Management in the Department of Health and Welfare

Follow-up Report
December 2007

Office of Performance Evaluations
Idaho Legislature

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Management in the Department of Health and Welfare

Follow-up Report

The Department of Health and Welfare—Idaho's largest state agency—is responsible for serving some of Idaho's most vulnerable citizens. Sound management of the department is critical to ensure citizens receive needed services and resources are used efficiently. In 2006, we made five recommendations to the department in areas of communication, staffing and workload, and turnover. In this follow-up report, we assess the implementation status of those recommendations and discuss changes in staff perceptions of key management issues since our last report.

Our recent survey of department staff indicates that overall staff perceptions of morale, job satisfaction, and communication have improved since 2006, as have their perceptions of management's skills, abilities, and leadership.

In response to our 2006 findings and recommendations, the Legislature increased the size and broadened the responsibilities of the Board of Health and Welfare. Organizational changes initiated by the department have included creating two new divisions: the Division of Behavioral Health and the Division of Communication and Regional Development.

The department has also implemented our recommendation to work with staff and make necessary changes to its communication processes. In addition to creating a new communications division, the department has clarified communication responsibilities and implemented a new process that offers opportunities to staff for providing feedback.

This follow-up review finds the department is making progress in implementing two of our recommendations on staffing and workload, as evidenced by several divisions that are updating, or plan to update, workload models for staff. The department has also implemented our recommendation for modifying its personnel data system to better monitor turnover. The department has not, however, implemented our recommendation for identifying the most cost-effective staffing, allocation, and scheduling methodologies for its institutions.

In 2006, we described how the department was experiencing difficulties in facility maintenance and long-term planning, and was not taking full advantage of federal financial participation. We suggested the department implement best practices to correct these issues, but the department reports that it has not taken any action. We reiterate our suggestion that the department evaluate facility issues in a systematic, comprehensive way and present its findings and recommendations to the Legislature and the Permanent Building Fund Advisory Council. The Legislature and the council should consider reviewing, and possibly amending, policies and procedures for facility planning, maintenance, and funding.

Chapter 1
Introduction

Following the release of our February 2006 report of management in the Department of Health and Welfare, the department made significant changes to its operations. This follow-up report focuses on those changes to address morale, communication, and turnover. The department has made progress in some areas and needs continued improvement in others. Additionally, the Legislature has strengthened the role of the Board of Health and Welfare in overseeing the operation of the department.

Background

In February 2006, the Office of Performance Evaluations released the report, *Management in the Department of Health and Welfare*. The evaluation focused on how the department was performing in certain key areas such as employee morale, communication, staffing and workload management, turnover, and facility maintenance. The evaluation also examined the roles and functions of the Board of Health and Welfare and provided the department best practices to use in making decisions about facility management.

The report identified the following areas of concern:

- Overall, staff were not satisfied with the management of the department
- Morale was low throughout most of the department
- Pay was a significant concern
- Staff fear of retaliation from management was high
- Communication needed improvement across most levels
- Efforts to monitor workload and assess staffing needs were limited in a number of program areas
- Department turnover was high
- The Board of Health and Welfare had fewer responsibilities than other state boards
- The department was at risk of, or was experiencing problems in, facility planning, maintenance, and funding

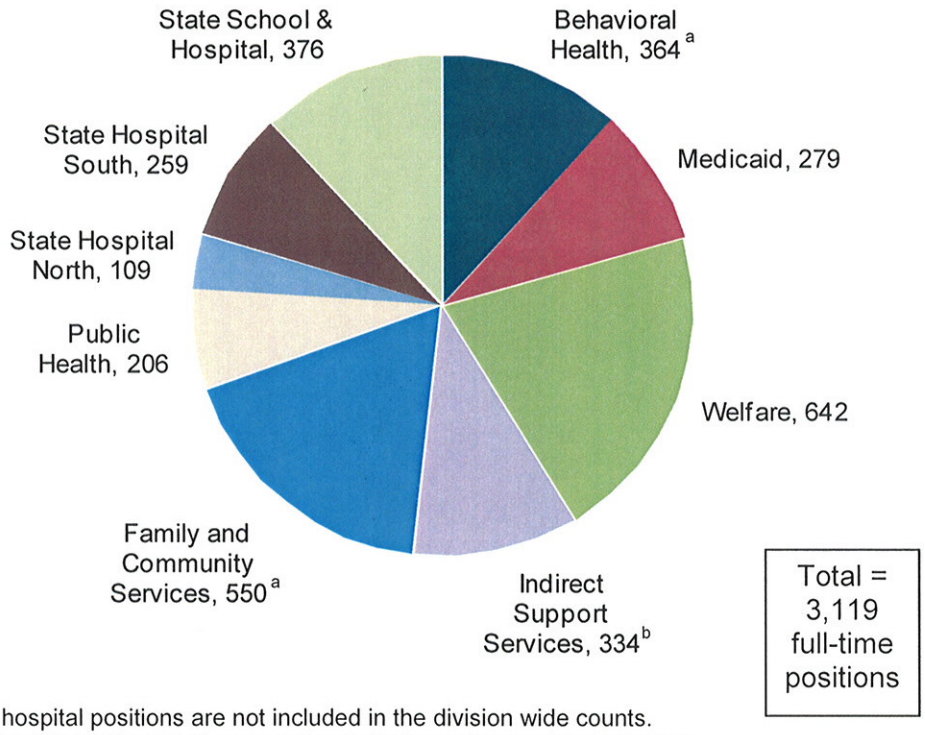
Our evaluation contributed to legislative and administrative changes. This follow-up report discusses those changes and current department efforts to address our findings and recommendations. In addition, this report discusses the extent to which staff and middle managers perceptions of key management issues within the department have changed since our last study.

Department Overview

The Department of Health and Welfare is the state's largest agency. It has nine divisions and 3,119 approved full-time positions located throughout seven regional offices and three institutions (see exhibit 1.1).[1] As shown in exhibit 1.2, the department's fiscal year 2008 appropriations are over $1.75 billion, of which 62 percent comes from the federal government.

[1] Four divisions and one program are combined into Indirect Support Services: Human Resources, Information Technology Services, Management Services, Communication and Regional Development, and the Office of the Director.

Exhibit 1.1: Authorized Positions in the Department of Health and Welfare, Fiscal Year 2008



[a] State hospital positions are not included in the division wide counts.
[b] Includes 13 positions that serve independent councils and commissions and the following divisions/program: Human Resources, Management Services, Information Technology Services, Communication and Regional Development, and the Office of the Director.

Source: Office of Performance Evaluations' analysis of data from legislative Budget and Policy Analysis, *Idaho Legislative Fiscal Report for Fiscal Year 2008.*

Exhibit 1.2: Annual Appropriations in the Department of Health and Welfare, by Fiscal Year

Fiscal Year	2006	2007	2008
General Fund	$ 457,682,300	$ 497,863,900	$ 544,842,800
Dedicated	115,433,800	118,999,700	127,567,800
Federal	1,024,457,900	1,039,162,000	1,084,525,700
Total	$1,597,574,000	$1,656,025,600	$1,756,936,300

Source: Office of Performance Evaluations' analysis of data from legislative Budget and Policy Analysis, *Idaho Legislative Fiscal Report for Fiscal Year 2008*.

After the release of our February 2006 report, the department made significant changes to its operations by creating two new divisions:

- The Division of Behavioral Health, formerly located within the Division of Family and Community Services, is responsible for addressing mental health and substance abuse issues. State Hospital North and State Hospital South are also a part of this division.

- The Division of Communication and Regional Development, formerly located in the Office of the Director, manages the department's communication, assists with public information, and supports regions with community development.

Exhibit 1.3 is an overview of responsibilities by division, program, and institution.

Two other divisions—Welfare and Information Technology Services—reorganized their approach to the delivery of services. Information Technology Services also placed staff in functions that better fit individual specialties and converted many contracted positions into full-time department staff.

Methodology

We used various methods to understand what changes have occurred since the release of our 2006 report:

- We replicated the surveys used in the first evaluation of (1) staff and frontline supervisors and (2) middle managers, allowing us to compare responses from 2006 to 2007. We included several new questions to capture changes that may have occurred between the two surveys and to give employees the opportunity to provide general comments.

Exhibit 1.3: Overview of Department of Health and Welfare Program Areas

Division of Behavioral Health

Adult Mental Health	Provides assessment, treatment, and rehabilitation for people with serious mental illness, e.g., intensive treatment for those having severe psychiatric problems and long-term services for those with significant on-going mental illness. Services are generally provided through state-operated regional community mental health centers and private providers.
Children's Mental Health	Provides services for families and children with serious emotional disturbances. Services are primarily provided through contracts and agreements with private providers.
Substance Abuse	Oversees substance abuse services.
State Hospital North	Located in Orofino, serves acute, court-committed psychiatric patients.
State Hospital South	Located in Blackfoot, provides psychiatric treatment and skilled nursing to adults and adolescents with serious mental illnesses.

Division of Family and Community Services (FACS)

Child Welfare	Investigates allegations of child abuse and neglect. Oversees the state's foster care system, adoption services, and the Independent Living Program that assists foster children in transitioning to independent adults.
Developmental Disabilities	Oversees and provides services for individuals with developmental disabilities, e.g., program for children from birth to three years of age, program for children from birth to 21 years of age, intensive behavioral program for children exhibiting challenging behaviors, court-required evaluations, and funding for families to care for individuals in the home.
Navigation	Assesses client needs and eligibility for department services and directs clients to the appropriate programs within the department.
Idaho State School and Hospital	Located in Nampa, serves severely impaired people with developmental disabilities.

Division of Public Health

Emergency Medical Services	Oversees, regulates, and implements a statewide system designed to respond to medical emergencies, e.g., licensure and certification of responding emergency medical personnel, and awarding grants for training, patient care supplies, and equipment to local emergency medical service organizations.
Laboratory Services	Performs testing for communicable diseases, environmental samples, and bioterrorism materials. Also administers regulations pertaining to private medical laboratories.
Physical Health Services	Oversees programs that address particular health issues, e.g., sexually transmitted diseases, childhood immunizations, nutrition, women's health, trends in diseases, food safety, risk behavior prevention, chronic disease control, and environmental health concerns.

Continued on the next page

Exhibit 1.3—continued

Division of Public Health—continued

Vital Statistics	Responsible for the collection and dissemination of data such as births, deaths, marriage, divorce, chronic diseases, and health behaviors.

