8. Optimizing Deployment of the Health Workforce

Doctors and nurses were what was needed. And especially nurses … The Red Cross had divided the country into 13 divisions, and the nursing committee chief of each one has already been told to find all people with any nursing training, not only professionals or those who had dropped out of nursing schools but down to and including anyone who had ever taken a Red Cross course in caring for the sick at home.

The Great Influenza, J.M. Barr

During an influenza pandemic, health care workers will be called upon to provide care for people who have influenza. They will also be asked to continue to maintain other health care services during a pandemic. But health care workers will also be affected by influenza. Based on the assumptions in this plan, at the peak of a pandemic wave as many as 20 to 25% of health care workers may be absent from work – either because of illness or because of caregiving responsibilities at home. When the demand for care will be greatest, the health system will be hard pressed to maintain its workforce.

To optimize the availability of health human resources (HHR) and to ensure patient-centred care during a pandemic, Ontario will take a competency-based approach to HHR planning. The objective of this section of the OHPIP is to explain competency-based HHR planning and its relevance to key stakeholders including local planners, health care providers, health regulatory colleges and volunteer agencies. Employers and unions may also find the section useful for planning. All sectors of the health care system must work together to plan a coordinated and comprehensive approach to optimizing the deployment of the health workforce during a pandemic.

There is some concern on the part of health care providers that they may be deployed without being part of the decision-making process. This is not the intent, and the OHPIP recognizes the role that self-regulating professions and their regulatory colleges play in determining competencies and establishing standards for safe care.

The framework for competency-based planning is a guide to a collaborative approach to deploying staff during a pandemic. In the proposed approach, health care planners and employers play a key role in identifying the competencies required during an influenza pandemic, while the professions and health care providers play a key role in assessing their competencies and determining how their knowledge and skills can best be used.

The framework described in this chapter and the tools included in Chapter 8A provide an opportunity for planners, providers and volunteers to participate in preparing for an influenza pandemic and to understand what is required to make competency-based HHR planning effective. They also provide a starting point for discussions which will lead to an integrated and coordinated HHR strategy.

The more detailed background papers and guides used to develop this chapter are available on request from the Emergency Management Unit, Ministry of Health and Long-Term Care.

8.1 Objectives

- To describe a competency-based approach to health human resources (HHR) planning.

- To identify the skills and competencies required to provide influenza care.
- To provide tools that planners can use to develop pandemic HHR plans.
- To provide tools that health care providers can use to assess skills.

8.2 Responsibility for HHR Planning

The competency-based approach to planning for pandemic influenza may be helpful for stakeholders planning in individual health care organizations, in the local community, within the Local Health Integration Networks (LHINs), and at the provincial level. HHR planning and staffing is usually done organization by organization. During a pandemic, each health care organization will continue to be responsible for managing its staff. However, as part of pandemic preparedness, the ministry recommends that key stakeholders work together at the local, regional and provincial levels to ensure that planning occurs across all care settings including: community and primary health care, emergency departments, acute care, long-term care, and critical care sites. Planning should occur in a bottom up fashion. This means that local planners would estimate the health human resources required to provide influenza care in all settings in their local planning area. They can then coordinate with regional and provincial planners to determine how to make the most effective use of available people and skills.

Engaging the workforce leadership in discussions about the competencies required to deliver care in a pandemic can help establish inter-disciplinary teams that can react quickly during a crisis.

8.3 A Competency-based Approach for Planners

Competencies are defined as the skills, knowledge and judgment required to deliver a particular health service. A competency-based approach identifies the competencies required and the competencies available to deliver the services that people need during an influenza pandemic.

The planning activities involved in this approach include both quantitative and qualitative data collection. Quantitative data would include information on such items as population size, attack rates and the number of providers available. Qualitative information would come from key informant interviews or focus group discussions with workforce leadership on the following:

- Are there non-registered providers (e.g., retirees) in our planning area who could be registered expeditiously?
- How can we get those providers who are in administration and research back into patient care?
- How do we shift part-time workers to full-time workers?
- What are the competencies of these providers?
- What is their level of productivity?

