile  
• Assistance to complete certification  
• Develop an education passport to eliminate duplication of training as employees more between employers  
• Examine the feasibility of regulation for HCAs  
• Evaluate the HCA program to determine if graduates are appropriately prepared to work in continuing care settings |
| **Recruitment** | • Recruitment campaigns targeted to under-represented segments of the workforce, e.g., new high school and university graduates, unemployed, people looking for a career change, parents re-entering the workforce, new retirees, volunteers or other staff who would like a formal HCA career  
• Targeted media campaign showing real life relationships between employees and residents  
• Education and relocation incentives  
• Competitive compensation packages |
| **Retention** | • Provide additional training and education, e.g., workplace English language and literacy, medication management  
• Structure work and initiatives to appeal to different generations and cultures  
• Staffing models that reflect actual care needs  
• Create FTEs and schedules that appeal to employees and allow for work/life balance  
• Create safe and positive work environments  
• Allow time to build relationships with residents  
• Funding to cover cost of temporary vacancies and HCAs receive further training  
• Develop HCA career paths (recognize prior learning) and HCA to LPN bridge programs |
# Licensed Practical Nurses

## Workforce Strategies and Best/ Promising Practices

<table>
<thead>
<tr>
<th>Employee Life Cycle</th>
<th>Strategies</th>
</tr>
</thead>
</table>
| **Attraction & Education** | • Promote and market continuing care as a workplace of choice, e.g., HealthForceOntario website for health professionals [http://www.healthforceontario.ca/](http://www.healthforceontario.ca/)  
  • Develop a profile of "What Makes a Great LPN" and target people or groups who meet the profile  
  • Evaluate the LPN program to determine if graduates are appropriately prepared to work in continuing care settings  
  • Collaborate with educational institutions to include more gerontology education in the curriculum |
| **Recruitment** | • Structure work and initiatives to appeal to different generations and cultures  
  • Increase FTEs  
  • Competitive compensation packages to match the level or responsibility and work done |
| **Retention** | • Responsive shift scheduling: matching resident needs with employee scheduling preferences  
  • Ensure LPNs work to their full scope of practice  
  • Define roles of RNs and LPNs  
  • Fixed hour schedules for each shift cycle  
  • Cluster home visits or residents  
  • Allow time to build relationships with residents  
  • Consider initiatives on role enhancements and provide required training  
  • Create best practices to promote a safe and positive workplace |
| **Retirement** | • 80/20 positions for late career LPNs in order to mentor new LPNs |
### Registered Nurses

#### Workforce Strategies and Best/Promising Practices

<table>
<thead>
<tr>
<th>Employee Life Cycle</th>
<th>Strategies</th>
</tr>
</thead>
</table>
| **Attraction & Education**        | • Develop a profile of "What Makes a Great RN" and target people or groups who meet the profile  
                                     • Examine RN program options, e.g., accelerating programming, virtual campus education and rural mentoring programs  
                                     • Provide bursaries for nurses wanting to re-enter the profession or to upgrade training, e.g., internationally trained nurses  
                                     • Collaborate with educational institutions to include more gerontology education in the curriculum  
                                     • Develop a targeted rural workforce strategy |
| **Recruitment**                   | • Promote and market continuing care as a workplace of choice, e.g., HealthForceOntario website for health professionals http://www.healthforceontario.ca/  
                                     • Financial incentives for relocation  
                                     • Offset tuition costs for RNs to receive training in skill areas that are most needed |
| **Retention**                     | • Structure work and initiatives to appeal to different generations and cultures  
                                     • Reduce administrative functions, e.g., budget and HR management, and allow RNs more time with residents and care planning  
                                     • Focus workplace improvement efforts on strategies to improve health and well-being of workers  
                                     • Clarify workplace roles for LPNs, RNs |

### Other Considerations

Workforce literature is extensive on several fronts, with other considerations also being noted.

1. **Generations Do Not Have The Same Work Expectations, Attitudes And Values**

The literature notes fundamental differences between the younger generation of workers and their older colleagues regarding their expectations and attitudes toward and values about work. Understanding these differences is important when addressing recruiting and retention practices. Work values were defined in five areas as shown in the following table.
<table>
<thead>
<tr>
<th>Values</th>
<th>Definition</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intrinsic</td>
<td>Provides mental stimulation and is psychologically rewarding</td>
<td>Interesting work, challenge, variety and intellectual stimulation</td>
</tr>
<tr>
<td>Extrinsic</td>
<td>Material aspects and tangible rewards</td>
<td>Pay, benefits and job security</td>
</tr>
<tr>
<td>Social</td>
<td>Allows for interaction with people</td>
<td>Relationships with co-workers, supervisors and others</td>
</tr>
<tr>
<td>Altruistic</td>
<td>Allows for benefit to society</td>
<td>The desire to help others and make a contribution to society</td>
</tr>
<tr>
<td>Prestige</td>
<td>That which is highly esteemed and recognized by others</td>
<td>Status, influence and power</td>
</tr>
</tbody>
</table>


Highest work values by generation are shown in the following table.

<table>
<thead>
<tr>
<th>Generation</th>
<th>Highest Values</th>
<th>Recruitment &amp; Retention Strategies</th>
</tr>
</thead>
</table>
| Matures (Born prior to 1945; 7% of Alberta's workforce)* | Altruistic ** Extrinsic** | • Emphasize the contribution of their work to the wellbeing of society  
• Provide opportunities for philanthropy and mentorship in their work  
• Emphasize the contribution of their work to the wellbeing of society  
• Provide opportunities for philanthropy and mentorship in their work  
• Value learning - emphasize intellectual stimulation and learning opportunities  
• Continuously engage |
| Baby Boomers (Born between 1945 & 1964; 42% of Alberta's workforce)* | Altruistic ** Extrinsic** |
| Generation X (Born between 1965 & 1979; 34% of Alberta's workforce)* | Intrinsic ** Extrinsic** |
### Generation Highest Values Recruitment & Retention Strategies

<table>
<thead>
<tr>
<th>Generation</th>
<th>Highest Values</th>
<th>Recruitment &amp; Retention Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Millennials</td>
<td>Social, Prestige, Extrinsic**</td>
<td>their minds and creative capabilities</td>
</tr>
<tr>
<td>(Born in 1980 or later; 18% of Alberta's workforce)*</td>
<td></td>
<td>• Emphasize the social and fun aspects of work and the working environment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Attach symbols of prestige or status to positions, e.g., official title, reward and recognition for their work</td>
</tr>
</tbody>
</table>

Source: *Alberta Employment and Immigration. (2008). Mature Workers in Alberta and British Columbia.* **Note:** Extrinsic values such as pay, benefits and job security are equally important across all the generations. This is an essential element of the employment relationship and is the foundation for any human resource initiatives. Organizations that do not adequately satisfy this aspect of work risk demotivating all four generations of employees.