Division of Medicaid

Facility Standards	Responsible for the inspection and licensure of hospitals, nursing homes, and residential and assisted living facilities. Responsible for ensuring compliance with state and federal requirements.
Medical Assistance Services	Administers the programs that cover the costs of medical services for eligible citizens.

Division of Welfare

Benefits	Administers programs that provide assistance to families, e.g., Food Stamps, Idaho Child Care Program, and Temporary Assistance for Families in Idaho. Also makes eligibility determinations for individuals applying for medical coverage under Medicaid.
Child Support	Provides services that include locating non-custodial parents, establishing paternity, enforcing and re-issuing child support.
Welfare Support	Provides support for all welfare programs, e.g., benefits, child support, research, and contract staff.

Indirect Support Services

Division of Human Resources	Responsible for the department's personnel and strategic planning, e.g., equal employment, workforce and development, recruitment and retention, compensation, human resource policies and employee relations, and employee benefits.
Division of Information and Technology Services	Responsible for technology applications, information systems, information technology projects, technical support, department hardware and infrastructure, and technology planning and coordination services.
Division of Management Services	Responsible for the administrative services within the department, e.g., financial and accounting services, contracts and purchasing, facilities management, and audits and investigations.
Division of Communi-cation and Regional Development	Manages the department’s communication, assists with public information, and supports regions with community development.
Office of the Director	Responsible for the overall direction of the department.

Source: Office of Performance Evaluations’ review of Department of Health and Welfare publications.

Our 2006 report included results from a November 2005 survey. This follow-up report includes results from a July 2007 survey. Survey results in this follow-up report are statistically significant unless otherwise noted. For readability, we use the generic term *staff* when referring to staff and frontline supervisors who participated in either survey, and we used the term *managers* when referring to middle managers who participated in either survey.

We used a web-based survey and included all permanent employees in the survey population. Overall, we received responses from 59.1 percent of the 2,739 staff and frontline supervisors and 81.5 percent of the 173 middle managers. See appendix A for more specific information about response rates in individual divisions and program areas. Appendices B and C summarize staff and manager responses.

- We conducted interviews with division and state hospital officials to understand how the department communicates with employees, monitors and adjusts workloads, and plans for facility maintenance. Appendix D describes the department's efforts to address our recommendations and concerns expressed by staff and managers.

- We interviewed members of the Board of Health and Welfare to gain an understanding of the responsibilities of the board.

- We gathered information from the Department of Health and Welfare and the Office of the State Controller to determine turnover rates. In this follow-up review, turnover rates were determined using the same formula as used by the State Controller, with two exceptions: we used both classified and non-classified positions and excluded temporary employees from our counts.

Because we used a different methodology to calculate turnover rates this time, we have not made any comparisons to previously reported turnover rates. Turnover rates presented in this report can be used by the management to decide which divisions and programs need increased attention.

The formula we used in this follow-up review is different from the formula in our February 2006 report. Two variables make up the main differences:

- Formula used in the 2006 report
  - Counted filled positions using a pay code
  - Used the number of filled positions for one point in time during the fiscal year

- Formula used in this follow-up report
  - Counted each filled positions using unique identifiers
  - Used the average of filled positions from the beginning of the fiscal year and the end of the fiscal year

Chapter 2
Staff Perceptions of Management

Our 2007 survey of Health and Welfare staff indicates that perceptions of morale, job satisfaction, and management's skills, abilities, and leadership have improved. The survey results also indicate that staff still have concerns in these areas. The department has, however, taken steps to address these concerns. Rewards, raises, and promotions based on merit continue to be a concern for staff. Department areas such as Vital Statistics and the Division of Behavioral Health posted some of the most positive survey responses, while Laboratory Services was among the most negative.

Staff Ranked Morale and Job Satisfaction Higher in 2007

In 2007, 44 percent of staff rated workplace morale as good or very good, up from 33 percent in 2006. Managers, however, perceived staff morale levels to be much higher. Seventy percent of managers rated morale as good or very good in 2007, an increase from 52 percent in 2006, suggesting a potential disconnect between manager and staff perceptions.

Negative factors that staff perceived to predominately affect morale have not changed since the release of our 2006 report.[1] Positive factors affecting morale have also remained relatively the same between the two surveys with one exception: staff in 2007 ranked co-worker interaction as a more positive factor than client interaction.[2] A breakdown of factors that affected morale is in appendix B.

Our 2006 report included results from a November 2005 survey. This follow-up report includes results from a July 2007 survey. Survey results in this follow-up report are statically significant unless otherwise noted. For readability, we use the generic term *staff* when referring to staff and frontline supervisors who participated in either survey, and we used the term *managers* when referring to middle managers who participated in either survey.

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1 In the 2007 survey of staff and frontline supervisors, the five most noted *negative* factors affecting morale were level of stress at work, workload, pay, management, and organizational change.

2 In the 2007 survey of staff and frontline supervisors, the five most noted *positive* factors affecting morale were pay, co-worker interaction, benefits, quality of supervision, and recognition.

When asked if staff were satisfied with their jobs, overall department responses improved between 2006 and 2007. In 2007, over 70 percent of staff agreed or strongly agreed that they were satisfied with their jobs compared to 66 percent in 2006. Furthermore, the 2007 survey indicated that 35 percent of staff felt valued by the department, which is up from 24 percent in 2006.

Increased Staff Morale

Results from 2006 indicated that staff morale was low in all divisions. The Division of Welfare only had 29 percent of staff that indicated morale to be good or very good. However, positive staff responses for morale in 2007 increased to 39 percent. As shown in exhibit 2.1, morale has improved across all divisions since the first survey.

At the program level, morale for staff in 2006 varied from 17 percent good or very good in Facility Standards to 69 percent in Human Resources. The 2007 survey results indicated improvements in morale in almost all programs. Seventy-six percent of staff in Administration and 68 percent of staff in Vital Statistics rated morale as good or very good.[3] The lower end of morale ratings were in Laboratory Services and State Hospital North, where staff rated morale as good or very good 13 and 30 percent respectively.

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[3] Administration includes the Division of Human Resources, the Division of Communication and Regional Development, and the Office of the Director.

Exhibit 2.1: Staff and Supervisor Ratings of Workplace Morale, by Division

"Overall, workplace morale among my co-workers is"

	Good or Very Good	Fair	Poor or Very Poor	2007 Average Rating[a]	2006 Average Rating[a]
Behavioral Health	48.8%	26.6%	24.6%	3.3%	–%[b]
Family and Community Services	41.3	34.9	23.7	3.2	2.9[b]
Health	47.0	22.9	30.2	3.2	2.9
Medicaid	39.0	35.6	25.4	3.1	2.8
Welfare	39.4	32.7	27.9	3.1	2.7
Indirect Support Services	49.7	22.4	27.8	3.3	3.0

Note: Percents may not sum to 100 due to rounding.

[a] Based on a 5-point scale where 5 is the most positive rating.
[b] In the 2006 survey, Behavioral Health was part of the Division of Family and Community Services.

Source: Office of Performance Evaluations' surveys of Department of Health and Welfare staff and supervisors, 2006 and 2007.

Job Satisfaction Remained High

Most of the staff in all programs indicated in 2007 that they were satisfied with their jobs. A few programs had satisfaction ratings higher than 85 percent: Administration, Vital Statistics, and Developmental Disabilities. Physical Health Services, which ranked last in 2006 for job satisfaction, posted a 16 percentage point improvement to 64 percent in 2007. Four programs declined in ratings of job satisfaction: Emergency Medical Services, State Hospital North, Information Technology Services, and Laboratory Services.

Feeling Valued

Despite generally high levels of job satisfaction, only 35 percent of staff indicated that they felt valued by the department. Staff in Administration had the most positive responses at 55 percent. Similar to reported low levels of morale, only 13 percent of Laboratory Services staff felt valued by the department.

In both 2006 and 2007, we found that almost 75 percent of staff reported feeling valued by their supervisor. In 2007, ratings were highest in Behavioral Health at 78 percent and lowest in Public Health at 69 percent. In addition, 79 percent of staff in Behavioral Health perceived that their supervisor listened to their recommendations compared to 59 percent of staff in Public Health.

Staff Perceptions of Management Skills, Abilities, and Leadership Have Improved

Staff were generally satisfied with the skills and abilities of management in 2006, but were not as satisfied with methods used by management for promotions, raises, and merit-based recognition. Employees in 2007 reported improvements in management's skills and abilities as well as efforts to reward staff on merit and performance, but some staff continued to have concerns (see the next section for further details).

In both 2006 and 2007, ratings of confidence in managers' skills and abilities were favorable overall. Confidence ratings were highest for frontline supervisors and lowest for upper management. In 2006, staff rated upper management's skills and abilities to be good or very good at 49 percent and frontline supervisors at 69 percent. In 2007, this rating increased to 57 percent for upper management and 74 percent for frontline supervisors. When asked about the quality of leadership frontline supervisors provided, 74 percent of staff said it was good or very good.[4]

[4] In 2006, 69.5 percent of survey respondents said that the quality of leadership provided by frontline supervisors was good or very good. However, this difference is not statistically significant.

In 2006, employees had less confidence in upper management decision-making capabilities than in 2007, as 40 percent of staff and 56 percent of managers provided a good or very good rating. Vital Statistics was among the highest ratings of confidence for staff at 71 percent. Only 24 percent of staff in Information Technology Services reported having confidence in upper management decision-making.

Department wide, 69 percent of staff reported that goals and objectives were clearly defined at the department, division, and program levels in 2007. The highest ratings, at about 74 percent for all levels, came from staff in the Division of Welfare, a 15 percentage point improvement from 2006.

Staff Continue to Express Concerns About Merit-Based Rewards

Staff expressed concerns in 2006 about the department's methods for determining rewards, raises, and promotions. As shown in exhibit 2.2, staff perceptions have improved. However, this issue remains a concern as less than 40 percent of staff believed that rewards were based on merit and performance.

In response to the 2007 statement on the survey "the department rewards staff (not necessarily monetarily) on the basis of merit and performance," staff in several programs within the Division of Health disagreed. For example, 73 percent of staff in Laboratory Services and 69 percent of Physical Health Services disagreed or strongly disagreed with the statement. Over 50 percent of staff in Information Technology Services and State Hospital North also did not perceive rewards were granted on the basis of merit and performance. In contrast, staff perceptions of merit-based rewards were consistently the highest in Administration and Vital Statistics.

In July 2006, the Department of Health and Welfare implemented a new four-tier performance evaluation system.[5] Department officials report that all divisions are staying current on employee performance evaluations using the new system. To more visibly acknowledge staff for their hard work, several divisions have incorporated employee recognition programs. The changes in evaluations and employee recognition programs appear to be a step in the right direction. However, the department should continue to work with staff on concerns identified throughout our 2007 survey results.