This approach is intended to increase the care capacity available for a large number of influenza patients by making strategic use of the competencies of all available health care providers, students, and volunteers. With this approach, planners consider the competencies rather than the professions required to meet the needs of the population. This may allow for more staffing options given the range of different professionals who may be able to provide

the required competencies during a crisis.

For example, if the emergency department (ED) triage nurses are suddenly unavailable due to illness during a pandemic, how would a hospital administrator know what other nurses might have the competencies to provide ED triage? One way could be to have hospital staff complete a skills/ competencies self-assessment survey, which might reveal that several nurses working in other capacities in the hospital have taken nursing triage courses or are military reservists with experience working in combat situations in the triage capacity. Another alternative would be to offer training in triage to other emergency and step down staff before a pandemic begins.

One of the goals of a competency-based approach to workforce deployment is to free up those health professionals who are specially trained and competent in influenza care to focus on those patients who are in greatest need.

Competencies by Setting

Different care settings provide different types and levels of service and, therefore, require different competencies. Different health care providers also have different levels of competencies. Planners use this information to find effective ways to address the "gap" in competencies (i.e., the difference between the competencies required and competencies supplied) by identifying people who have or could be quickly trained to provide those competencies such as: health care providers, students, volunteers and others. During the interpandemic period, planners are encouraged to engage workforce leaders in conversations to develop the appropriate provider networks and "up-skilling" training programs.

In the competency-based approach, planners attempt to answer two key questions:

- What is the spectrum of competencies required to meet the needs of patients in each care setting?
- What competencies can be supplied by providers in that planning area?

To answer these questions in terms of influenza care, planners will: estimate the number of influenza patients by care setting (i.e., using sample numbers provided by "FluSurge" or "FluAid"); identify the services provided in those settings and the competencies required to provide those services; and identify the professions who can deliver those competencies. With this information, planners can then think beyond traditional credential-based silos and consider a broader range of staffing options to meet the population's health needs.

Note: this section focuses on HHR planning for influenza care only. Health care settings and regions will also have to plan for the HHR required to maintain other essential health services during an influenza pandemic.

8.4 Influenza Care Competencies

To provide care for people with influenza, different health care settings will require different competencies depending on the type of services they provide. See Chapter 8A: Health Human Resources Tools for a comprehensive list of influenza care competencies – that is, the competencies the health care system requires to provide care for people with influenza – organized into the following categories:

- administrative support
- transportation
- education

- infection control
- care services.

8.5 Influenza Competencies Required

As Figure 8.1 illustrates, the mix and quantity of influenza care competencies (ICCs) an individual health care setting or a geographic area will require during an influenza pandemic will depend on:

- the size and mix of population served in the setting or area (demographics)
- health status, attack rate, mortality, and morbidity (epidemiology of the virus)
- the type and level of service provided in the care setting or area
- the competencies required to provide that type and level of service.

For more detailed information on how to assess these factors, see *Key Questions for Planners* in a competency-based HHR approach in Chapter 8A: Health Human Resources Planning Tools.