2. **Self sufficiency in health human resources needs more attention moving forward... it's more than numbers**

Self-sufficiency is defined as the ability to attract, develop and retain the right supply and mix of skilled health care providers working within each jurisdiction’s service delivery models to provide high quality, timely, safe care that meets the population’s changing health needs. Faced with a global shortage of skilled health providers, all countries are struggling, and often competing, to develop and maintain a stable, adequate health workforce. Developed countries like Canada are under pressure to become more self-sufficient in health human resources (Federal/Provincial/Territorial Advisory Committee on Health Delivery and Human Resources – Canada (July 2009). *How Many are Enough? Redefining Self-Sufficiency for the Health Workforce.*)

Self-sufficiency strategies need to address:

- Changing health needs of Canadians
- Increased investment in health promotion and chronic disease management and the resulting need for different skills and deployment
- Advances in technology that may change the type and amount of care required
- New service delivery models, e.g., use of inter-professional teams
- Extended scopes of practice and new deployment models and roles
- The distribution of the workforce across the country and within each jurisdiction
• Other factors that affect the need for and supply of workers, such as the feminization of certain sectors of the health workforce, generational differences in working patterns and the many reasons why people stay in or leave the workforce
• Economic and policy factors

3. Workforce planning success factors and strategies are not “rocket science”

The goal of health workforce planning is to ensure that projected population demand for health care services is matched by workforce supply and to take necessary steps to ensure that populations most in need receive essential services. Recruitment and retention strategies must be considered together, recognizing that it is not enough to bring people into the workforce; they must also be encouraged to stay in the workforce and develop their careers. The following table summarizes the key success factors and related strategies as found in the literature.

<table>
<thead>
<tr>
<th>Key Success Factors</th>
<th>Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Collaboration among industry, labour, government,</td>
<td>• Stay consumer focused</td>
</tr>
<tr>
<td>education and public sector partners - effective</td>
<td>• Align with service delivery plans and government strategies</td>
</tr>
<tr>
<td>management and leadership who can work together</td>
<td>• Create and utilize multidisciplinary teams</td>
</tr>
<tr>
<td>across sectors and communities to drive change</td>
<td>• Utilize a holistic approach to workforce issues - balance responding to</td>
</tr>
<tr>
<td>• Create a culture of continuous improvement</td>
<td>immediate workforce needs with addressing long term issues</td>
</tr>
<tr>
<td>• Plan for the future with the right partners</td>
<td>• Reorganize work to minimize duplication of effort and make best use of</td>
</tr>
<tr>
<td>• Attract the right employees</td>
<td>available staff</td>
</tr>
<tr>
<td>• Engage employees in the right way</td>
<td>• Examine the extension of existing roles and scope of practice</td>
</tr>
<tr>
<td>• Ensure employers have the right knowledge to make</td>
<td></td>
</tr>
<tr>
<td>informed decisions</td>
<td></td>
</tr>
<tr>
<td>• Avoid fragmentation and duplication of</td>
<td></td>
</tr>
</tbody>
</table>
### Key Success Factors

- Implementation activities within and across sectors
- Create healthy, safe, high performance work environments in order to build and maintain a sustainable workforce

### Strategies

- Determine the feasibility of creating new professional or assistant roles to meet current and evolving needs
- Encourage innovation and creativity
- Accelerate and expand the assessment and integration of internationally trained health providers
- Collaborate on education programs to develop a skilled workforce
- Develop programs to target potential workers and attract them to the sector - targeted approaches to attract people from a variety of cultures, skills and attributes
- Understand staff needs and develop corresponding training programs and opportunities

---

**Summary of Major Themes from the Literature**

**Current staffing and service provision models are not sustainable in the long term.** The continuing care sector is not alone in experiencing a workforce shortage. As baby boomers age and retire, the next generation is significantly fewer in numbers; there will not be enough people to fill currently existing jobs, not only in seniors care or the health system, but across the entire workforce spectrum. Not only will there be competition between continuing care
providers and health providers for workers, there will also be competition with all other industries and employers.

Reliance on international recruitment poses ethical challenges. Not only are Alberta and Canada experiencing a shortage of workers in continuing care as well as the whole health system, there is also a severe global shortage of health workers. The World Health Organization has stated that the health workforce shortage is a crisis in 57 developing countries. Yet international recruitment is seen as a viable option for increasing the workforce in Alberta and a significant percentage of the current workforce are from other countries. To address this challenge, ethical principles and practices for international recruitment have been developed by the WHO that discourages active recruitment from developing countries facing critical shortages of health workers. Other workforce solutions must be developed in order to reduce continued reliance on migrant workers to “fill gaps” in the health care workforce.

Successful strategies cannot be done in isolation. Implementing successful strategies to meet staffing needs cannot be done in isolation by individual employers, or even by one health or industry sector. Successful recruitment and retention programs will require collaboration and cooperation among all stakeholders including government departments, employers, labour unions, educational institutions, communities, etc.

Attracting people to a career in continuing care requires creativity and innovation. Considerable time and money have already been spent on recruitment initiatives with limited or no success, particularly in recruitment of HCAs. While academic institutions have been licensed to provide HCA education programs, there are limited applicants and in some instances, programs have been cancelled. Continually doing the same types of initiatives will not produce different results. Creativity and innovation will be required in promoting the continuing care sector as a workplace of choice and developing viable and exciting career paths to attract and retain staff. Targeted, rather than general initiatives may be more successful.

Health care staff need to be prepared for work in continuing care. Current education of RNs, LPNs and HCAs may not appropriately prepare them for working in the continuing care sector. Consequently, when new graduates enter the continuing care workforce, they may feel overwhelmed by, and unprepared for the actual workload and job demands. Staff shortages and high workloads of existing staff severely limit opportunities for mentorship of new staff. This is a factor in new graduates deciding to leave the continuing care sector in the first one to two years on the job. Strategies that allow for mentorship of new staff by existing staff are vital to retaining new graduates.
Recruitment and retention strategies require attention to multiple factors. Understanding the characteristics of the different generations and their value systems and responding as much as possible to those values is key to success in the workplace. Other concerns must be addressed such as availability of fulltime equivalent positions, compensation and benefit variances, continuing education, safe and positive work environments, potential for career advancement and overall job satisfaction, especially for health care aides.

Traditional workforce planning models need adjustment. Models for projecting workforce shortages and needs exist and some can be accessed online. However, workforce planning has occurred largely in isolation of, or separately from, other aspects of health. The general approach has tended to focus exclusively on particular provider groups and consists of estimating shortfalls or surpluses in those groups or calculating changes in the size of training programs required to eliminate those imbalances. While these projections suggest that the demand for workers will increase, the actual number of jobs may be tempered by the rate of economic growth and the extent to which governments, taxpayers and seniors are willing or able to pay. At the same time, as baby boomers approach old age, the pool of potential new workers will also be substantially smaller. Traditional workforce planning models may therefore be limited as to the "total picture" provided about actual future workforce needs, changes in the range of services (e.g., changing expectations and demands of seniors, government policy and strategies, funding limitations), population health status changes (e.g., healthier and longer living seniors than 20 years ago), potential technological advances, or other health and societal changes.
APPENDIX C: ACCA WORKFORCE SURVEY AND MODEL

THE ACCA WORKFORCE SURVEY

To develop the workforce strategy, an accurate picture was needed of the current staffing situation as it relates to three key health care roles: RNs, LPNs and unregulated health care workers (Health Care Aides, Personal Care Aides, Home Care Aides, Health Support Worker and Nursing Attendants). Using this information as a baseline, the future needs for these staff positions along with other changes happening in continuing care could be determined.