[5] All state agencies are required to implement the new evaluation system. The four tiers are exemplary performance, solid sustained performance, achieves performance standards, and does not achieve performance standards. The four-tier evaluation system is different from the system used in the past that had two tiers: meets expectations and does not meet expectations.

Exhibit 2.2: Staff and Supervisor Ratings of Department Efforts to Reward Staff on Merit and Performance

"To the extent possible, the Department of Health and Welfare rewards (not necessarily monetarily) staff on the basis of merit and performance:"

	Agree or Strongly Agree	Neither Agree nor Disagree	Disagree or Strongly Disagree	Average Rating[a]
2006 survey	18.1%	19.5%	62.3%	2.3
2007 survey	31.6%	24.3%	44.1%	2.7

"To the extent possible, decisions about the distribution of merit raises are made in a fair and equitable way:"

	Agree or Strongly Agree	Neither Agree nor Disagree	Disagree or Strongly Disagree	Average Rating[a]
2006 survey	24.2%	23.9%	51.9%	2.5
2007 survey	39.5%	25.5%	35.1%	3.0

"To the extent possible, decisions about promotions are based on merit and performance:"

	Agree or Strongly Agree	Neither Agree nor Disagree	Disagree or Strongly Disagree	Average Rating[a]
2006 survey	29.0%	24.4%	46.7%	2.6
2007 survey	38.3%	25.2%	36.6%	2.9

Note: Percents may not sum to 100 due to rounding.

[a] Based on a 5-point scale where 5 is the most positive rating.

Source: Office of Performance Evaluations' surveys of Department of Health and Welfare staff and supervisors, 2006 and 2007.

Additional Questions Provide Insight into Employee Perceptions

In our 2007 survey, we added several questions for employees that participated in the survey used in our 2006 report. The questions gave staff the opportunity to provide additional comments and focused on overall perceptions of the department, changes in morale, and management decision-making between the two surveys.

Overall Perceptions

When asked about the overall perceptions of change in the department, 49 percent of staff perceived the department had not changed since 2006 and 28 percent felt that the department had improved. However, 40 percent of staff felt that improvements had occurred at the program level. Examples of positive comments provided by staff focused on many different areas of department operations:

- "Overall, I feel that the department has worked hard to increase pay and develop [a] merit system that allows those who go above and beyond to be compensated."
- "Upper management now is much more open and much more caring. The previous administration did not seem to like state employees."
- "We have a new administrator and I have a different supervisor. Both of them are wonderful and have improved my perception."

About 25 percent of staff believed that all levels of the department have declined. Comments from these individuals fell primarily in three categories: heavy workloads, lack of communication, and ineffective management:

- "I strongly believe the workload has surpassed current staffing capabilities no matter how frequently we are told to find a way to manage work."
- "I feel that the department doesn't listen to the voice of the line workers who are the ones getting the job done. Instead decisions are made at a higher level with little consideration for what reality is in the field."
- "My unit has no direction from any level nor does it have any competent supervision."

Morale

Staff who participated in both our 2006 and 2007 surveys felt that morale needed to be improved. When asked about changes in morale among co-workers in 2007, 25 percent felt that it had improved, and 62 percent indicated pay as the factor most affecting morale. Thirty-four percent perceived morale to have declined, and 55 percent indicated level of stress at work to be the major factor affecting morale. Forty-one percent of staff, however, believed morale had remained the same since 2006.

Management Decision-Making

In 2007, we asked about confidence in decision-making capabilities for the different levels of management, and almost half of the responses indicated their

confidence remained the same for all three levels as in 2006. Thirty-seven percent of staff indicated their confidence in frontline supervisors improved or greatly improved. Examples of positive comments provided by staff focused mostly on the new managers in the department:

- "The changes in upper management has been wonderful."
- "My program manager is a great communicator."
- "My supervisor is very supportive and encourages staff's goals and problem solving."

In contrast, 30 percent of staff indicated their confidence in upper management declined or greatly declined. Comments from those individuals focused primarily on perceived disconnects between staff and management, lack of communication, and new managers:

- "Upper management seems to pull all the strings with no knowledge of what happens in the trenches."
- "Upper management does not communicate well and this leads to poor morale."
- "The program manager is not around a lot and seems to be very combative if opinions are different than theirs."

Potential Areas for Further Study

In our 2007 survey, we identified several areas of concern among staff: low morale, not feeling valued by the department, and not being rewarded based on merit and performance. The department should consider a more in-depth review in the following department units that consistently had low survey ratings:

- Laboratory Services, Division of Health
- State Hospital North in Orofino
- Division of Information Technology Services
- Physical Health Services, Division of Health

Chapter 3
Communication

In 2006, only 35 percent of staff reported they received enough information from top management to do their job well. Since then, the department has made several changes to its communication structure that includes clarification of communication responsibilities, a new communications division, and implementation of a new communication process. In the 2007 survey, 43 percent of staff said that top management provided enough information. Also, two-thirds of staff believed that communication with their direct supervisor was good or very good.

Department Is Making Efforts to Improve Communication

To help the department formulate an integrated vision and improve its communication between staff and management, we recommended the following:

The Department of Health and Welfare should

a. examine the causes for employees' lack of confidence when communicating with management; and

b. take steps to address these concerns and build two-way communication between staff and management by examining structures and policy language of the employee grievance resolution process, and encouraging intermediate and informal alternatives for staff.

Although no formal assessment was conducted to examine the causes for employees' lack of confidence when communicating with management, department management at all levels have met with staff to identify and discuss communication problems. Furthermore, the department created the Division of Communication and Regional Development. This new division is tasked with communication flow in the department and to legislators, media, and the public.

The department has implemented a new communication process with a built-in mechanism for staff to provide feedback to management. This process provides opportunities for consistent communication between management and staff. However, no formal process is in place to ensure that top management receives or considers staff input, if provided. With this new process, staff receive the

same information from management twice: once at their regional meeting and once at their divisional meeting. The department intended for this repetition to ensure staff receive the necessary information.

The communication process is designed for communication to flow from management to staff and then from staff back to management. In our 2007 survey, we added questions to identify employee perceptions of communication flow in the department. When asked about changes in communication between 2006 and 2007, most staff indicated that it had remained the same. Approximately 35 percent of staff felt communication had improved, and about 20 percent felt it had declined. Examples of positive comments by staff include the following:

- "Upper management is more accessible and frequently interacts with department staff"
- "[My supervisor] is excellent at giving feedback and listening to ideas"
- "In my new position, I work for individuals that do listen and encourage expanded communication"

Examples of negative comments by staff include the following:

- "If upper management is supposed to be supporting us, I never know. There is no contact!"
- "Not allowed to present important information on subjects that I work on daily, watch in horror as bits and pieces of what is important are relayed up the chain of command"
- "Management is defensive and avoids communication"

Problem-Solving Process

In 2006, only 27 percent of staff felt the problem-solving (grievance) process was fair and equitable, as compared with 33 percent in 2007. To address this issue, the department's Division of Human Resources revised its *Personnel Policies and Procedures Manual* to create a section that more clearly articulates the problem-solving process. In February 2006, Human Resources publicized this section by writing about it in newsletter articles and posting it on the department's electronic information network, called InfoNet. Human Resources staff also attended staff meetings to explain and answer any questions about the grievance process. Based on staff feedback, Human Resources made further changes to the policy in March 2007. The department stated that it will continue to solicit feedback.

Status: Assuming the department continues to improve its communication methods and grievance process, this recommendation has been **implemented**.

Fear of Retaliation Continues to Be a Concern for Staff

In 2006, 24 percent of staff reported that they could talk openly with upper management about work related problems without fear of retaliation. In 2007, many staff still feared retaliation, but survey results indicated improvement in staffs' perception as 31 percent of staff felt that they could talk openly with upper management. Unlike communication with upper management, the communication is perceived to be much more open between staff and their immediate supervisors. Seventy-four percent of staff felt comfortable talking openly with their direct supervisor without a fear of retaliation, up from 69 percent in 2006.

When asked if retaliation had occurred to themselves or their co-workers for participating in our last survey, only 10 percent of staff indicated that they perceived some form of retaliation. When managers were asked if retaliation had occurred to themselves or those they manage, only 7 percent perceived that retaliation had occurred. Although a relatively small percentage of staff and managers reported perceived retaliation, any occurrence of retaliation should be of concern to the management.

Department Has Increased Training Opportunities

In the 2007 survey, 73 percent of staff in the Division of Behavioral Health and 65 percent of staff in the Division of Welfare agreed or strongly agreed that training was adequate. Over 86 percent of staff in Administration, which includes Human Resources, reported training was adequate. Seventy-seven percent of State Hospital South staff reported adequate training, whereas only 26 percent of Laboratory Services staff felt that training was adequate. The disparity of perceptions in training adequacy may suggest that the department needs to continue enhancing its training opportunities for all employees, particularly in those programs that ranked low in our survey.

The Division of Human Resources has implemented several training opportunities for managers, supervisors, and line staff. One key program, called Crucial Conversations, teaches managers and supervisors how to effectively communicate with staff.[1] The department reports it is continually working on providing other training opportunities for managers and staff and identifying more training opportunities for employees.

[1] Crucial Conversations is a registered trademark of VitalSmarts, L.C., 2005.

Potential Areas for Further Study

The department has made strides in improving its communication and building better relationships with staff. Department efforts that may benefit from further review include the following:

- Revisit the problem-solving process to ensure staff fully understand their options for resolving conflict
- Evaluate communication processes for their effectiveness
- Identify why many employees continue to fear retaliation from management

Chapter 4
Staffing and Workload Analysis

In 2006, we found that the Department of Health and Welfare lacked well-developed staffing and workload models in some of its programmatic areas. Several programs relied on simple formulas or had limited methods, if any at all, in place to assist with staffing decisions. This lack of well-developed methodologies limited the department's ability to address the following management tasks:

- *Assess staffing needs*
- *Identify the most cost-effective work processes*
- *React optimally to changes in funding levels*
- *Assist the Legislature in understanding the relationship between funding, staffing, and the delivery of services*

We recommended the department make several changes to its workload analyses and staffing methodologies. Several programmatic areas have made progress in the management of staff workloads, but more needs to be done.

Department Needs to Continue Expanding the Use of In-house Expertise for Workload Management

To help improve its workload management, we made the following recommendation to the department in 2006:

The Department of Health and Welfare should leverage its expertise and experience to set standards for and to develop more useful workload and staffing models for programs that would benefit from them.