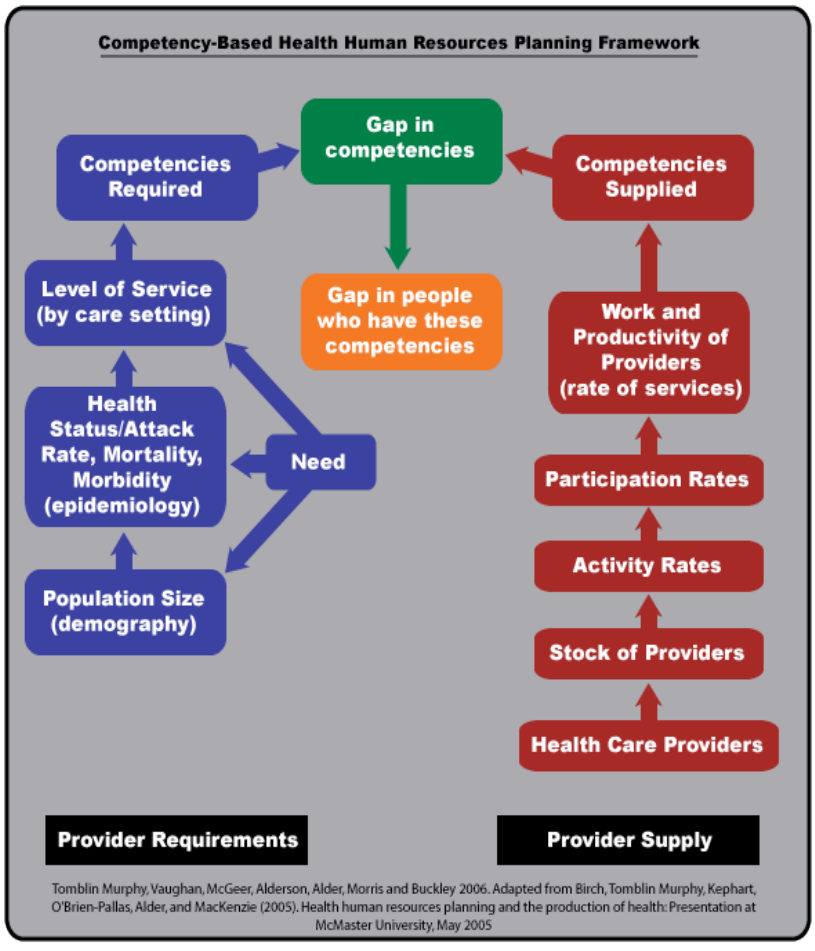
Planners would use the information on available competencies to deploy staff to meet needs. If – after redeployment of existing staff – there is still a gap between the competencies required and the competencies available, planners would then look beyond the current workforce (e.g., students, retired health care providers, people with some first aid or other training, volunteers).

It is also important to note that the most useful means of extending the human resources available is not by identifying staff with competence for individual acts. In order to be useful in teams providing care, staff will need to be able to perform several of the competencies.

Assessment Competencies

Many competencies are needed to provide care to influenza patients; however, the most important competencies, and those which will be most difficult to supply, are the competencies to assess patient status, to develop a care plan for the patient, to identify whether additional care is needed, and to determine whether the patient can be discharged from the care site. These competencies are also the most difficult to assess.

Figure 8.1: Competency-Based Health Human Resources Planning Framework



8.6 Identifying Competencies Available

As Figure 8.1 also illustrates, the influenza care competencies available to the setting (i.e., from existing providers) will depend on:

- the number and mix of health care providers in the setting or area
- their productivity – which is a function of the stock of providers and their activity and participation rates (i.e., how many hours they work and how much care they can deliver).

To prepare for an influenza pandemic, health care settings and/or local planners need information on the number of health care providers available and their competencies. See Chapter 8A: Health Human Resources Planning Tools for Key Questions for Planner on Provider Supply.

The tools chapter also includes a self-assessment tool developed to help health care providers reflect on their own abilities and competencies to provide care during an influenza pandemic. Planners may be able to collaborate with their workforce to use this tool to help quantify the competencies available.

To understand the actual amount of influenza care the existing workforce can provide; planners would then have to take into account the number of providers and the hours they work – as well as the potential 20% or higher absenteeism rates that are likely to occur at the peak of the first pandemic wave.

When considering the competencies available, health care settings may also contact and include recently retired employees, part-time employees who might be willing to work more hours during a pandemic and students. As part of HHR planning, employers are encouraged to talk to staff and other health care providers about the province's pandemic plan and to discuss how health care workers can contribute to both the planning process and pandemic response.

8.7 Health Care Providers' Role in Identifying Competencies

Health care providers and their professional colleges and associations will play a crucial role in optimizing the deployment of the health workforce during a pandemic. Health care providers and their regulatory colleges can assist in identifying competencies, determining the types of care that individuals can safely provide, and ensuring that health care providers do not end up in situations that are beyond their knowledge and skills.