Respondents were asked questions on:

Q1. Profile of respondent setting, including: setting type, location, and setting name(s)
Q2. What twenty-four hour response period in February would be practical for them to use to pull data for subsequent questions
Q3. Number of clients served in reporting period
Q4. Whether any short staffing occurred during the reporting period, and if so, to describe it
Q5. Profile of the staff working in the reporting period, including: worker type, employment type, hours worked, birth date, and date of most recent employment with the employer
Q6. Percentage of services provided through a contractual arrangement with AHS during the reporting period
Q7. Definition of overtime
Q8. Employee turnover between January 1 and December 31, 2010

A copy of the full survey may be found in Appendix D.

METHODOLOGY

The following methodology was used in the dissemination of the survey:

- A survey was developed to look at the targeted staff positions in home care (HC), supportive living (SL) and facility living (LTC) settings. The survey was entered into the Survey Monkey database and piloted in August 2011.
- The survey was distributed in the first week of September 2011. Potential respondents were identified using the Alberta Seniors’ Accommodation Standards Licensing Database and the ACCA member database.
- Respondents were asked to respond by September 30, 2011. The survey deadline was extended to October 15, 2011 and then to October 20, 2011.
Two waves of reminder phone calls were given to all recipients of the survey in early October 2011. The first wave focused on under-represented groups and a second broad wave to all who had not responded. A number of individuals in the Accommodation Standards Licensing Database were not able to complete the survey as they did not hire their own HCAs, LPNs and RNs.

Respondents were asked to provide information for one 24 hour (3 shift) period of their choice in February 2011 that was not a weekend or holiday. This was done to reduce double counting of staff (although this was not assured as the same 24 hour period was not applied) and to ensure comparative staffing was being reported by all respondents.

Data for questions 1, 2, 3, 4, 6, 7 and 8 was entered directly into a Survey Monkey database. Data for question 5 was submitted into an MS Excel spread sheet and submitted via email. The resulting answers were manually entered into a question 5 database.

The answers for question 5 were manually matched to responses for questions 1, 2, 3, 4, 6, 7 and 8.

**Assumptions**

The following assumptions were used when cleaning and matching data in preparation for analysis:

- Matching data between question 5 and questions 1, 2, 3, 4, 5, 6, 7 and 8 was done by facility name and by respondent email address. Where no survey was completed for questions 1, 2, 3, 4, 5, 6, 7 and 8, the average responses for setting type by zone were used.
- When data was provided for a health worker and only partial turnover data was provided remaining data was placed to 0.
- When data was provided up to question 2, but no further data was provided, the respondent was removed from the database.
- In question 5, where respondents included administrative or managerial staff, the individual reported was removed.
- Aides reported were coded as HCAs as these positions will likely have to be completed by a certified HCA in the future. Registered Psychiatric Nurses were coded as RNs.

**Challenges**

Survey design was a compromise between information needed to drive the model and the voluntary nature of the survey. The intent was to be as informative as possible but remain manageable for operators. Consequently, certain changes to the original survey design occurred.
(not limiting the 24 hour reporting period to a mandatory single date in February, reducing the level of information requested, etc.).

- Self-selection bias causes the significance of supportive living responses to appear lower than they are, as not all operators hire HCAs, LPNs and RNs.

**Significance Rate**

Response rates for the survey are difficult to calculate as the size of the respondent population is unknown. The majority of supportive living settings do not have a contract with AHS and do not hire their own HCAs, LPNs and RNs. Instead, these settings rely on home care to provide their care services. However, the information on which operators do and do not hire this staff is not available. For home care, the number of providers in the province is not clear. Furthermore, both very large and small operators exist in the province, which results in a large discrepancy in reporting should pure number of respondents be used, as larger respondents are more representative of the province than small respondents. Consequently, the number of respondents is not the best way to calculate significance rates.

The number of clients in supportive living, long term care, and home care is known. The use of facility capacity weighs the size of facilities better and provides a more representative account of whether data is representative. Consequently, capacity was used to determine response rates.

**Table 12: Response Rates as Percentage of Total Capacity of Setting Type, February 2011**

<table>
<thead>
<tr>
<th>Setting Type</th>
<th>Percentage of Total Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long Term Care Settings(s)</td>
<td>28%</td>
</tr>
<tr>
<td>Supportive Living Settings(s)</td>
<td>11%</td>
</tr>
<tr>
<td>Home Care</td>
<td>9%</td>
</tr>
</tbody>
</table>

- Long term care responses can be considered representative with a 99% confidence level, within +/- 1.7%.
- Supportive living responses can be considered representative with a 99% confidence level, within +/- 3%.
- Home care responses can be considered representative with a 99% confidence level, within +/- 1.3%.
SURVEY FINDINGS
A total of 131 responses were collected over the course of the survey. Of these, 94, could be matched between Q5 and the remaining questions on Survey Monkey. Consequently, these 94 responses represent the total number of responses included in the model.

Q1A: RESPONDENT DEMOGRAPHICS

TABLE 13) RESPONSES BY GEOGRAPHIC REGION, NOVEMBER 2011

The majority of responses were collected from the Central Zone, with the least number of responses being collected in the North Zone.

TABLE 14) NUMBER OF SURVEY RESPONDENTS BY SETTING TYPE, NOVEMBER 2011

The majority of responses were collected from the Central Zone, with the least number of responses being collected in the North Zone.
The majority of total responses were collected from supportive living settings; however, all three settings are approximately equally represented by the model.

**Q2: Number of Clients Served**

**Table 15) Reported Number of Clients Served in 24 Hour Reporting Period, February 2011**

<table>
<thead>
<tr>
<th></th>
<th>Number of Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Care</td>
<td>9,362</td>
</tr>
<tr>
<td>Long Term Care Settings(s)</td>
<td>4,083</td>
</tr>
<tr>
<td>Supportive Living Setting(s)</td>
<td>2,187</td>
</tr>
</tbody>
</table>

Respondents were asked to report the number of clients they were serving in the 24 hour reporting period. Responses represent 15,600 clients with the majority reported in Home Care.

**Q3: Short Staffing**

**Table 16) Reported Prevalence of Short Staffing by Setting Type, 2011**

- **Home Care (HC)**: 28% said "Could Not Fill";
- **Supportive Living (SL)**: 15% said "Could Not Fill";
- **Long Term Care (LTC)**: 40% said "Could Not Fill"
Respondents were asked whether there were any hours that they could not fill in the reported 24 hour period. A minority (27%) could not fill all required hours in the reporting period. The majority of these were in long term care settings (40% of respondents could not fill at least one position.)