Our recommendation for this section focuses on three divisions: Family and Community Services (FACS), Behavioral Health, and Medicaid. These divisions share a common characteristic—they work directly with clients.

FACS has made some progress in monitoring workload for the Child Welfare program and has moved closer to developing an in-house process for staff allocation. In 2006, FACS contracted with the American Humane Association

for a workload assessment study and staff allocation model.[1] Although the department identified some study limitations, FACS is using the results of the study as part of its justification for staffing decisions. FACS officials said they would like to use the time data collection tool provided by the American Humane Association to conduct a similar in-house workload assessment analysis for the developmental disabilities program.[2]

The Division of Behavioral Health does not have a reliable way to measure workload. Division officials said that they need to update and improve their data automation system before they can accurately analyze staff workload. They are, however, meeting with workload experts in the Division of Welfare to identify alternative options.

The Division of Medicaid reports it intends to develop a staffing workload analysis tool. Medicaid is currently working to ensure that regions are reporting information consistently and that processes for handling cases are standardized. Medicaid officials said that once they ensure processes are uniform among regions, they will track and measure workload factors such as travel time to conduct fieldwork, type of cases, and administrative time spent handling paperwork.

The Department of Health and Welfare needs to continue expanding the use of its in-house expertise for workload management in the Division of Family and Community Services, the Division of Behavioral Health, and the Division of Medicaid. For future workload analyses, the department can benefit from the in-house expertise (developed in the use of the Resource Utilization Model as discussed in the next section) and the knowledge gained from using the data collection tool (provided by the American Humane Association).

Status: This recommendation is **in process**.

Division of Welfare Is Adjusting Its Workload Model

In 2006, staff in the Division of Welfare expressed concerns about methods used for adjusting workloads. We therefore recommended the following:

The Department of Health and Welfare's Division of Welfare should evaluate the reasons for staff perceptions that workload adjustments are not made when needed, and include an evaluation of options and expected results of applying alternative methods of balancing workloads among offices.

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[1] American Humane Association completed the study in April 2007 for two programs: Child Welfare and Children's Mental Health.

[2] FACS officials also noted that such a study would require additional staffing resources. For more information about the Child Welfare program, see our 2007 follow-up report, *Child Welfare Caseload Management.*

This recommendation had two parts: (1) identify reasons why staff do not perceive that workload is adjusted when needed, and (2) evaluate options and expected results of balancing workloads among division offices.

To address part one of the recommendation, Division of Welfare officials said that they have provided training to staff on *how* and *why* workload decisions are made. Although such training may be useful, the division may need to further work with staff on workload issues. In our 2006 report, we noted that Welfare had a well-developed workload assessment tool called the Resource Utilization Model that relies on random moment sampling.[3] The division is currently gathering data to update this model. Once this update is complete, data may show the need for a change in staff allocation. Additional communications with staff about workload decisions may be most beneficial after the update is completed and more is known about how staffing within the division should be reallocated.

To address part two of the recommendation, the division is awaiting the update of the Resource Utilization Model and the replacement of its computer eligibility system:

- Since the time of our recommendation, the Child Support program has undergone a statewide reorganization by consolidating services, which allows managers to better manage staff and workload distribution.[4] This reorganization made the current Resource Utilization Model outdated. Division officials indicate that they will have useable staffing analysis data from the model updated by early 2008 and will then be able to address part two of our recommendation.

- The Benefits program is currently waiting for the completion of the Eligibility Programs Integrated Computer System (EPICS) replacement project. Division officials indicate that in early 2009, once EPICS is replaced, Benefits will also be able to use the Resource Utilization Model for workload management.

Status: This recommendation is **in process** and will be best evaluated upon completion of the workload model update and data system replacement.

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[3] Random moment sampling is a method for obtaining measurement of how much time staff spend on certain activities related to cases. It relies on staff to report their activities when prompted by an e-mail at randomly occurring times. Because the sample size can be large, a high level of confidence in the accuracy of the measurements is possible.

[4] Consolidating services means that any welfare office in the state can fill a client's request for services, including a different office than where the client is physically located.

Department Does Not Have Necessary Tools for Scheduling Institution Staff

In 2006, the department did not have the capabilities to ensure it was scheduling and allocating its institution staff in a cost-effective manner. We therefore recommended the following:

The Department of Health and Welfare should evaluate alternatives, including the development of in-house analytical capacity, to assist the state hospitals in identifying the most cost-effective staffing, allocation, and scheduling methodologies.

Our recommendation is comprised of two parts: (1) determine the best ways to schedule state hospital staff, and (2) determine the most cost-effective mix of staff resources.

Idaho has three state hospitals:

- State Hospital North in Orofino, which serves acute court committed psychiatric patients
- Idaho State School and Hospital in Nampa, which serves severely impaired people with developmental disabilities
- State Hospital South in Blackfoot, which provides psychiatric treatment and skilled nursing to adults and adolescents with serious mental illnesses

State Hospital South determines nursing workload with a staffing model that assigns points based on daily patient care situations. The model relies on nursing managers to input daily information on several criteria, e.g., number of patients, number of staff assigned, number of close monitoring and observation hours, and additional precautions for patients. Based on these criteria, nursing managers allocate the appropriate number of staff for each shift. This model addresses part one of our recommendation about determining how many staff should be scheduled to work. However, Hospital South officials acknowledge that it does not address part two of the recommendation related to the mix of staffing resources.

State Hospital North has recently adopted a staffing model similar to the one already in place at State Hospital South. Like Hospital South, Hospital North does not have a methodology for determining the best mix of staff.

Idaho State School and Hospital officials said that they have been conducting random moment sampling studies. However, they did not provide documentation of how they have applied the study results to the hospital operations.

The staffing models used at State Hospital South and State Hospital North are important tools for deciding how many staff are needed during shifts at the two institutions. The models do not, however, fully address the most cost-effective ways of providing needed staffing. The department's institutional controller, who is tasked with providing financial and analytical expertise for the institutions, said that both parts of the recommendation were important for the success of the hospitals. However, she had not found a way to implement the entire recommendation yet.

Institutions still do not have the necessary tools to ensure that they are scheduling staff efficiently and using the most cost-effective mix of staff. Department headquarter officials need to increase their role and involvement in the development of staffing and scheduling methodologies for the state hospitals.

Status: This recommendation has **not been implemented**.

Potential Areas for Further Study

Although the department has made some progress in improving its staffing and workload analyses, more work needs to be done in the following areas:

- Develop efficient and effective workload models
- Identify and work with staff to address imbalances in workload
- Identify the most cost-effective schedules and staff allocations at the state institutions

Chapter 5
Employee Turnover

In 2006, we reported that the department was not adequately monitoring turnover for specific divisions, programs, or work locations. Because turnover can have negative consequences on agency operations, we recommended the department make changes to its personnel data to more specifically monitor employee turnover. The department has implemented our recommendation by changing the way it now monitors employee turnover. For fiscal year 2007, turnover in the department was 16.7 percent and varied from a high of 42.3 percent in Emergency Medical Services to a low of 2.5 percent in Vital Statistics.

Department Can Now Monitor Turnover at a More Detailed Level

Because turnover can negatively impact agency operations, we made the following recommendation to the department:

The Department of Health and Welfare should make changes to the structure of its personnel data to allow for regular monitoring of turnover rates in specific divisions, programs, and work locations, as well as by job classification.

In January 2007, the department completed the recoding of pay locations that identify division, program/bureau, work location, and job classification. The department uses these codes to generate separation reports identifying where turnover is most frequent. On a semi-annual basis, management has started reviewing exit interviews of employees leaving the department. These interviews provide the department with information to address areas of concern. As a result, the department now has the capabilities to monitor turnover at a more detailed level.

Status: This recommendation has been **implemented**.

Staff Perceptions of Reasons for Turnover Have Changed

To address turnover, the department should understand *why* employees are leaving. Staff survey responses in our 2006 report indicated that pay, level of

stress at work, workload, and management were the most common reasons staff left the department. In the 2007 survey, staff reported the following most common reasons why employees leave the department:

- Organizational change
- Level of legislative support
- Relocation
- Level of stress at work[1]

In the last survey, most staff perceived they were underpaid. The department acknowledged that pay for many positions was below market value and used data collected by the Division of Human Resources to request a budget enhancement in fiscal year 2007. The Legislature approved the enhancement to address recruitment and turnover problems for several positions such as nurses, social workers, and clinicians.

Turnover Rates Among Divisions, Programs, and Work Locations

In fiscal year 2007, the turnover rate at the department was 16.7 percent.[2] The Divisions of Family and Community Services (FACS), Public Health, Medicaid, and Human Resources all posted turnover rates higher than the department average. As shown in exhibit 5.1, Human Resources had the highest turnover rate at 25.6 percent, whereas Management Services' turnover rate was the lowest among divisions at 11.1 percent.

By program, turnover was greatest in Emergency Medical Services at 42.3 percent, while Vital Statistics was only 2.5 percent. Five programs posted turnover rates higher than 20 percent, and two programs had rates below 10 percent.

