

**Newfoundland and Labrador**  
**Health Human Resource Indicator Report 1999 to 2003**  
**Introduction**



**GOVERNMENT OF  
NEWFOUNDLAND AND LABRADOR**  
Department of Health and Community Services

The **Health Human Resource Indicator Report 1999 to 2003** is comprised of the following separate documents to facilitate ease of distribution, verification, and update:

**Executive Summary**

**Introduction**

**Part 1 – Who’s Who**

**Part 2 – Full-Time Equivalents**

**Part 3 – Overtime, Callback, and Relief**

**Part 4 – Workforce Wellness**

**Part 5 – Workforce Movement**

**Part 6 – Retirement Estimates**

**Part 7 – Definitions**

**This document is:**

**Introduction**

**This document provides supporting notes necessary for understanding the other documents that collectively form the Human Resource Indicator Report 1999 to 2003. For the purposes of dissemination, the Executive Summary and Introduction will be attached when one or more of the parts of the report are distributed.**

**Health Human Resource Indicator Report 1999 to 2003 Introduction**

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The Health and Community Services Human Resource Planning Unit represents a partnership agreement between the Government of Newfoundland and Labrador Department of Health and Community Services, and the Newfoundland and Labrador Health Boards Association. Please direct inquiries related to this report to the Newfoundland and Labrador Health Boards Association.

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## 1. Preamble

This document provides background, methodology, limitations, privacy and confidentiality principles, and other supporting notes that apply to all Parts of the complete Human Resource Indicator Report 1999 to 2003.

The Government of Newfoundland and Labrador's (NL) decision to transform 14 health boards into four regional integrated health authorities (RIHAs) was announced on September 10, 2004, and governance structures were established in early 2005. Data and analysis in this document can be regrouped to reflect new RIHA structures. Please direct inquiries to the Human Resource Planning Unit (HRPU). Contact information is shown at the beginning of this document.

## 2. Background

### Calendar Year 1999 Data

The HRPU initially collected key health board workforce data for calendar year 1999, for selected occupational groups including audiologists, licensed practical nurses, medical laboratory technologists, medical radiation technologists, occupational therapists, pharmacists, clinical psychologists, physiotherapists, registered nurses, speech language pathologists, social workers and salaried physicians.

A report based on the 1999 data titled Health and Community Services Baseline Human Resources Indicator Report (June 2000) provided an analysis of about 60 pieces of data from each health board on calendar year 1999 activities (referred to as HRIS 1999 throughout the remainder of this document). The statistics were "rolled-up" to the board level, for each occupational group mentioned above.

HRIS 1999 was the first time such a provincial exercise had been undertaken and it is likely there were errors in extracting information and in the use of consistent definitions. Health boards were challenged with completing the exercise due to the lack of electronic information. As well, there were several indicators that some health boards could not report, as the information was not held in either electronic or manual format. The "rolled-up" nature of the statistics made it difficult to check the integrity of the data, however as the project evolved corrections and updates were made and it was felt the final data had fair reliability. The information has proven to be a useful foundation for several initiatives and has since been referenced in various documents and presentations throughout the health and community services system.

Calendar year 1999 data is absent in many Parts of the Human Resource Indicator Report 1999 to 2003 as many statistics are at a level lower than was obtained in 1999 data, and certain data were not deemed reliable enough for inclusion.

### Fiscal Year 2000/01 Data

A second initiative to collect human resource (HR) data by HRPU from the health boards (referred to as the HRIS 2000 throughout the remainder of this document) was different from the HRIS 1999 in several ways:

1. Several occupational groups were added including dietitians, prosthetists/orthotists, recreation specialists, respiratory therapists, and radiation therapists.
2. Salaried physician data was not collected.
3. The HRIS 1999 Report considered calendar year data whereas the HRIS 2000 Report focused on the fiscal year 2000/01 to better align with financial and other data.
4. Some indicators were dropped and others added in 2000/01.
5. In addition to a template for health boards to manually submit data, information on earned hours was also obtained through direct downloads (electronic abstractions) from health boards' information systems using centrally developed electronic queries in Meditech. This provided detail on all earned hour types at the Management Information System (MIS)<sup>1</sup> primary account code level. This makes it possible to compare health boards at the *department level*.

The biggest single change was the level of detail for which the majority of the data was obtained. Obtaining detail at the lowest possible level within each organization was an important improvement over the HRIS 1999. Calculated indicators such as overtime per full-time equivalent (FTE) at the board level are useful, but do not give enough focus on potential best practices or opportunities for improvement. Finally, every attempt was made to reduce errors stemming from the inconsistent abstracting of information between health boards, but some variability is unavoidable. A report based on the 1999 and 2000/01 data titled Health Human Resources Indicator Report 2000/2001 (October 2002) provided an analysis of data collected to that date.