**Table 17**  Reported Prevalence of Short Staffing by Setting Type by Worker Type, February 2011

<table>
<thead>
<tr>
<th>Setting Type</th>
<th>RNs</th>
<th>LPNs</th>
<th>HCAs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long Term Care Setting(s)</td>
<td>12</td>
<td>6</td>
<td>14</td>
</tr>
<tr>
<td>Supportive Living Setting(s)</td>
<td>2</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Home Care</td>
<td>6</td>
<td>7</td>
<td>9</td>
</tr>
</tbody>
</table>

Respondents who reported being short staffed in the reported 24 hour period were asked to report the number of hours they were short. Of those who indicated being short staffed, HCAs were most likely to be reported short and LPNs were least likely to be reported short. This finding is consistent with the comparative volumes of each worker type in continuing care. Respondents reported being short staffed for more than one type of position.
Q6: Percentage of Hours of Service Provided Through Formal Arrangements with Alberta Health Services

Table 18) Percentage of Services Provided by Contract with AHS by Worker Type by Setting Type on Reported Day, February 2011

Respondents were asked to estimate the percentage of hours of service provided by worker type directly through a contract arrangement with Alberta Health Services. On the day chosen by respondents, the majority (86%) of services were provided under a contract with AHS. A small percentage of services were provided through private pay or other contract arrangements (for example, by contract through Workers Compensation). Of all the setting types, supportive living settings reported the greatest proportion of services being provided by HCAs, LPNs or RNs outside of AHS contracts.
Respondents were asked to indicate how their organization defined overtime hours for each of the three worker types. The information was then used to define a full time equivalent. On average, a full time equivalent is:

- Between 8.10 to 8.70 hours a day for RNs
- Between 7.99 and 9.16 hours a day for LPNs
- Between 8.06 to 10.02 hours a day for HCAs

Home care tends to have the highest number of hours per full time equivalent for LPNs and especially for HCAs.
Table 20: Turnover Rate by Worker Type by Setting Type, February 2011

Respondents were asked to calculate the turnover rate for their employees by worker type between January 1, 2010 and December 30, 2010. Respondents were asked to not consider retirement and turnover in casual positions. The following formula was used:

\[
\text{Turnover Rate} = \frac{\text{Headcount of Staff in that Position Leaving} - \text{Headcount of Staff in that Position Retiring}}{\text{Average Headcount of Staff in that Position}} \times 100
\]

Overall, reported turnover rates were highest in supportive living settings (17%) and lowest in home care (12%). The highest average turnover rate was reported in RNs (16%), with the highest turnover rate overall being reported in RNs in long term care (20%) and in supportive living (19%).

Q5: Employee Demographics

Question five focused on the demographics of staff whose activities had been documented in the survey questions. Respondents were asked to provide a listing of their staff who worked in the reporting period (with the names removed). For each of the staff, respondents were asked to identify the number of regular hours worked, the number of overtime hours worked, the worker type, the year that workers began working with the employer, and the year of the employee’s birth.
A total of 3,750 staff were reported by respondents. Staff were predominantly HCAs (82%). A smaller proportion of staff were LPNs (8%) and RNs (10%).

An aging continuing care health workforce is shown by the data. Table 22 illustrates the distribution of the continuing care health workforce by age (x axis) by worker type as a proportion of all workers of that type reported. The majority of health workers are shown as being over the age of 45, with most RNs being over the age of 50. LPNs are most evenly distributed across age groups, with a bimodal distribution (two peaks) one at 25 to 29 and one at 55 to 59.
Table 23) Reported Worker Ages by Age Cohort by Proportion of Setting Type, February 2011

Table 23 looks at the distribution of the continuing care health workforce by age (x axis) by continuing care stream as a proportion of all workers in that stream. In Supportive Living, the reported staff ages shows a large number of individuals poised to retire within the next five years. Long term care settings show a fairly normal distribution of health worker ages. Interestingly, although most staff retire at 65, home care retains the greatest number of staff over the age of 65, and has the greatest proportion of staff over the age of 45 overall (63%).

Table 24) Workers by Employment Type As Proportion of All Workers in Setting Type, February 2011
Table 24 displays the proportion of workers (of all reported for that setting type) who are employed in either a part time, full time, or casual position. Supportive living operators are most likely to report staff in full time positions (60% of supportive living staff). Both home care and long term care operators are more likely to report staff in part time positions (48% and 52%). Casual staff are a relatively small percentage of the worker pool, and are most likely to be reported by home care operators (17%).

**Table 25** Proportion of Workers by Employment Type by Worker Type, February 2011

Table 25 displays the proportion of workers (of all reported for that worker type) who are employed in either a part time, full time, or casual position. LPNs are the most likely to report being in a full time position (65%), HCAs and RNs are more likely to report being in a part time position (48% and 53%). A smaller percentage of staff are reported in casual positions; RNs at 17% with HCAs at 11% and LPNs at 8%. 
Table 26 displays the number of years an individual is with their employer (x axis) as a percentage of employees of that worker type (y axis). The duration of employment was calculated based on the year of most recent employment.

When comparing employees’ first or second year, we find that:

- Twenty-eight percent (28%) of reported HCAs were in their first or second year with the employer
- Thirty-one percent (31%) of reported LPNs were in their first or second year with the employer
- Thirty-five percent (35%) of reported RNs were in their first or second year with their employer.

When comparing employees who have been with their employer for four or more years:

- Sixty percent (60%) of HCAs were with their employer for four or more years
- Fifty-three percent (53%) of LPNs were with their employer for four or more years
- Fifty-seven percent (57%) of RNs were with their employer for four or more years

When comparing employees who have been with their employer for over ten years:
Eighteen percent (18%) of reported HCAs were with their employer for over ten years
Twenty-four percent (24%) of reported LPNs were with their employer for over ten years
Twenty-eight percent (28%) of reported RNs were with their employer for over ten years

A number of factors impact retention of staff; in the case of the demographics, the numbers are subject to job reclassification (some employees may use bridging programs to change from one designation to another), scope of practice changes, and changes in the hiring practices of employers due to changes in funded staffing models.

Table 27 displays the number of years an individual was reported as staying with their employer (x axis) as a percentage of employment type (y axis). The duration of employment was calculated based on the year of most recent employment. We find that:

- A large percentage of casual workers are in their first or second year of employment (39%). The majority (63%) of casual employees are in their first to fourth year with an employer.
- Both full time and part time workers experience a lower drop off in employment than casual staff; 25% of full time and 27% of part time staff are in their first year with an employer. Forty six percent (46%) of full time and 50% of part time employees are in their first to fourth year with an employer.
A number of factors impact retention of staff. In the case of employment type, the numbers are subject to job reclassification (some employees may change their classification from one type of employment to another over the duration of employment) and most recent employment (employees may leave an employer for a few years and return, only their return date is considered).

**Reported Staffing Ratios**

The number of overtime hours, short hours, and regular work hours worked in the reporting period by worker type and setting type were added and divided by the number of clients that were served in that setting by the reporting period. Table 28 outlines the staffing ratios averaged for Alberta.

**Table 28** System Staffing Ratios by Worker Type by Setting Type, February 2011

<table>
<thead>
<tr>
<th></th>
<th>Heads/FTE (RN)</th>
<th>Heads/FTE (LPN)</th>
<th>Heads/FTE (HCA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HC</td>
<td>0.95</td>
<td>0.90</td>
<td>0.68</td>
</tr>
<tr>
<td>SL</td>
<td>0.79</td>
<td>0.94</td>
<td>0.88</td>
</tr>
<tr>
<td>LTC</td>
<td>1.01</td>
<td>1.04</td>
<td>0.93</td>
</tr>
</tbody>
</table>

It should be noted that these staffing ratios represent those of the system overall for each of the setting types. The individual ratios do differ between employers and zones, the zone ratios by service type are used within the model.