The department's turnover rates vary among different locations. As shown in exhibit 5.2, Region IV (21.8 percent) and Idaho State School and Hospital (21 percent) had the highest turnover by location. In contrast, Region I had a turnover rate of 9.9 percent and Institution support staff posted a turnover of 4 percent.[3]

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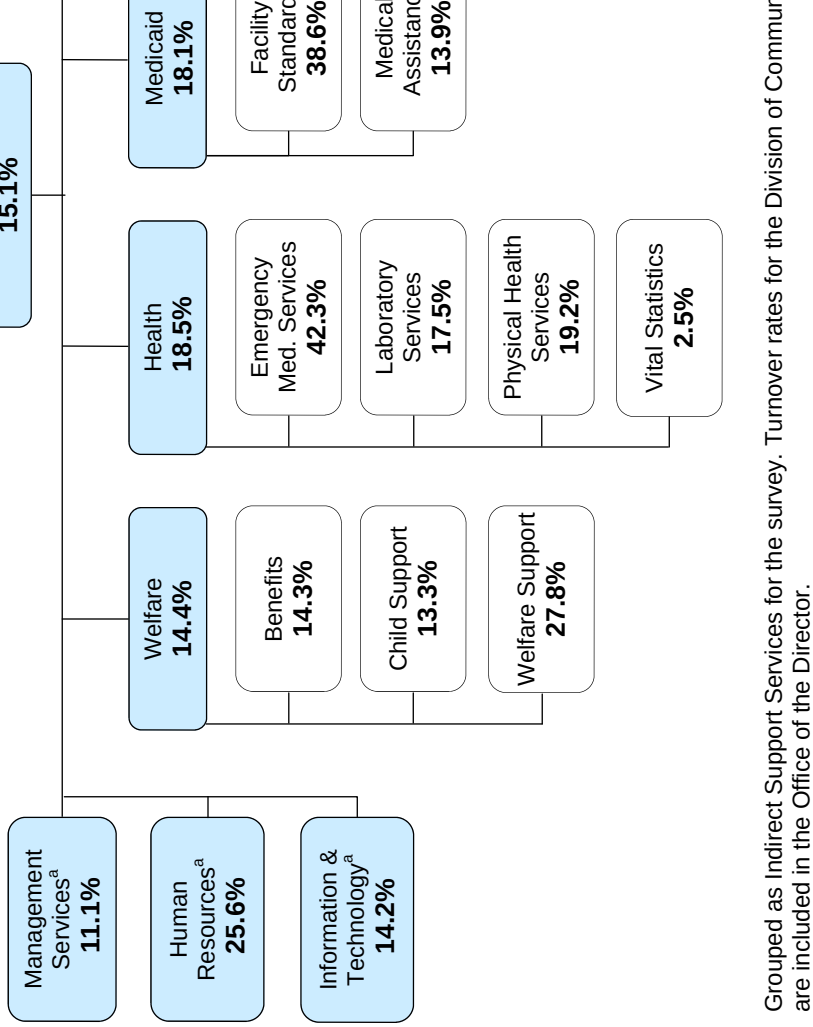
[1] Middle managers indicated the same top three reasons for turnover, but indicated the fourth most important factor was physical work environment.

[2] Because we revised our methodology to better align with the methodology used by the Office of the State Controller to calculate turnover rates, we cannot make reliable comparisons to previously reported turnover rates.

[3] Institution support staff included department employees who worked for other divisions, but were physically located at one of the state hospitals.

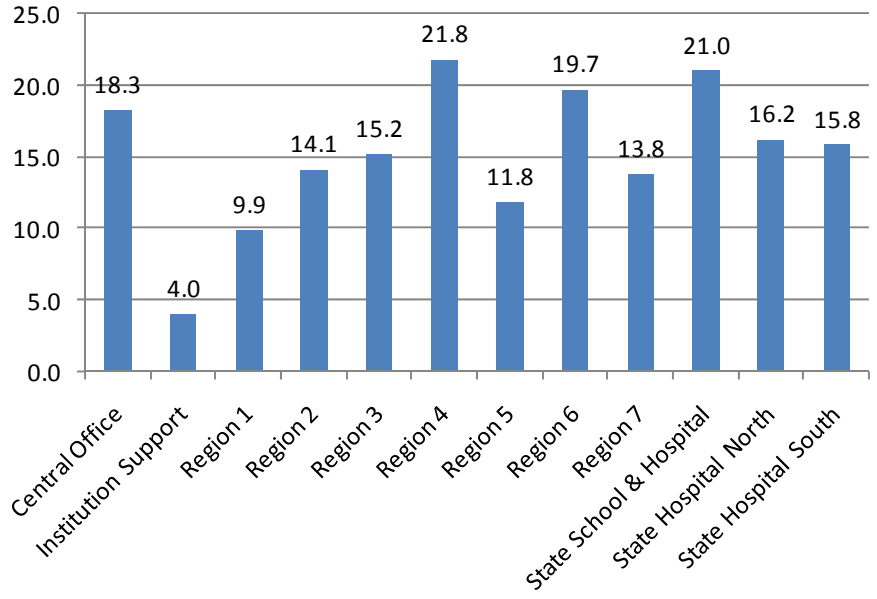
Exhibit 5.1: Turnover Rates in the Department of Health and Welfare, by Division and Program, Fiscal Year 2007



[a] Grouped as Indirect Support Services for the survey. Turnover rates for the Division of Communication and Regional Development are included in the Office of the Director.

Source: Office of Performance Evaluations' analysis of personnel information from the Office of the State Controller's Idaho Business Intelligence Solution (IBIS) and the Department of Health and Welfare.

Exhibit 5.2: Department Turnover by Work Location, Fiscal Year 2007



Source: Office of Performance Evaluations' analysis of personnel information from the Office of the State Controller's Idaho Business Intelligence Solutions (IBIS) and the Department of Health and Welfare.

Potential Areas for Further Study

Given the variation in turnover rates throughout the department, the department should work to identify reasons for turnover where it is relatively high, including:

- Emergency Medical Services, Division of Health
- Facility Standards, Division of Medicaid
- Division of Family and Community Services
- Region IV
- Region VI
- State School and Hospital
- Welfare Support, Division of Welfare

Chapter 6
Facility Planning, Maintenance, and Funding

In 2006, we found that the Department of Health and Welfare was at risk of, or was incurring, problems in facility maintenance and long-term planning. We also found that the department was not taking full advantage of federal financial participation in paying for buildings and equipment. To receive federal reimbursement, a state must first invest in its assets. We suggested that the department implement best practices to correct these issues, but it has not implemented our suggestions.

Department Could Benefit from Facility Management Best Practices

Our 2006 report discussed facility management in the context of best practices, including the importance of facility planning, maintenance, and funding. We noted that failing to follow best practices can cause both immediate and long-term problems, such as:

- Responding to maintenance problems on an emergency, rather than a planned basis
- Not obtaining the full useful life of assets
- Incurring additional costs associated with maintaining obsolete and ill-repaired buildings, systems, and equipment

The report listed five best practices that could potentially benefit the State of Idaho and the department by reducing costs over time and by protecting the state's investments in its facilities. These practices are best implemented together, but they are also useful if implemented independently:

- Engage in long-term planning
- Inventory and assess facility and major maintenance needs and costs
- Identify cost effectiveness through life-cycle cost analysis and set funding priorities
- Follow a preventive maintenance program
- Establish financial reserves for major maintenance and system replacements

Facility Management Still Needs Work

The department has made little change with facility management in its three institutions: State Hospital North, State Hospital South, and Idaho State School and Hospital. Department officials maintain that funding for major capital projects, alterations, and repairs is beyond their control.

Idaho Code § 67-5711 defines how major facility projects are to be funded. State agencies may request through the Permanent Building Fund additional funds for major capital projects and any alterations and repairs over $30,000.[1] Similarly, state agencies must request all other general maintenance and upkeep through their department budget.

As addressed in the 2006 report, deferring the replacement of inefficient assets and major systems denies the institutions access to federal funding. The department reported that it is limited in what it can do with funding facility maintenance. However, should the Legislature change the current code, the department has indicated it would be interested in exploring the kinds of facility management and budgeting practices identified in our 2006 report.

Institutions Want to Improve Facilities

The three institutions have made some internal changes to their operations. State Hospital North said that in order to save money, one of the hospital's maintenance staff became certified in air-conditioning repair. Staff told us this certification reduces the costs associated with maintaining the air-conditioning units and also allows Hospital North to buy replacement parts at wholesale. State Hospital South reports it needs a new air-conditioning system. With the internal expertise of air conditioning repair at Hospital North, the department believes that Hospital South should purchase the same brand of air-conditioners.

Idaho State School and Hospital and State Hospital North are now implementing the same maintenance tracking software that State Hospital South has been using for the past several years. As discussed in our 2006 report, this software is a computerized maintenance management system that is designed to help improve facility management in areas such as asset management, preventive maintenance, inventory control, work orders, and purchasing. Both headquarters and hospital staff acknowledge that use of this tool does not result in meeting all of the department's facility maintenance and equipment replacement needs; however, having and using the tool allows for progress toward better facility management.

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[1] IDAHO CODE § 57-1108 refers to the Permanent Building Fund request process only. The $30,000 threshold is a Division of Public Works policy.

Potential Areas for Further Study

Given limited department efforts to initiate facility planning, improve facility maintenance, and increase federal funding, we provide the following suggestions:

- The department should evaluate facility issues in a systematic, comprehensive way and present its findings and recommendations to the Legislature and the Permanent Building Fund Advisory Council.

- The Legislature and Permanent Building Fund Advisory Council should consider reviewing and possibly amending policies and procedures for facility planning, funding, and maintenance. To avoid unscheduled corrective actions at potentially higher costs, we recommend using the best practices that were outlined in our 2006 report and reiterated in this follow-up report.

- As discussed in our 2006 report, the Legislature could consider using the Department of Health and Welfare for a more in-depth case study of the strengths and limitations of facility planning, maintenance, and funding in state government.

Chapter 7
Board of Health and Welfare

In 2006, we reported that the Board of Health and Welfare had limited responsibilities especially when compared to other state boards. We suggested ways that the Board of Health and Welfare could be more involved, including increasing board oversight of the department. The Legislature has enacted our suggestion by increasing the size of the board and its responsibilities. This chapter provides board members' perspectives on their expanded role and offers suggestions for further improvement in how the board carries out its responsibilities.

Board Members' Perspectives on New Responsibilities

Policymakers passed legislation during the 2006 and 2007 legislative sessions that incorporated our suggestions to increase the scope and size of the board.[1] The board is now comprised of seven voting members and four non-voting members that include department officials and legislative members. The board now has additional roles and responsibilities, including:

- Provide oversight
- Provide annual reports to the Governor and Legislature
- Ensure board members posses appropriate professional expertise or have access to additional training
- Require board concurrence on department budgets and strategic plans
- Establish regular meetings (at least once every two months)

We interviewed all current voting board members to gauge their perceptions on the expanded role of the board. When asked about the new responsibilities and the increased frequency of meetings, almost all board members reported being satisfied. Two members told us that it might be advantageous for the board to meet monthly during the legislative session. Most members, however, acknowledge that they are a part-time citizen board and are limited by time, resources, and other commitments.

[1] HB 832 was passed in 2006, and SB 1093 was passed in 2007.

Members Offer Suggestions for Improvement

Although current board members were generally satisfied with their new responsibilities, they said the interaction between the board and the department could be improved. They suggested three areas of improvement: training and orientation, roles of subcommittees, and communication between the board and department.

Board Training and Orientation

All current members said that the department provided a good basic orientation, but they would find more value in meeting with department staff and supervisors. Meeting with staff would help board members fully understand the department's daily operations. One member said that he had met with a department employee in his region and learned more about department operations than he would have on a guided tour.