### **Fiscal Years 2001/02 and 2002/03 Data**

The third initiative to collect HR data from the health boards by HRP (referred to as the HRIS 2003 throughout the remainder of this document) was more extensive than previous exercises. Two years of data were collected simultaneously: fiscal 2001/02 and fiscal 2002/03. Key differences from previous exercises include:

1. Queries were revised, which allowed mapping to standardized categories.
2. HRIS 2003 collected data on the total health board workforce.
3. Manually collected data was still requested but reduced in quantity and scope, and limited to selected occupational groups. An electronic query was developed to extract data regarding employee counts as well as earned hours.

This document, the Human Resource Indicator Report 1999 to 2003, presents data from all three HRIS initiatives.

## **3. Methodology**

Data collected can be divided into two general groups: data collected manually and data collected electronically. Manually collected data included statistics for 30 occupational categories, on employee separations, internal and external hires, and workers compensation incidents. Electronically collected data was gathered for all employees, for all earnings and job descriptions, at the facility and department level. A specification/template was written and extensively revised to facilitate the efficient gathering of health board data.

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<sup>1</sup> MIS is the Guidelines for Management Information Systems in Canadian Health Service Organizations, developed by the Canadian Institute for Health Information.

A short discussion on the structure of the health boards' data is necessary before describing the method by which it was obtained:

- Health boards were using the MIS framework during the study period. Each department within a board is identified by a primary account code. A secondary account code captures financial and statistical data. The secondary codes are linked directly to the primary codes. The primary account codes are nine digits in length and facilitate the “rolling-up” of five levels of data. For example, **714103020** is made up of **71**:Functional Centre for Revenue, Expenses, and Statistics - Operating Fund, **4**:Diagnostic and Therapeutic Services, **10**:Clinical Laboratory, **30**:Hematology, **20**:Routine Hematology. Each lower level is a subdivision of the preceding level. All health boards use the same account code structure however, not all uses the same level of detail.
- The MIS Guidelines facilitate the standardized collection of statistics including the earned hours. Information was not available using the statistical accounts, as most boards did not have their statistical general ledger in place at the beginning of this project. Health boards could only extract the data based on earning codes implemented in their board. These earning codes are not standardized throughout the province, proving to be a significant challenge in this process. The MIS Data Quality Committee and its working groups have made substantive progress in standardizing the reporting of financial and statistical data in this regard.
- Without custom queries, health boards can extract data by bargaining group but not occupational group from Meditech. For example, licensed practical nurses can belong to more than one bargaining group with other employee types making it difficult to isolate licensed practical nurse data. The Association of Allied Health Professionals is a good example of a union group representing several different types of professionals. Health boards are currently using a variety of coding methodologies.

To obtain consistent results and to avoid duplication of effort, one set of electronic queries were developed for all health boards to use. In HRIS 2003, queries used in HRIS 2000 were simplified to extract raw data from Meditech systems, and health boards were not required to perform any mapping of data into standardized categories. HRP staff completed this mapping centrally to minimize errors stemming from inconsistencies. The primary mapping exercise involved occupations and earning codes, however union, facility, department, payroll, and employee type codes all required mapping into standardized categories.

Without the development of standard electronic queries, it is unlikely that all health boards would have been able to submit the data in this consistent format. This project has essentially replicated data that would be available from a single centralized payroll system, as is the case in some other provinces. Centralized payroll and/or an HRIS would however provide a much more effective platform for human resource planning.

A grouping methodology was used to report key statistics. Occupational groups or health boards were assigned to categories of low, moderate or high, based on the magnitude of the indicator reported. To derive ranges, primary occupations having an indicator in the top 20 per cent of the range at the provincial level were considered the high level for the indicator; the next 40 per cent was considered the moderate level, and the bottom 40 per cent was considered the low level. At lower levels of detail, there was much variation of statistics. Table 1 shows the ranges for the assigned categories.

**Table 1. Indicator Classification**

Indicator	Level		
	Low	Moderate	High
<b>Overtime including Callback</b> (as a per cent of earned hours)	< 2.5%	2.5% to 5.0%	> 5.0%
<b>Sick Leave</b> (as a per cent of earned hours)	< 3.0%	3.0% to 4.5%	> 4.5%
<b>Injury Leave</b> (as a per cent of earned hours)	< 1.0%	1.0% to 2.0%	> 2.0%
<b>Retirements</b> (10-year projection)	< 15.0%	15.0% to 40.0%	>40.0%

It is important to note that these levels were used to compare statistics within health boards in NL and have no relevance to national statistics. National statistics are cited throughout the report wherever comparable, timely data were available. Additionally, it is not always meaningful to compare occupational groups with vastly different attributes or health boards with different mandates or attributes.