**The ACCA Workforce Model**

Considerable work has been done to address health human resource issues at international, national, provincial and operator levels, including: assessing demand and supply issues, projecting staffing needs, developing forecasting and human resource planning models, and developing human resource strategies and policies. In Alberta, AHS recently published Modeling Options for the Alberta Nursing and Health Care Aide Workforce (2010) in an effort to predict workforce supply and demand provincially across acute and continuing care. Other models and organizations have been working to develop staffing
recommendations: Covenant Health using the Ottawa Hospital Workforce Model (2009), Canadian Medical Association, Canadian Association of Nurses, Canadian Medical Forum, and the Federal/Provincial/Territorial Advisory Committee on Health Delivery and Human Resources.

The intent of this workforce survey was to gather data, which was used to develop a workforce model specific to Alberta’s Continuing Care system. To create the model, we:

1. Gathered information on current staffing needs (the survey).
2. Used the information gathered to forecast future staffing needs.
3. Used the information gathered to forecast future staff availability.
4. Compared the future staffing needs to future staffing availability and identify gaps.

**Methodology**

Using the survey findings as a baseline, the future needs for these staff positions were determined. The gap between the current staffing situation and the future staffing needs provided information to help identify the actions to be taken in the Workforce Strategy.

**Figure 1: Overview of the Workforce Model**

In Figure 1, we show the following components of the model:

- The foundation of the model is Alberta’s population, which is used to determine the future client needs and the workers available.
On the left hand side, we show future clients. “Future clients” refers to the individuals who will require placement in continuing care. Projections are based on Alberta Health Services projections and institutionalization rates (LifePaths). Current situation is based on the ACCA Workforce Survey.

Stemming from the future clients, we show future demand. “Future demand” refers to the number of staff that are needed to provide care to the future clients. Future demand is based on the staffing ratios (ACCA Workforce Survey) needed to provide care to clients in home care, supportive living, and long term care.

On the right hand side, we show future supply. “Future supply” refers to the number of workers who are projected to work in continuing care. The current situation is based on the numbers reported in the ACCA Workforce Survey. Projections are based on the ratio of continuing care workers compared to the Alberta population.

The difference between future demand and future supply is the “gap” that is being considered by the ACCA Workforce Strategy.

**The Status Quo Model Assumptions**

The status quo model is based on Alberta population predictions. The number of Albertans by age cohort helps determine both the demand placed on the system (future clients and future staff demanded) and the staff likely to be available in the system as a proportion of the population (future supply).

The status quo model supplies the baseline scenario on which policy decisions can be made. The model assumes that political, economic, worker socio-demographics, and technology do not change. The model is not intended to accurately show the future, instead it is meant as a test case to show what might happen if only Alberta’s population changes. Unfortunately, not all data on the system is available for programming purposes, consequently, a number of estimates and assumptions are used to illustrate the future. Many of these assumptions were listed above; these will be described in greater detail in the following sections:

**Alberta’s Future Population Projections**

Two models are available to estimate Alberta’s future population:

- The 2011 Alberta Finance population projection. The model is relatively linear.
- Alberta Health and Wellness population projection. The model presents a less linear population growth pattern.
Both models consider migration in and out of the province. Furthermore, in both projections, the baby boom is followed by a larger age cohort, the “echo boom”. Due to its strong economy, Alberta is an importer of talent, which has resulted in Alberta remaining a relatively “young” province, in part due to its large number of “echo boomers”. The Alberta Health and Wellness population projections provide a third population wave, the children of the “echo boomers”.

**Table 29) Alberta Finance Population Projections, 2010 - 2035**

**Table 30) Alberta Health and Wellness Projections, 2010 - 2035**

Due to a less linear approach, and better approximation of the echo boom, and the availability of a high/medium/low population scenario, the Alberta Health
and Wellness Population projections were chosen as the basis of the status quo model. The model provides projections up to 2039.

**Future Client Projections**

Once the population of Alberta is established, it is necessary to determine the number of clients who may access the system. LifePaths is a tool developed by Statistics Canada to predict the impact of policy changes on the social determinants of health in the Canadian population. The tool includes information on heuristics used to estimate various population indicators including institutionalization; which is the placement of an individual in an institution. This is based on census data, which includes both long term care and supportive living in its calculations. The 2001 indicator is age and gender specific and based on Canada wide data.

<table>
<thead>
<tr>
<th>Institutionalization (LifePaths)</th>
<th>Survival (LifePaths)</th>
<th>Institution-level Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overflow</td>
<td></td>
<td>Supportive Living</td>
</tr>
<tr>
<td>HC ratios by region from 2003/4</td>
<td>2004/5 adjusted for</td>
<td>HC</td>
</tr>
<tr>
<td>number in 2011</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Figure 2** is a representation of model logic in placing clients. The model makes use of the institutionalization rate (LifePaths) of the population to determine the likelihood of an Alberta resident of a certain age entering into long term care or supportive living. The model assumes that:

- If someone is institutionalized by the model they have a preference for a long term care setting (i.e., long term care settings fill up to capacity first). The number of long term care spaces available is shown as depreciating over time, to reflect Alberta’s policy of not opening new long term care spaces.
- Should no long term care spaces be available, the institutionalized individual is placed in supportive living (Overflow). AHS has indicated that they will open 6000 new continuing care spaces by 2015. The model ensures that these spaces are opened and filled in 2015.
• The total number of home care clients is based on ratios by zone by population from a 2006 study of home care services in Alberta. The ratio used pertains to the number of clients by percentage of population by Regional Health Authority. This information is adjusted for zone populations.

Once institutionalized, a resident is unlikely to leave supportive living and long term care, and consequently:

• The individual is removed from the population that can be institutionalized (the Alberta population).

• The individual’s length of stay in supportive living and long term care is modeled using survival rates by age and gender (from LifePaths.)

To initiate the model, the number of individuals being provided health services in supportive living and long term care in 2010 is needed. Home care clients are estimated as a percentage of the population. Supportive living and long term care residents/clients are estimated as follows:

• Alberta Health Services operates long term care and designated supportive living spaces across Alberta. To estimate AHS’s 2010 supportive living and long term care capacity, the rate of spaces by population by zone were used:

<table>
<thead>
<tr>
<th>Zone</th>
<th>2010/11</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>NORTH</td>
<td>3.82</td>
<td>5.8</td>
</tr>
<tr>
<td>CENTRAL</td>
<td>7.58</td>
<td>5.8</td>
</tr>
<tr>
<td>SOUTH</td>
<td>8.39</td>
<td>5.8</td>
</tr>
<tr>
<td>EDMONTON</td>
<td>7.1</td>
<td>5.5</td>
</tr>
<tr>
<td>CALGARY</td>
<td>4.63</td>
<td>5.5</td>
</tr>
</tbody>
</table>

*Source: AHS Presentation at ACCA Workforce Strategy, September 2011
AHS Presentation at ACCA Designated Assisted Living Workshop; May 2011*

• Although the majority of continuing care is operated by AHS, some is operated through other arrangements. The number of AHS spaces were adjusted using the ratio of public to private spaces reported in the ACCA survey.