Board Subcommittees

In our 2006 evaluation, we suggested that administrators from each division attend board meetings to discuss relevant issues. To address this suggestion, the board created four subcommittees:

- Support Services
- Community and Legislative Services
- FACS and Welfare Services
- Health Services

These subcommittees allow board members to focus on specific areas of the department rather than members trying to become experts on all department matters. Most board members indicated that the intent of the subcommittees was being met; however, board members were limited in the time they have to review board meeting information. Recognizing this limitation, several members suggested increasing communication and enhancing the information flow from the department to the board. One member suggested that subcommittees receive their information weeks in advance of the board meeting to allow for research, discussions, and time to prepare a report for the full board.

Communication Between Board and Department

Several board members acknowledged a much improved relationship with the department, but still felt more could be accomplished in regards to communication. They suggested that communication be in simple language and with minimal acronyms.

Board members expressed appreciation to the director for the reports he presented at each meeting and felt that his straightforward approach was helpful

in keeping them current with department activity. In addition to the director's reports, board members also stated that the department has done a good job presenting budget information at each meeting and has provided strategic plans when available.

Appendix A

Department of Health and Welfare 2007 Employee Survey Response Rates

Table 1: Staff and Supervisors

	Surveyed	Responding	Rate
Division of Behavioral Health	**672**	**335**	**49.9%**
Adult Mental Health	248	161	64.9
Children's Mental Health	75	57	76.0
State Hospital North	97	24	24.7
State Hospital South	236	79	33.5
Substance Abuse[a]	16	14	87.5
Division of Family & Community Services	**841**	**396**	**47.1**
Child Welfare	340	210	62.0
Developmental Disabilities	145	95	66.0
Idaho State School & Hospital	332	74	22.3
Navigation[a]	24	17	66.7
Division of Health	**160**	**118**	**73.8**
Emergency Medical Services	25	20	80.0
Laboratory Services	36	23	63.9
Physical Health Services	62	53	85.5
Vital Statistics	37	22	59.5
Division of Medicaid	**228**	**166**	**72.8**
Facility Standards	40	27	67.5
Medical Assistance Services	188	139	73.9
Division of Welfare	**576**	**402**	**69.8**
Benefits	392	267	68.1
Child Support	169	122	72.2
Welfare Support[a]	15	13	86.7
Indirect Support Services	**262**	**201**	**76.7**
Director's Office[b]	9	9	100.0
Communication & Regional Development[b]	7	6	85.7
Human Resources[b]	16	14	87.5
Information Technology Services	105	81	77.1
Management Services	125	91	72.8
Total	**2,739**	**1,618**	**59.1%**

[a] Classified in the survey as Other.
[b] Classified in the survey as Administration.

Appendix A—continued

Table 2: Middle Managers

	Surveyed	Responding	Rate
Division of Behavioral Health	37	32	86.5%
Division of Family & Community Services	40	29	72.5
Division of Health	33	25	75.8
Division of Medicaid	21	17	81.0
Division of Welfare	21	19	90.5
Indirect Support Services	21	19	90.5
Grand Total	**173**	**141**	**81.5%**

Note: Middle manager survey responses were not analyzed by program due to the small numbers in the survey population.

Source: Office of Performance Evaluations' survey of Department of Health and Welfare staff and supervisors and middle managers, July 2007.

Appendix B
Staff and Supervisors' Survey 2007 Responses

The following tables provide department-wide results of our survey of staff and frontline supervisors in the Department of Health and Welfare. The average scores in the right-hand column were calculated based on a scale of 1 to 5, where 5 was the most positive response (very good, strongly agree, or greatly improved) and 1 was the most negative response (very poor, strongly disagree, or greatly declined). Therefore, the higher the score, the more positive the overall response from employees. Each question gave employees the option to indicate that they did not know the answer. "Don't know" responses were not included when calculating the percentages for each question.

Table 1: Management and Leadership

	Very Good	Good	Fair	Poor	Very Poor	Average Rating (5-point scale)
1. Rate the quality of leadership provided by each of the following levels of management within the Department of Health and Welfare:						
Upper management (N = 1,473)	13.6%	36.3%	29.1%	11.9%	9.1%	3.3
Program managers (N = 1,564)	24.5	37.9	21.9	9.7	6.0	3.7
Frontline supervisors (N = 1,546)	36.5	37.7	15.7	5.4	4.8	4.0

	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Average Rating (5-point scale)
2. I have confidence the following levels of management have the skills and abilities needed to perform their jobs:						
Upper management (N = 1,472)	16.1%	40.6%	25.8%	11.1%	6.4%	3.5
Program managers (N = 1,564)	24.4	44.0	16.4	10.4	4.7	3.7
Frontline supervisors (N = 1,553)	29.4	44.3	13.9	8.2	4.2	3.9
3. Goals/objectives are clearly defined at each of the following organizational levels:						
Department (N = 1,584)	17.9	51.1	18.2	8.9	3.9	3.7
Division (N = 1,572)	21.9	47.1	15.0	12.2	4.3	3.6
Program (N = 1,579)	21.8	46.9	15.0	12.1	4.3	3.7

Table continued on next page

Appendix B, Table 1—continued

	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Average Rating (5-point scale)
4. I have the opportunity to participate in the process of setting goals and objectives at the following organizational levels:						
Department (N = 1,554)	5.2%	12.8%	22.9%	37.5%	21.5%	2.4
Division (N = 1,555)	5.5	14.2	25.1	35.1	20.1	2.5
Program (N = 1,575)	13.5	30.0	19.7	22.9	14.0	3.1
5. Staff work responsibilities in my program or work unit are clear. (N = 1,604)	25.7	47.4	9.7	12.0	5.2	3.8
6. Cooperation is effective within my						
Division (N = 1,522)	11.5	36.8	27.5	17.9	6.4	3.3
Program (N = 1,576)	25.6	43.3	13.6	12.2	5.4	3.7
7. I have the authority I need from superiors to do my job effectively. (N = 1,609)	28.2	44.4	10.8	11.9	4.7	3.8
8. I have confidence in upper management decision-making. (N = 1,589)	9.1	31.2	26.1	22.0	11.6	3.0

Table 2: Workload and Staffing

	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Average Score (5-point scale)
1. I generally have enough time to do the work assigned to me. (N = 1,610)	8.6%	38.6%	12.7%	22.7%	17.4%	3.0
2. The following levels of management regularly monitor staff workload for my program:						
Upper management (N = 1,330)	6.5	21.4	31.5	25.6	15.0	2.8
Program managers (N = 1,482)	12.9	37.7	24.3	16.5	8.6	3.3
Frontline supervisors (N = 1,533)	28.8	45.1	13.6	8.2	4.0	3.9
3. To the extent possible, the following levels of management make adjustments to staff workload when necessary:						
Upper management (N = 1,348)	4.5	15.0	32.2	28.5	19.8	2.6
Program managers (N = 1,480)	10.5	31.9	25.9	19.5	12.2	3.1
Frontline supervisors (N = 1,529)	23.2	44.5	13.9	11.6	6.8	3.7

Table continued on next page

Appendix B, Table 2—continued

	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Average Score (5-point scale)
4. My program or unit has enough staff to carry out its responsibilities. (N = 1,603)	6.6%	21.8%	9.7%	32.9%	29.1%	2.4
5. My program or unit has sufficiently qualified staff to carry out its responsibilities. (N = 1,603)	18.5	42.2	11.2	17.9	10.1	3.4
6. Upper management sets high standards for the services we provide. (N = 1,556)	24.7	48.5	17.9	5.7	3.1	3.9
7. All employee are held personally accountable for the quality of work they produce. (N = 1,586)	12.9	41.2	13.4	22.0	10.6	3.2
8. To the extent possible, the Department of Health and Welfare rewards (not necessarily monetary) staff on the basis of merit and performance. (N = 1,570)	4.3	27.3	24.3	26.2	17.9	2.7
9. Workload is appropriately allocated among the staff in my program/office who are doing the same type of work I do. (N = 1,566)	9.7	43.7	18.4	18.6	9.5	3.3

Table 3: Policies and Training

	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Average Score (5-point scale)
1. My program has established adequate standards, policies, and procedures to guide me in my work. (N = 1,610)	13.5%	53.1%	15.7%	13.0%	4.7%	3.6
2. Upper management encourages training and development of its employees. (N = 1,565)	13.9	42.4	20.9	15.3	7.5	3.4
3. The training I receive is adequate for my current assignment. (N = 1,607)	11.5	50.7	19.0	13.9	4.9	3.5
4. I have enough time to participate in the training I need for my current assignment. (N = 1,610)	5.6	38.0	20.2	27.0	9.3	3.0
5. The problem-solving (grievance) process is fair and equitable to all employees. (N = 1,259)	6.6	26.1	35.8	16.2	15.3	2.9
6. To the extent possible, decisions about promotions are based on merit and performance. (N = 1,376)	6.8	31.5	25.2	20.8	15.8	2.9
7. To the extent possible, decisions about the distribution of merit raises are made in a fair and equitable way. (N = 1,363)	6.6	32.9	25.5	19.4	15.7	3.0

Appendix B—continued

Table 4: Communication

	Very Good	Good	Fair	Poor	Very Poor	Average Score (5-point scale)
1. Communication among my co-workers is (N = 1,613)	31.1%	37.9%	21.0%	6.1%	3.8%	3.9
2. The communication I receive from my supervisor is (N = 1,614)	36.4	32.3	18.9	6.8	5.6	3.9
3. Overall, communication within the Department of Health and Welfare is (N = 1,541)	3.5	27.2	40.0	19.5	9.8	3.0

	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Average Score (5-point scale)
4. I receive enough information from upper management to do my job well. (N = 1,583)	8.3%	35.0%	32.1%	17.1%	7.5%	3.2
5. The InfoNet is a useful source of information for employees. (N = 1,600)	20.8	55.8	16.8	5.3	1.4	3.9
6. My supervisor lets me know exactly what is expected of me. (N = 1,613)	23.9	49.0	14.5	8.6	4.0	3.8
7. The atmosphere in my program encourages people to be open and candid with upper management. (N = 1,589)	11.3	27.2	21.4	20.5	19.7	2.9
8. I can talk openly with the following levels of management about work-related problems without fear of retaliation:.						
Upper management (N = 1,383)	8.7	22.6	29.7	20.0	19.0	2.8
Program managers (N = 1,541)	18.8	34.0	18.1	15.5	13.6	3.3
Frontline supervisors (N = 1,551)	31.9	42.1	10.4	7.2	8.4	3.8
9. The following levels of management encourage my suggestions and complaints:						
Upper management (N = 1,408)	7.5	22.8	32.1	19.5	18.1	2.8
Program managers (N = 1,542)	18.0	34.4	20.6	13.8	13.2	3.3
Frontline supervisors (N = 1,554)	28.7	42.3	13.6	8.0	7.5	3.8
10. The following levels of management listen to the recommendations of staff:						
Upper management (N = 1,368)	4.8	22.4	31.7	21.7	19.4	2.7
Program managers (N = 1,516)	14.4	36.2	22.0	14.2	13.2	3.2
Frontline supervisors (N = 1,535)	26.1	44.7	15.0	7.6	6.7	3.8