Finally, to effectively manage the data associated with the wide variety of employees working in health boards, it was necessary to define a grouping system for occupations. The following three groups were defined:

### **Primary Occupations**

Primary occupations provide direct patient care, diagnostic services, or manage the health system (including clinical and non-clinical managers). They also meet one or more of the following conditions: there exists a regulatory body and/or professional association, and/or their post-secondary educational background is generally in excess of a single year (i.e. technologist vs. technician). Examples include registered nurses, psychologists, medical laboratory technologists, and speech language pathologists.

### **Ancillary Occupations - Clinical**

These are individuals that do not fit the **Primary Occupations** category but may provide direct patient care or diagnostic services, and generally work under the direction of primary occupations. Examples include medical laboratory technicians, personal care attendants, and recreation therapy workers.

### **Ancillary Occupations – System**

These are individuals that support the system. They do not fit the **Primary Occupations** or **Ancillary Occupations – Clinical** categories. Examples include laundry, dietary, housekeeping, and information systems staff.

## **4. Limitations**

Noted below are several limitations associated with the analysis contained in the Human Resource Indicator Report 1999 to 2003.

- Inconsistency in data resulting from variations in coding processes is noted. Each health board has a unique set of earning codes and its own methods for reimbursing employees. One health board may have 20 earning codes for capturing reasons for overtime, while another might have only two or three reasons. This may negatively impact other codes. For instance, if overtime is incurred for sick leave relief it may simply be coded as overtime, and the reason for the employee working, normally captured as sick leave relief, is lost. It is important to note that the main purpose of earning codes is not to produce HR data, but to ensure employees are compensated properly.
- Boards may not be following MIS guidelines when naming functional centers. For example, at least six facilities in the province have long-term care beds but there is no functional center “long-term care” reporting data for those facilities. Consequently, this greatly understates the earned hours attributable to the provincial “long-term care” picture and overstates statistics for other functional centers.
- The MIS structure is fixed but there remains flexibility within that structure. Also, health boards use varying levels when subdividing functional centres, and extreme caution must be used when comparing at the lower levels of detail. Due to the program management structure/model adopted by the Health Care Corporation of St. John’s, staff hours are attributed to functional centres within programs rather than functional centres for specific professional types. For instance, dietitian earned hours may be attributed to surgical units or intensive care. In another health board, hours may be assigned to a functional centre “clinical nutrition” which was specifically formed for these employees.
- Assigning employees to certain occupational groups can be challenging, as different types of professionals may be able to fill a particular position. The “profession vs. position” approach has recently been a challenge for the Canadian Institute for Health Information (CIHI) who are currently enhancing the MIS guidelines to capture data for specific groups. Assigning employees to occupational groups is a straightforward exercise for the vast majority of employees. The drawback of this approach is that it masks specialized sub-groups. For example, addictions counselors and mental health counselors are both typically social workers in NL, and grouped together as such.
- Employees are permitted to “bank” hours to be paid or taken as time off at a later date. The practice of banking hours introduces several difficulties. This is discussed more fully in Part 3 – Overtime, Callback and Relief.

- St. John’s Nursing Home Board payroll data was not available for download for fiscal year 2001/02.

## **5. Privacy and Confidentiality**

The HRPU adheres to a list of principles concerning privacy and confidentiality issues. “Information” is a dataset or data sets collected by the HRPU in the fulfillment of its mandate of health human resource planning. The principles are as follows:

### **Principle 1 – Accountability**

The HRPU is accountable for information under its control. The Manager of Human Resource Planning is accountable for ensuring the HRPU is in compliance with these principles.

### **Principle 2 – Scope**

The HRPU avoids collecting person-identifiable information. Person-identifiable information is a data set, or linked data sets, that could be used to identify an individual.

### **Principle 3 – Consent**

Informed consent of the information provider is required for the collection, use, or disclosure of their information.

### **Principle 4 – Purpose and Use**

The purpose(s) for which information is collected shall be identified at or before the time the information is collected.

### **Principle 5 – Collection and Transmission**

Both the amount and type of information collected are limited to what is necessary to fulfill the identified purposes. Due diligence is to be taken to transmit information in a secure manner.

### **Principle 6 – Use, Access, Disclosure**

Information shall not be used or disclosed for purposes other than those stated, except with the consent of the information provider. Resulting reports, analysis, and summaries shall always respect the privacy and confidentiality of individuals and organizations at a level appropriate for the purpose of the document.

### **Principle 7 – Security**

Information shall be protected by security safeguards appropriate for the information and against unintended or unauthorized access, use, or intrusion, or such dangers as accidental loss or destruction.

### **Principle 8 – Deletion and Disposal**

Person-identifiable information shall be retained only as long as necessary for the fulfillment of the stated purpose. The HRPU shall ensure that information is destroyed.

This concludes this Part of the Human Resource Indicator Report 1999 to 2003. Before proceeding to other Parts of the report, the reader is advised to review a list of terms and definitions contained in Part 7 – Definitions.