To give individual health care providers an opportunity to reflect on their own ability to assist during a pandemic, Ontario has developed a self-assessment tool made up of two major components:

- **Part I** is an assessment of personal abilities as they relate to influenza care and to the health care provider's own professional and personal circumstances.
- **Part II** is an *RHPA* Controlled Act/ICCs Decision Tree that places ICCs within the regulatory context and provides an accessible overview of certain key questions and consequences in assessing abilities to assist in an influenza pandemic.

The self-assessment tool attempts to be as inclusive as possible recognizing that individual circumstances will vary depending upon the profession, the practice setting and the nature of the professional practice of the heath care provider. A resources handbook is available to guide

health care providers wishing to assist in the pandemic response.

8.8 Matching Competencies

Once employers/planners have an understanding of the influenza care competencies required as well as the competencies of existing staff, they will go through a matching process to determine whether they will have the right mix and amount of competencies to meet needs in each setting during a pandemic.

Many influenza care competencies (e.g., administrative support) can be provided by a variety of people from volunteers to regulated health professionals; some can only be provided by people with specific training or skills.

When matching competencies, planners and health care providers must work within the legislative framework for health care in Ontario: the RHPA specifies a number of controlled acts (or health care procedures) which are authorized ONLY to specific professions (see Chapter 8A: Health Human Resources Planning Tools) – although being in a certain profession doesn't necessarily mean that an individual has the necessary skill, education or experience to perform the controlled act safely and competently. For example, a physician who has practiced only psychiatry for the last 20 years may not be competent to intubate even though intubation is within the scope of practice of a physician. This reinforces the value of a competency-based rather than credential or profession-based approach to deploying the health workforce during a pandemic.

While any controlled act may be delegated by someone authorized to perform that act to another regulated health professional or non-regulated person, the ability to use delegation as a way to provide more care is often limited by profession specific standards of practice (e.g., a health care worker who feels he or she cannot perform the act safely can refuse to do so) and institutional rules that may prohibit delegation.

In addition to the restrictions placed on health care professions by the *RHPA*, regulatory college regulations, institutional rules, or their own self assessment of their skills, there are other legislative limitations. For example, under Regulation 965 of the *Public Hospitals Act*, only a physician can order tests and treatment for hospital in-patients and outpatients while Registered Nurses in the Extended Class can only order tests and treatment for outpatients of the hospital.

Even when influenza care competencies are not controlled acts, they may require a certain level of education, training and judgement to be done effectively. For example, "assessment" and a number activities associated with assessment -- such as taking a pulse, blood pressure measurement, assessing breathing or skin colour -- are not controlled acts, but people doing these activities must have the skill to interpret the results. Some activities can only be performed by a person who holds an appropriate registration/license to do so (e.g., registration with the College of Physicians and Surgeons of Ontario).

Given these restrictions and limitations, Chapter 8a: Health Human Resources Planning Tools sets out the influenza care competencies that are in the public domain as well as those that require more skills or are controlled acts.

8.9 Structuring Care to Make Effective Use of Provider Competencies

Health care settings can structure care in a number of ways that allow them to make

the most effective use of provider skills. For example, they can:

- use detailed care plans and algorithms – which rely more on set patterns of care rather than the judgement of the health care worker
- have experienced staff supervise less experienced staff (i.e., designing care to be delivered in "teams" or "pods") – which also provides the greatest support to providers working in extended or new roles
- use a "cascade" system for deploying resources – that is, as resources need to be extended, moving staff whose competencies require the least supplementation to take on new/different roles. For example, the triage role in the emergency department requires the highest level of competence in initial assessment and is usually provided by a subset of emergency nurses. As triage resources become stretched, the setting would first move other emergency nurses into this role, followed by nurses from in-patient units who have assessment/ED technical skill capacity being moved from in-patient units into the ED – who would be replaced in the inpatient units by student/retired nurses.
- differentiate between the competencies required to assess patients and the competence to discharge patients from the particular care site: referring to a "more competent" practitioner provides a safety net.

Chapter 8A includes an example of one approach to using competency assessments to create teams of care providers for different care settings. In this framework, providers are generally categorized as support providers, assessment providers, and decision-makers.