• To estimate the number of long term care spaces in 2010, the long term care capacity, as published by the Accommodation Standards licensing database (Alberta Seniors) was used. This number includes both spaces operated by AHS and those operated through other arrangements.

• Although the Accommodations Standards licensing database also collects supportive living capacity, these numbers were not used as the majority of supportive living does not provide health services. Instead,
the AHS continuing care ratios adjusted for public/private less long term care capacity were used.

- As supportive living that provides health services and long term care experiences a near 100% occupany of beds/spaces, capacity was used to determine the number of supportive living and long term care clients/residents in 2010.

The 2010 clients in supportive living and long term care are then aged over the course of the model. The model assumes that these individuals are, on average, 75 years old. Their subsequent survival rates are calculated over the course of the model.

**Table 31** Status Quo: Predicted Demand

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
<th>2030</th>
<th>2035</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Home Care</strong></td>
<td>112,794</td>
<td>124,010</td>
<td>135,151</td>
<td>145,865</td>
<td>156,010</td>
<td>165,614</td>
</tr>
<tr>
<td><strong>Supportive Living</strong></td>
<td>9,745</td>
<td>19,776</td>
<td>27,019</td>
<td>37,822</td>
<td>50,978</td>
<td>67,276</td>
</tr>
<tr>
<td><strong>Long Term Care</strong></td>
<td>14,357</td>
<td>11,706</td>
<td>9,545</td>
<td>7,783</td>
<td>6,346</td>
<td>5,174</td>
</tr>
</tbody>
</table>

The graph above shows the number of clients/residents being estimated by the model between 2010 and 2035:

- Home Care (purple): The number of home care clients is shown as increasing over time, from approximately 112,000 clients to 165,000.
- Supportive Living (green): The number of clients (non-home care) in supportive living who are provided with health services increased from approximately 10,000 clients to 67,000. The black and yellow striped column is meant to represent the overflow of the institutionalization measure.
• Long term care (blue): The number of clients in long term care is shown as decreasing over time (due to the number of long term care spaces depreciating) from approximately 14,000 to 5,000.

**Future Staff Demand Projections**

Once the number of clients in each of the setting types is determined, the volume of each worker type required can be calculated. The calculation is based on the staff to client ratios reported in the ACCA workforce survey. The model makes the assumption that:

• The time worked by an employee during the reporting period would typically be worked each day.
• The ratio of worked hours to clients served remains the same over time by Alberta Health Service zone by setting type.

Note: As the number of long term care spaces decreases, more clients who would be considered for institutionalization in long term care are placed into supportive living. This kind of shift would result in greater client acuity in supportive living, which would require an adjustment in supportive living staffing ratios. This calculation is not included in the status quo model, which artificially depresses the staffing volume projections.

**Table 32: Status Quo: Predicted FTEs Needed by Staff Type, 2010-2035**

<table>
<thead>
<tr>
<th></th>
<th>Heads/FTE (RN)</th>
<th>Heads/FTE (LPN)</th>
<th>Heads/FTE (HCA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>LC</td>
<td>1.01</td>
<td>1.04</td>
<td>0.93</td>
</tr>
<tr>
<td>SL</td>
<td>0.79</td>
<td>0.94</td>
<td>0.88</td>
</tr>
<tr>
<td>HC</td>
<td>0.95</td>
<td>0.90</td>
<td>0.68</td>
</tr>
</tbody>
</table>

Average system FTEs are highest in long term care and lowest overall for HCAs in home care and RNs in supportive living. In long term care, one LPN will do more than the work of one.
The model shows the demanded number of staff FTEs by worker type as predicted by the status quo model. The volume of staff needed is shown as steadily increasing over time, including an increase past 2030. Further propagation of the model past 2035 using the Alberta Finance projections (not shown here) supports this trend. In Alberta, due to the size of the echo boom, as the baby boom “peaks,” the risk factor for institutionalization increases for the aging echo boom and results in them being placed in continuing care.

Of the three worker types, HCAs are seen as increasing in greatest number. As a percentage of their original numbers, RNs and LPNs show the greatest increase (approximately 3.7 times their original number) as compared to HCAs (approximately 2.6 times their original number).

**Future Staff Available Projections**

The number of staff who are available in the system may be predicted in one of two ways: staff can be considered as a percentage of all Albertans in their age group, this would suggest that staff enter and exit continuing care over time; staff can be modeled as staying within continuing care across their lifetime.

On considering the staffing demographics gathered from the ACCA workforce survey, it was decided that both methods may be used to model available staff. Staff such as LPNs and RNs enter the system after completing their schooling and generally remain in continuing care past that time; LPNs enter after the age of 30 and RNs after the age of 35. HCAs, whose education is more flexible and
who tend to enter into continuing care at a more advanced age enter and exit their profession as a proportion of Alberta’s population until the age of 50, after which they remain in the system.

Staff are assumed to retire at 65. This assumption has been contested in the past as some staff remain employed well into their 70s, however the number of reported employees who remain in employment in continuing care past 65 is low (7% for RNs, 3% for LPNs, and 4% for HCAs).

Table 34 summarizes the above calculations for estimating future staff headcount available in the system.

Table 34) Calculations for estimating future staff headcount

<table>
<thead>
<tr>
<th>Group</th>
<th>Age Cohort</th>
<th>Calculation</th>
</tr>
</thead>
<tbody>
<tr>
<td>RN</td>
<td>&lt;35</td>
<td>Entry into CC based on ABpopulation&lt;35* ProportionRN&lt;35inCC SURVEY</td>
</tr>
<tr>
<td></td>
<td>35 to 65</td>
<td>RNs By Age Cohort(Y-5) * Δ ABPopulationAgeCohort(Y to Y-5)</td>
</tr>
<tr>
<td>LPNs</td>
<td>&lt;30</td>
<td>Entry into CC based on ABpopulation&lt;30* ProportionLPNs&lt;30inCC SURVEY</td>
</tr>
<tr>
<td></td>
<td>30 to 65</td>
<td>LPNs By Age Cohort(Y-5) * Δ ABPopulationAgeCohort(Y to Y-5)</td>
</tr>
<tr>
<td>HCAs</td>
<td>&lt;50</td>
<td>Entry into CC based on ABpopulationHCAsAgeCohort&lt;50* ProportionHCAsAgeCohort&lt;50</td>
</tr>
<tr>
<td></td>
<td>50 to 65</td>
<td>HCAs By Age Cohort(Y-5) * Δ ABPopulationAgeCohort(Y to Y-5)</td>
</tr>
</tbody>
</table>

Once the headcount of available staff is established, a system FTE ratio (based on the ACCA survey) is applied to the headcount. The system FTE is measured as the number of hours worked by all employees of a worker type plus the number of hours short for that worker type divided by the number of workers that did the work divided by the average hours that define a full time equivalent for that worker type. The measure assumes that the same employee was not reported by two operators in the same reporting period.
Table 35 shows the predicted system FTEs by worker type. Due to an increase in the Alberta population, the number of workers overall are expected to rise; however, due to staff retirement, the model predicts that the system numbers of RNs and LPNs will begin to fall after 2010, as nurses retire. LPNs numbers begin to rise after 2020 as new LPNs enter the workforce to replace retirees. This is not the case with RNs. RN entrance rates into continuing care do not replace those RNs predicted to retire.