Appendix B—continued

Table 5: Morale and Job Satisfaction

	Very Good	Good	Fair	Poor	Very Poor	Average Score (5-point scale)
1. Overall, workplace morale among my co-workers is (N = 1,610)	11.3%	32.6%	29.9%	15.7%	10.5%	3.2

	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Average Score (5-point scale)
2. In general, I am satisfied with my job. (N = 1,614)	21.8%	48.8%	14.3%	10.3%	4.5%	3.7
3. Turnover within the Department of Health and Welfare significantly impedes organizational effectiveness. (N = 1,591)	48.7	36.5	11.4	2.8	1.0	4.3
4. Management creates an environment that makes me want to do my very best each day. (N = 1,609)	9.1	32.1	32.4	18.8	7.7	3.2
5. I feel valued by my supervisor. (N = 1,605)	36.3	38.6	11.4	8.1	5.6	3.9
6. I feel valued by the Department of Health and Welfare. (N = 1,568)	6.3	28.4	31.5	22.0	11.8	3.0

7. In your opinion, what factors have the greatest positive impact on employee morale within your work unit or division? (Please rank your top three choices.) (N = 1,614)

	N	Percent		N	Percent
Pay	870	53.9%	Workload	209	13.0%
Co-worker interaction	836	51.8	Management	203	12.6
Benefits	594	36.8	Physical work environment	140	8.7
Quality of supervision	453	28.1	Promotional opportunities	117	7.3
Recognition	375	23.2	Other	58	3.6
Work schedule	292	18.1	Equipment	52	3.2
Client interaction	284	17.6	Level of legislative support	44	2.7
Level of stress at work	248	15.4	Organizational change	36	2.2

8. In your opinion, what factors have the greatest negative impact on employee morale within your work unit or division? (Please rank your top three choices.) (N = 1,594)

	N	Percent		N	Percent
Level of stress at work	951	59.7%	Promotional opportunities	152	9.5%
Workload	715	44.9	Physical work environment	152	9.5
Pay	551	34.6	Recognition	140	8.8
Management	447	28.0	Benefits	117	7.3
Organizational change	340	21.3	Work schedule	103	6.5
Level of legislative support	323	20.3	Client interaction	91	5.7
Quality of supervision	292	18.3	Equipment	77	4.8
Co-worker interaction	218	13.7	Other	66	4.1

Table continued on next page

Appendix B, Table 5—continued

9. In your opinion, what are the primary reasons employees choose to leave the Department of Health and Welfare? (Please rank your top three choices.) (N = 1,609)

	N	Percent		N	Percent
Organizational change	1039	64.6%	Benefits	107	6.7%
Level of legislative support	953	59.2	Family reasons	96	6.0
Relocation	560	34.8	Return to school	93	5.8
Level of stress at work	475	29.5	Recognition	71	4.4
Physical work environment	287	17.8	Quality of supervision	59	3.6
Promotional opportunities	246	15.3	Client interaction	53	3.3
Retirement	199	12.4	Pay	34	2.1
Management	193	12.0	Other	34	2.1
Work schedule	150	9.3	Workload	31	1.9
Co-worker interaction	129	8.0	Equipment	5	0.5

Table 6: Additional Questions

	Yes	No	Unsure
1. Did you complete the original survey conducted by the Office of Performance Evaluations in November/December of 2005? (N = 1,616)	64.8%	22.2%	13.0%
2. Some respondents to the survey in late 2005 voiced a concern that retaliation might occur if they completed that survey. Since the OPE report on the original survey was released in February 2006, do you believe retaliation has occurred to you or your co-workers? (N = 1,025)	9.7	90.3	n/a

	Greatly Improved	Improved	Remained the Same	Declined	Greatly Declined	Average Rating (5-point scale)
3. To what extent has your overall perception of the department, your division, and your program changed since you completed the original survey in late 2005?						
Department (N = 1,005)	3.5%	24.6%	49.3%	17.2%	5.5%	3.0
Division (N = 987)	5.7	27.6	40.3	18.9	7.5	3.1
Program (N = 983)	9.4	30.4	35.3	17.1	7.8	3.2
4. Since I completed the original survey in 2005, my confidence in management decision-making has						
Upper Management (N = 998)	3.6	17.3	49.2	20.5	9.4	2.9
Program Managers (N = 1,003)	7.6	21.6	45.3	16.5	9.1	3.0
Frontline Supervisors (N = 985)	10.6	26.0	46.5	11.0	6.0	3.2

Table continued on next page

Appendix B, Table 6—continued

	Greatly Improved	Improved	Remained the Same	Declined	Greatly Declined	Average Rating (5-point scale)
5. Since you completed the original survey in late 2005, communication from upper management to department staff/frontline supervisors has (N = 958)	4.3%	30.2%	43.2%	16.2%	6.2%	3.1
6. Since you completed the original survey in late 2005, communication from department staff/frontline supervisors to upper management has (N = 851)	5.3	28.9	48.2	12.9	4.7	3.2
7. Since I completed the original survey in late 2005, morale among my co-workers has (N = 1,020)	3.0	22.4	40.6	24.8	9.2	2.9

Respondents who believed that morale among those they managed either improved or greatly improved were asked to rank the top three factors that have contributed most to the improvement. (N = 260)

	N	Percent		N	Percent
Pay	161	61.9%	Level of legislative support	19	7.3%
Co-worker interaction	104	40.0	Other	19	7.3
Quality of supervision	95	36.5	Benefits	17	6.5
Management	86	33.1	Physical work environment	12	4.6
Organizational change	80	30.8	Client interaction	11	4.2
Recognition	50	19.2	Equipment	11	4.2
Level of stress at work	43	16.5	Work schedule	9	3.5
Workload	35	13.5	Promotional opportunities	5	1.9

Respondents who believed that morale among those they managed either declined or greatly declined were asked to rank the top three factors that have contributed most to the decline. (N = 347)

	N	Percent		N	Percent
Level of stress at work	191	55.0%	Other	30	8.7%
Management	179	51.6	Recognition	29	8.4
Workload	156	45.0	Benefits	21	6.1
Organizational change	113	32.6	Physical work environment	18	5.2
Quality of supervision	113	32.6	Promotional opportunities	10	2.9
Pay	73	21.0	Work schedule	9	2.6
Co-worker interaction	51	14.7	Client interaction	4	1.2
Level of legislative support	36	10.4	Equipment	1	0.1

Note: Percents may not sum to 100 due to rounding.

N = Number of respondents for each question.

Source: Office of Performance Evaluations' survey of Department of Health and Welfare staff and supervisors, July 2007.

Appendix C
Middle Managers' Survey 2007 Responses

The following tables provide department-wide results of our survey of middle managers in the Department of Health and Welfare. The average scores in the right-hand column were calculated based on a scale of 1 to 5, where 5 was the most positive response (very good, strongly agree, or greatly improved) and 1 was the most negative response (very poor, strongly disagree, or greatly declined). Therefore, the higher the score, the more positive the overall response from employees. Each question gave employees the option to indicate they did not know the answer. "Don't know" responses were not included when calculating the percentages for each question.

Table 1: Management and Leadership

	Very Good	Good	Fair	Poor	Very Poor	Average Rating (5-point scale)
1. Rate the quality of leadership provided by each of the following levels of management within the Department of Health and Welfare:						
Upper management (N = 137)	19.0%	46.0%	21.2%	7.3%	6.6%	3.6
Program managers (N = 138)	41.4	48.6	8.7	0.0	1.4	4.3
Frontline supervisors (N = 131)	39.7	47.3	9.9	1.5	1.5	4.2

	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Average Rating (5-point scale)
2. I have confidence the following levels of management have the skills and abilities needed to perform their jobs:						
Upper management (N = 137)	21.9%	48.9%	12.4%	8.0%	8.8%	3.7
Program managers (N = 138)	35.5	52.9	8.0	2.2	1.4	4.2
Frontline supervisors (N = 131)	29.0	55.0	10.7	4.6	0.8	4.1
3. Goals/objectives are clearly defined at each of the following organizational levels:						
Department (N = 141)	14.2	50.4	21.3	12.1	2.1	3.6
Division (N = 141)	24.1	48.9	11.3	9.2	6.4	3.8
Program (N = 140)	37.9	50.7	6.4	2.1	2.9	4.2

Table continued on next page

Appendix C, Table 1—continued

	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Average Rating (5-point scale)
4. I have the opportunity to participate in the process of setting goals and objectives at the following organizational levels:						
Department (N = 141)	8.5%	18.4%	24.1%	34.0%	14.9%	2.7
Division (N = 140)	24.3	32.9	12.1	20.7	10.0	3.4
Program (N = 141)	52.5	33.3	6.4	3.5	4.3	4.3
5. I have the authority I need from superiors to do my job effectively. (N = 141)	39.7	44.0	5.0	7.1	4.3	4.1
6 I am given sufficient opportunity to provide input as the budget request for my program or unit is being developed. (N = 141)	27.0	39.0	11.3	18.4	4.3	3.7
7. I have an appropriate level of control over the budget that has been set for my program or unit. (N = 140)	25.7	28.6	20.7	15.7	9.3	3.5
8. Staff responsibilities in my program or unit are clear. (N = 141)	30.5	56.7	7.1	5.0	0.7	4.1
9. Cooperation is effective within my						
Division (N = 138)	21.0	47.8	15.9	10.9	4.3	3.7
Program (N = 139)	48.2	44.6	2.2	4.3	0.7	4.4
10. I have confidence in upper-level management decision-making. (N = 139)	13.7	42.4	20.1	12.9	10.8	3.4

Table 2: Workload and Staffing

	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Average Score (5-point scale)
1. I generally have enough time to do the work assigned to me. (N =141)	5.7%	40.4%	15.6%	27.7%	10.6%	3.0
2. I regularly meet with my staff to review their assignments. (N = 141)	34.0	60.3	5.0	0.7	0.0	4.3
3. I routinely monitor staff workload within my program or unit. (N = 141)	34.8	60.3	2.1	2.8	0.0	4.3
4. Accurate data is available to assist me in assessing staff workload. (N = 139)	10.8	46.0	25.9	12.2	5.0	3.5
5. I have the authority I need to appropriately allocate workload within my program or unit. (N = 141)	22.0	58.2	7.8	6.4	5.7	3.8