- Support providers are those who can provide some, but not all, of the technical skills. They are not sufficiently competent to assess the overall status of the patient.
- Assessment providers may or may not be able to provide all of the technical skills, but they have the competency to assess the status of the patient, and provide a care plan for some, but perhaps not all, patients. They can recognize when patients need additional care, but do not have the competence to discharge patients from the care setting.
- Decision-maker providers are those with the competence to assess all patients in the care setting, make final decisions regarding care plans, and discharge patients.

This framework also has some relatively specialized functions: telephone triage of patients, emergency department triage of patients, provision of psychosocial support and rehabilitation, and discharge planning

8.10 The Role of Volunteers

When planners identify a gap between the influenza care competencies required and those available from existing health care providers, they will have to look beyond their traditional workforce for assistance.

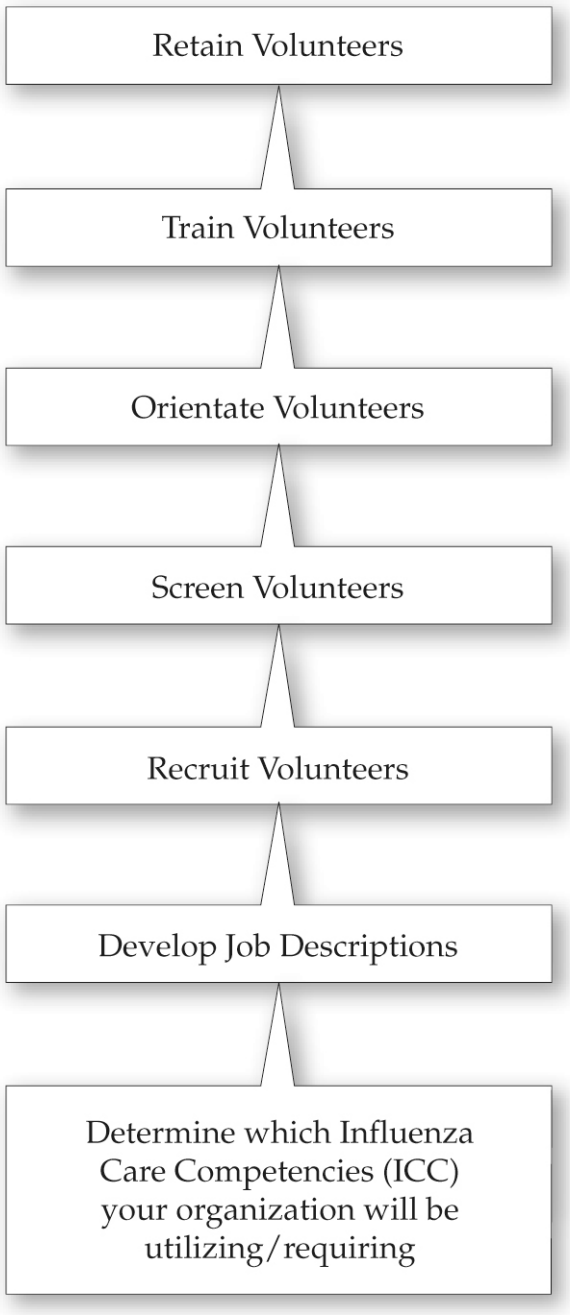
Volunteers provided valuable assistance in past pandemics and in other emergency situations. For example, in the 1918 pandemic, a doctor in Ottawa, Ontario, provided a two-day course and trained hundreds of women to help care for people at home. Organizations like the Red Cross and St. John's Ambulance also provided much needed medical personnel and administrative support. In just the last few years, volunteers played key roles in

responding to Hurricane Katrina and the tsunami. Past experience offers valuable lessons on how to plan for and use volunteers, including:

- Integrate local volunteer organizations early into the planning process – before a pandemic occurs.
- Develop effective working relationships/partnerships with local chapters rather than national organizations.
- Develop effective communication among volunteer groups, governments, local communities and other stakeholders.

Figure 8.2 illustrates the steps in planning for the use of volunteers during an influenza pandemic.