**Model Findings**

The following graphs show the difference between anticipated demand, future estimated headcounts of health workers, and the future estimated continuing care system FTEs for health workers (HCAs, LPNs, and RNs) in the status-quo scenario (which assumes clients use the same volumes of service, services are supplied by the same ratios of staff, and same rates of graduation occur).
The system FTEs of RNs in 2010 was estimated by the model as being sufficient to meet the needs of the entire continuing care system across Alberta. However, the model predicts that unless changes are made to the status quo, the system will begin experiencing unmet RN demand as early as 2015 (985 unmet RN FTEs). The figures follow the dramatic drop in the number of available RN FTEs as RNs retire.

As the system FTEs are high (therefore headcount and FTEs are very similar) minimal improvements would be realized in the system if more RNs worked a full time equivalent. This is significant, as it suggests that the system is experiencing a manpower shortage that must be addressed through attracting additional workers.
The system FTEs of LPNs in 2010 was estimated by the model as being sufficient to meet the needs of the entire continuing care system across Alberta. However, the model predicts that unless changes are made to the status quo, the system will begin experiencing unmet LPN demand as early as 2015 (805 unmet LPN FTEs). The initial shortage occurs due predominantly to retirement of LPNs and an increase demand for LPNs. After 2020, more LPNs are predicted to enter the system but in insufficient quantities to keep up with the rising demand.

As the system FTEs are high (therefore headcount and FTEs are very similar) minimal improvements would be realized in the system if more LPNs worked a full time equivalent. This is significant, as it suggests that the system is experiencing a manpower shortage that must be addressed through attracting additional workers.

<table>
<thead>
<tr>
<th>Year</th>
<th>Need (LPN System FTEs)</th>
<th>Have (LPN Head Count)</th>
<th>Have (LPN System FTEs)</th>
<th>Non Cum. FTE Shortage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>1,732</td>
<td>1,890</td>
<td>1,778</td>
<td>-46</td>
</tr>
<tr>
<td>2015</td>
<td>2,581</td>
<td>1,882</td>
<td>1,776</td>
<td>805</td>
</tr>
<tr>
<td>2020</td>
<td>3,197</td>
<td>1,937</td>
<td>1,827</td>
<td>1,370</td>
</tr>
<tr>
<td>2025</td>
<td>3,955</td>
<td>2,172</td>
<td>2,051</td>
<td>1,904</td>
</tr>
<tr>
<td>2030</td>
<td>4,873</td>
<td>2,499</td>
<td>2,358</td>
<td>2,516</td>
</tr>
<tr>
<td>2035</td>
<td>6,008</td>
<td>2,763</td>
<td>2,607</td>
<td>3,401</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Year</th>
<th>Need (HCA System FTEs)</th>
<th>Have (HCA Head Count)</th>
<th>Have (HCA System FTEs)</th>
<th>Non Cum. FTE Shortage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>19,815</td>
<td>27,439</td>
<td>20,052</td>
<td>-237</td>
</tr>
<tr>
<td>2015</td>
<td>25,731</td>
<td>28,417</td>
<td>20,620</td>
<td>5,111</td>
</tr>
<tr>
<td>2020</td>
<td>30,040</td>
<td>30,207</td>
<td>21,802</td>
<td>8,238</td>
</tr>
<tr>
<td>2025</td>
<td>35,022</td>
<td>31,702</td>
<td>23,066</td>
<td>11,957</td>
</tr>
<tr>
<td>2030</td>
<td>40,871</td>
<td>33,382</td>
<td>24,374</td>
<td>16,497</td>
</tr>
<tr>
<td>2035</td>
<td>47,943</td>
<td>35,356</td>
<td>25,683</td>
<td>22,261</td>
</tr>
</tbody>
</table>

The system FTEs of HCAs in 2010 was estimated by the model as being sufficient to meet the needs of the entire continuing care system across Alberta. Similarly to LPNs and RNs, the model predicts that the system will experience unmet HCA demand starting in 2015 (5,111 unmet HCA FTEs).

As the system FTEs for HCAs are low, the difference between the number of HCAs in the system and the number of FTEs they represent is very different. Consequently, large improvements can be realized if more HCAs work a greater number of hours (i.e., if each HCA represents a higher system FTE). The model predicts that an increase in system FTEs would address the shortage issue until 2020, after which more workers would need to be attracted to Alberta’s continuing care system. However, “efficiency” is not the only concern when addressing the FTEs worked by HCAs, other factors need to be considered: HCAs’ preferences for working full time, the availability of employer funding to hire full time HCAs, the feasibility of hiring full time HCAs when work volumes...
vary greatly (if predictably) each day. Should no solution to these factors be presented, attraction will need to be the main strategy in addressing the predicted shortage.
APPENDIX D: ACMA WORKFORCE SURVEY

Introduction

The Alberta Continuing Care Association (ACCA) was successful in obtaining funding to develop a Workforce Strategy for Continuing Care in Alberta in collaboration with a number of government departments, Alberta Health Services (AHS) and other stakeholders. The development of a workforce strategy is pivotal to the future of the continuing care sector in Alberta’s health system.

As part of developing such a strategy, the Alberta Continuing Care Association Workforce Strategy Steering Committee needs an accurate picture of the current staffing situation as it relates to three key health care roles: Registered Nurses (RNs), Licensed Practical Nurses (LPNs) and unregulated HCAs (Health Care Aides, Personal Care Aides, Home Care Aides, Health Support Worker and Nursing Attendants). The survey will look at these staff positions in home care, supportive living and long term care settings. Using this information as a baseline, the future needs for these staff positions along with other changes happening in continuing care will be determined. The gap between the current staffing situation and the future staffing needs will provide information to help identify the actions to be taken in the Workforce Strategy.

Carol Blair and Associates Inc. have been retained as consultants to support the work required on this project, specifically Carol Blair as the project manager and lead consultant, Dominika Warchol, consultant employed by Carol Blair and Associates.

Your organization has been identified to complete a workforce survey as one of Alberta’s continuing care providers. The following information gives the details on the survey. If you have any questions about the survey, please feel free to contact Dominika Warchol who is administering the survey. Her contact information is given below. If you have any questions about the project, you may direct those to Bruce West, Executive Director, ACCA, at bwest@ab-cca.ca or by telephone at 780-435-6099.

Information on the Workforce Survey

In order to develop a forward-looking strategy, current workforce models must be adjusted to include all of Alberta’s Continuing Care System. They must be sufficiently flexible to identify types of continuing care operators and the needs specific to a geographic region. To create such a feasible staffing model, we need your help. The intent of this document is to provide you with an overview of the staffing model being developed and to collect information from your organization on your operations and current staffing situation (HCAs, LPNs, and RNs). Your responses are critical to developing an accurate and useful workforce strategy.
This document has three sections:

- **Section 1 Introduction**: overview of the project to develop the Workforce Strategy for Continuing Care.
- **Section 2 The Model**: This section explains the model and how survey information will be used to forecast future demand.
- **Section 3 The Data Requested**: This section outlines the information being requested and the format in which the data may be available in your organization.

**PLEASE ENTER YOUR RESPONSES ONLINE AT THE ADDRESS PROVIDED IN THE COVERING EMAIL AND/OR EMAIL YOUR RESPONSES TO DOMINIKA WARCHOL AT DOMINIKA@CAROLBLAIRASSOCIATES.COM NO LATER THAN SEPTEMBER 30, 2011. SHOULD YOU HAVE ANY QUESTIONS OR CONCERNS, PLEASE DO NOT HESITATE TO CONTACT ME AT 780.619.6452.**

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**THE MODEL**

Considerable work has been done to address health human resource issues at international, national, provincial and operator levels, including: assessing demand and supply issues, projecting staffing needs, developing forecasting and human resource planning models, and developing human resource strategies and policies. In Alberta, AHS recently published *Modeling Options for the Alberta Nursing and Health Care Aide Workforce (2010)* in an effort to predict workforce supply and demand provincially across acute and continuing care. Other models and organizations have been working to develop staffing recommendations: Covenant Health using the Ottawa Hospital Workforce Model (2009), Canadian Medical Association, Canadian Association of Nurses, Canadian Medical Forum, and the Federal/Provincial/Territorial Advisory Committee on Health Delivery and Human Resources.

The intent of this workforce survey is to gather data, which will be used to develop a workforce model specific to Alberta’s Continuing Care system. To create the model, we:

- Gather information on current staffing needs (the survey).
- Use the information gathered to forecast future staffing needs.
- Gather information on current supply of staff (a separate interview process).
- Use the information gathered to forecast future staff availability.
- Compare the future staffing needs to future staffing availability and identify gaps.
- Determine actions needed to fill or reduce that gap.
DATA REQUEST

The following section describes the information being collected through the online survey and email.

Please note: the more accurate the data we gather, the better the output of the model. Each of the following questions should be answered by site/service type (home care, supportive living site, or long term care site) and Geographic Service Region in which the site(s) operate. For example:

• If you operate two SL settings, one LTC setting, and provide home care services in Red Deer, you would answer the survey three times (one for each type of setting).
• If you operate two SL settings (one in Calgary and one in Edmonton), one LTC setting in Calgary and provide home care in Edmonton, you would answer the survey four times.
• If you operate a blended facility and cannot separate staff assignment, please answer once, but indicate how many SL and how many LTC units/beds the staff is overseeing (Question 8)

Question 1: Please fill out the following questions by site/service type and the city or town in which the site(s) operate:

• Setting/Service Provider Name(s)
• Setting/Service Provider Type
• Geographic Service Area in which the listed site(s) operate

Question 2: Please choose one 24 hour (3 shift) period of your choice in February that is not a weekend or holiday. You will use this time period for all subsequent reporting.

Question 3: On the day you chose, how many clients were you serving?

• Note: Please do not include clients served in adult day programs such as CHOICE or C3. All other speciality units (e.g., speciality rehabilitation units) should be included.

Question 4: On the day you chose, were all your positions filled? [Yes/No] If no, how many hours do you estimate you were short: RNs, LPNs, HCAs

Question 5: The following table asks for data on each of your RNs, LPNs, and HCAs who worked within the 24 hour period you chose. Please generate a report/worksheet/table with the following information from your payroll system, accounts payable system or finance department in .xls, .csv or html formats. A Microsoft Excel template has been provided at: .
• Note: Supervisory and front line positions may be reported together for each employee position.
• Note: To protect staff privacy, please do not provide employee names, salaries, or the month and day of birth.

Questions included in the Microsoft Excel template are:
• Unique IDs of RNs, LPNs and HCAs employed who were working on the day you chose – you may use a made-up number unique to each employee
• Employee’s position - RN, LPN, HCA
• Employee’s status - full-time, part-time, or casual worker
• Hours worked by employee in the 24 hour period you chose: Regular Hours
• Hours worked by employee in the 24 hour period you chose: Overtime Hours
• Employee’s year of: Birth
• Employees year of: Most recent employment

**Question 6:** On the day you chose, what percentage of hours of service provided by the staff listed above were provided directly through a contract arrangement with Alberta Health Services (Formal Arrangement)? what percentage were provided through private pay? [RNs, LPNs, HCAs]

**Question 7:** How does your organization define overtime hours for each of the following employee positions? [RNs, LPNs, HCAs]

**Question 8:** Between Jan. 1 and Dec. 31, 2010, what was the average percentage turnover (voluntary and non-voluntary but not including retirement) for the setting(s) described above? Please answer for each of the following positions:[RNs, LPNs, HCAs]

To calculate the headcount, please use the following formula:

\[
\text{Average Headcount of Staff in that Position} \times \frac{\text{Headcount of Staff in that Position Leaving} - \text{Headcount of Staff in that Position Retiring}}{\text{Average Headcount of Staff in that Position} \times 100}
\]

*for one calendar year
## Appendix E: Registered Psychiatric Nurses

<table>
<thead>
<tr>
<th>Which Stream</th>
<th>Predominantly long term care.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role Summary</td>
<td>Provide professional nursing and mental health nursing services in mental health care facilities and in the community. They promote and help people restore and maintain good mental health.</td>
</tr>
<tr>
<td>Duties</td>
<td>Provide holistic, client centered nursing care</td>
</tr>
<tr>
<td></td>
<td>Complete health histories, physical examinations and mental status assessments</td>
</tr>
<tr>
<td></td>
<td>Develop, implement, evaluate and update nursing care plans</td>
</tr>
<tr>
<td></td>
<td>Administer and assess the effects of prescribed medications and treatments</td>
</tr>
<tr>
<td></td>
<td>Assess, report and respond appropriately to observed behavioural changes</td>
</tr>
<tr>
<td></td>
<td>Implement strategies to promote optimal mental and physical health and well-being of clients</td>
</tr>
<tr>
<td></td>
<td>Serve as advocates for clients and their families.</td>
</tr>
</tbody>
</table>

### Educational Requirements
- Minimum educational requirement for psychiatric nurses is a diploma in psychiatric nursing.
- Grant MacEwan University in Edmonton and Ponoka offers a two year diploma. Mount Royal College in Calgary offers a one-year post-basic Advanced Studies in Mental Health certificate.
- Under Alberta’s Health Professions Act and Registered Psychiatric and Mental Deficiency Nurses Profession Regulation registration with the College of Psychiatric Registered Nurses of Alberta (CPRNA) is mandatory.
- Registered members, who are authorized by the College, provide restricted activities specified in the Regulation. Only registered members may call themselves registered psychiatric nurses or psychiatric nurses.

### Salary
- According to the 2009 Alberta Wage and Salary Survey, Albertans in the Registered Nurses group earned from $30.80 to $40.43 an hour. The average wage was $36.55 an hour.
- Specific salary information for Registered Psychiatric Nurses was unavailable.

### Advancement
- Advancement to supervisory or administrative positions may require additional education.

### Statistics
- 1202 RPNs practicing in Alberta*
- 74.9% female, 25.1% male (2009)**
- 47.5 average age of RPNs (2009)**
- 8.7% working in LTC (2009)**

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Sources:
For further information please contact

The Alberta Continuing Care Association

120 9405 50 Street NW

Edmonton, AB T6B 2T4

Info@ab-cca.ca (780) 435-0699