Figure 8.2: Steps in Planning for the use of Volunteers during an Influenza Pandemic



Identify Roles for Volunteers

To identify roles for volunteers, health care setting/planners will consider the following questions:

- Which influenza care competencies can be done by volunteers?
- Are there tasks currently performed by health care staff that could be done by volunteers during a pandemic?

Based on that assessment, the health care setting can develop job descriptions that will clearly lay out the roles and responsibilities, as well as the knowledge and skills required (see sample in the Chapter 8A.)

Recruit and Screen Volunteers

Planners may consider recruiting volunteers from a number of sources including:

- the organization's existing volunteers
- organizations who employ people with some health care training or skills (e.g., Red Cross, St. John Ambulance)

- volunteer centres in the community
- family members of residents (i.e., in long-term care homes)
- high schools, colleges and universities
- faith-based organizations.

The local pandemic planning committee may consider establishing a central clearinghouse for volunteers that would help recruit, orient and train volunteers as required for all care settings in the community. They may allow for more efficient use of volunteer resources during a pandemic.

A central mechanism for recruiting volunteers could also be responsible for screening volunteers. While it is possible to do a detailed screening of volunteers before a pandemic, once an emergency exists, this will be more difficult. Screening will likely consist of an application form (see Tools section) that collects some of the information required to meet legal (e.g., Child and Family Services Act, Safe Schools Act, Long-Term Care Act) and liability requirements, as well as other procedures, such as:

- interviews
- medical checks
- reference checks
- police record checks
- specialized testing
- orientation/training/probation
- buddy system
- regular supervision/evaluation
- unannounced spot checks.

Health care settings would give some thought to how they will manage screening and other volunteer activities during a pandemic. Here are some questions to consider:

- If a volunteer does not have the necessary competencies can training be provided to bring them up to the appropriate level?
- Are there any conditions that will automatically disqualify a volunteer from the position?
- If a volunteer is disqualified for one position, can they be used in another?
- Can your organization's screening protocols be modified to fit the context of a pandemic?
- Could a third party assist in screening volunteers?
- Who will develop and apply the screening process?
- Will you apply the process to current volunteers and those starting with the organization, or will you apply the process to only episodic volunteers present during the pandemic?
- Can the cost of some screening processes (e.g., a criminal record check be waived during an influenza pandemic)?

Orient and Train Volunteers

Volunteers will require effective orientation to the health care setting and training for their duties. During a pandemic, orientation programs will be less detailed. They should include:

- an overview of influenza
- a description of the volunteer position/s – with a written job description
- information volunteers need about the facility, patients and setting
- a volunteer orientation manual (if available).

Training may also have to be more focused than in a non-pandemic situation; however, it should include:

- infection control practices and procedures
- the duties/tasks of the job
- any other information the volunteer requires to perform the task
- supervision
- how to cope with any fear, stress or grief associated with their work.

Depending on the demands on the health care setting, more experienced volunteers may be responsible for providing the orientation and training for new volunteers.

When planning volunteer orientation and training programs, health are settings will consider the following:

- Can existing training programs be modified for use in a pandemic?
- Can volunteers be trained in advance?
- Are there third party organizations that could provide some of the necessary training for your volunteers?
- Are there online resources that could be used for training?
- Will training be done before the volunteer starts the position or on the job?
- Can more experienced volunteers provide training/mentoring to incoming volunteers?

Retain Volunteers

Because of the likely shortage of workers during a pandemic, it will be crucial for health care setting to retain their volunteers. One of the best ways to keep volunteers is to ensure they are kept informed and supported in their roles. If volunteers feel that they are receiving all necessary information, they are less likely to succumb to fear and more likely to stay involved. When developing strategies to retain volunteers, consider the following:

- How do you currently communicate with your volunteers? How will you communicate during a pandemic?
- How will volunteers provide feedback express concerns during an influenza pandemic?
- What spiritual/emotional supports are available for volunteers during and post pandemic? Who will provide these supports?
- What volunteer recognition initiatives could be carried out during an influenza pandemic?
- How do you expect to counteract the fear the pandemic will cause?

See Chapter 8A: Health Human Resources Planning Tools for a list of Ontario Volunteer Centres.

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