Table continued on next page

Appendix C, Table 2—continued

		Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Average Score (5-point scale)
6.	Upper management has a clear understanding of the workload in my program area. (N = 139)	8.6%	37.4%	15.8%	27.3%	10.8%	3.1
7.	Upper management distributes resources, including staff, appropriately to my program or unit. (N = 140)	9.3	34.3	21.4	24.3	10.7	3.1
8.	My program or unit has enough staff to carry out its responsibilities. (N = 140)	3.6	30.7	10.7	40.0	15.0	2.7
9.	My program or unit has sufficiently qualified staff to carry out its responsibilities. (N = 140)	20.7	46.4	12.1	15.0	5.7	3.6
10.	High service and productivity standards have been set for staff in my program or unit. (N = 141)	39.0	53.2	5.7	2.1	0.0	4.3
11.	Department employees are held accountable for the work they produce. (N = 140)	18.6	54.3	16.4	6.4	4.3	3.8
12.	The department rewards (not necessarily monetary) staff on the basis of merit and performance. (N = 140)	7.9	35.0	21.4	27.1	8.6	3.1

Table 3: Policies and Training

		Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Average Score (5-point scale)
1.	My job responsibilities are clear. (N = 141)	31.2%	55.3%	5.7%	5.7%	2.1%	4.1
2.	The department's strategic plan appropriately guides the agency. (N = 140)	4.3	43.6	37.1	11.4	3.6	3.3
3.	My division has established clear policies to guide me in managing my program or unit. (N = 140)	13.6	48.6	24.3	8.6	5.0	3.6
4.	Upper management supports department policies. (N = 135)	23.7	46.7	16.3	10.4	3.0	3.8
5.	The problem-solving (grievance) process is fair to all employees. (N = 118)	13.6	37.3	35.6	7.6	5.9	3.5
6.	The training I receive from the department adequately prepares me for my management responsibilities. (N = 140)	14.3	53.6	22.1	7.1	2.9	3.7
7.	I have the ability to request and receive relevant training. (N = 141)	31.2	55.3	7.1	5.0	1.4	4.1

Appendix C—continued

Table 4: Communication

	Very Good	Good	Fair	Poor	Very Poor	Average Score (5-point scale)
1. Communication within or between the following organizational levels is						
From upper management to my program (N = 137)	21.9%	32.8%	24.1%	12.4%	8.8%	3.5
Within my program (N = 136)	44.9	41.2	11.0	1.5	1.5	4.3
2. Overall, communication within the Department of Health and Welfare is (N = 138)	2.9	43.5	39.9	10.1	3.6	3.3

	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Average Score (5-point scale)
3. The atmosphere within the department encourages candidness between the following groups of people:						
Program managers with division management (N = 134)	24.6%	42.5%	14.9%	12.7%	5.2%	3.7
Line staff and supervisors with program managers (N = 135)	41.5	45.9	5.9	4.4	2.2	4.2
4. Employees may talk openly about work-related problems without fear of retaliation from management. (N = 138)	16.7	54.3	11.6	8.7	8.7	3.6
5. My input is valued at the next higher level of management. (N = 140)	41.4	43.6	6.4	5.7	2.9	4.2
6. I have sufficient access to stakeholders. (N = 141)	18.4	56.0	14.9	7.8	2.8	3.8
7. Stakeholder concerns are adequately conveyed to me. (N = 139)	15.8	54.0	18.0	9.4	2.9	3.7
8. Legislators have a good understanding of my program's						
Required functions (N = 130)	0.8	16.9	22.3	36.2	23.8	2.4
Resource needs (N = 131)	0.8	12.2	19.1	38.9	29.0	2.2
9. Legislators' concerns are adequately conveyed to me. (N = 135)	9.6	39.3	25.2	21.5	4.4	3.3
10. The department's performance measures adequately inform legislators about the effectiveness of the agency. (N = 121)	4.1	30.6	38.0	19.8	7.4	3.0
11. The department effectively uses methods other than its published performance measures to inform legislators about the functions and effectiveness of the agency. (N = 113)	8.0	38.1	39.8	12.4	1.8	3.4

Appendix C—continued

Table 5: Morale and Job Satisfaction

	Very Good	Good	Fair	Poor	Very Poor	Average Score (5-point scale)
1. Overall, morale among the people I manage each day is (N = 141)	15.6%	53.9%	26.2%	2.8%	1.4%	3.8

	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Average Score (5-point scale)
2. In general, I am satisfied with my job. (N = 141)	31.9%	53.9%	7.8%	3.5%	2.8%	4.1
3. Voluntary turnover within the Department of Health and Welfare significantly impedes organizational effectiveness. (N = 136)	27.9	48.5	13.2	9.6	0.7	4.1
4. Overall, I feel the following organizational levels are headed in the right direction:						
Department (N = 135)	14.1	43.7	26.7	11.1	4.4	3.7
Division (N = 136)	29.4	41.9	15.4	8.8	4.4	3.9
Program (N = 139)	38.8	45.3	11.5	2.9	1.4	4.2

5. In your opinion, what factors have the greatest positive impact on employee morale within your work unit or division? (Please rank your top three choices). (N = 141)

	N	Percent		N	Percent
Pay	79	56.0%	Workload	21	14.9%
Co-worker interaction	66	46.8	Client Interaction	11	7.8
Quality of supervision	50	35.5	Physical work environment	11	7.8
Benefits	39	27.7	Promotional opportunities	10	7.1
Recognition	37	26.2	Organizational change	10	7.1
Level of stress at work	27	19.1	Level of legislative support	5	3.5
Work schedule	26	18.4	Other	4	2.8
Management	24	17.0	Equipment	1	0.7

6. In your opinion, what factors have the greatest negative impact on employee morale within your work unit or division? (Please rank your top three choices). (N = 140)

	N	Percent		N	Percent
Level of stress at work	84	60.0%	Recognition	14	10.0%
Workload	71	50.7	Physical work environment	11	7.9
Pay	51	36.4	Benefits	10	7.1
Organizational change	41	29.3	Work schedule	10	7.1
Level of legislative support	35	25.0	Equipment	10	7.1
Management	29	20.7	Promotional opportunities	9	6.4
Co-worker interaction	16	11.4	Other	6	4.3
Quality of supervision	15	10.7	Client interaction	4	2.9

Table continued on next page

Appendix C, Table 5—continued

7. In your opinion, what are the primary reasons employees choose to leave the Department of Health and Welfare? (Please rank your top three choices.) (N = 139)

	N	Percent		N	Percent
Organizational change	107	77.0%	Benefits	11	7.9%
Level of legislative support	64	46.0	Promotional opportunities	10	7.2
Relocation	48	34.5	Recognition	10	7.2
Physical work environment	35	25.2	Quality of supervision	9	6.5
Level of stress at work	24	17.3	Workload	5	3.6
Retirement	24	17.3	Other	4	2.9
Management	21	15.1	Pay	2	1.4
Work schedule	15	10.8	Client interaction	2	1.4
Family reasons	12	8.6	Co-worker interaction	0	0.0
Return to school	12	8.6	Equipment	0	0.0

Table 6: Additional Questions

	Yes	No	Unsure
1. Did you complete the original survey conducted by the Office of Performance Evaluations in November/December of 2005? (N = 141)	86.5%	9.9%	3.5%
2. Some respondents to the original survey in late 2005 voiced a concern that retaliation might occur if they completed that survey. Since the OPE report on the original survey was released in February 2006, are you aware of any retaliation that has occurred to you or those you manage? (N = 122)	7.4	92.6	n/a

	Greatly Improved	Improved	Remained the Same	Declined	Greatly Declined	Average Rating (5-point scale)
3. To what extent has your overall perception of the department, your division, and your program changed since you completed the original survey in late 2005?						
Department (N = 121)	8.3%	36.4%	40.5%	11.6%	3.3%	3.4
Division (N = 121)	15.7	40.5	28.1	12.4	3.3	3.5
Program (N = 120)	16.7	42.5	34.2	5.8	0.8	3.7
4. Since I completed the original survey in 2005, my confidence in upper management decision-making has (N = 122)	7.4	40.2	30.3	16.4	5.7	3.3

Table continued on next page

Appendix C, Table 6—continued

	Greatly Improved	Improved	Remained the Same	Declined	Greatly Declined	Average Rating (5-point scale)
5. Since I completed the original survey in late 2005, communication from upper management to department staff/frontline supervisors has (N = 116)	7.8%	41.4%	37.1%	10.3%	3.4%	3.4
6. Since I completed the original survey in late 2005, communication from department staff/frontline supervisors to upper management has (N = 113)	6.2	42.5	42.5	8.8	0.0	3.5
7. Since I completed the original survey in late 2005, morale among those I manage has (N = 119)	5.9	47.9	33.6	9.2	3.4	3.4

Respondents who believed that morale among those they managed either improved or greatly improved were asked to rank the top three factors that have contributed most to the improvement. (N = 64)

	N	Percent		N	Percent
Pay	44	68.8%	Level of stress at work	5	7.8%
Organizational change	30	46.9	Workload	4	6.3
Quality of supervision	24	37.5	Level of legislative support	3	4.7
Co-worker interaction	22	34.4	Promotional opportunities	2	3.1
Management	22	34.4	Work schedule	2	3.1
Recognition	11	17.2	Client interaction	1	1.6
Benefits	7	10.9	Equipment	1	1.6
Other	6	9.4	Physical work environment	1	1.6

Respondents who believed that morale among those they managed either declined or greatly declined were asked to rank the top three factors that have contributed most to the decline. (N = 15)

	N	Percent		N	Percent
Management	7	46.7%	Work schedule	2	13.3%
Organizational change	7	46.7	Co-worker interaction	1	6.7
Level of stress at work	6	40.0	Level of legislative support	1	6.7
Pay	6	40.0	Other	0	0.0
Workload	5	33.3	Benefits	0	0.0
Recognition	4	26.7	Client interaction	0	0.0
Promotional opportunities	3	20.0	Equipment	0	0.0
Quality of supervision	3	20.0	Physical work environment	0	0.0

Note: Percents may not sum to 100 due to rounding.

N = Number of respondents for each question.

Source: Office of Performance Evaluations' survey of Department of Health and Welfare middle managers, July 2007.

Appendix D

Update of Implementation Efforts

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER - GOVERNOR
RICHARD M. ARMSTRONG - DIRECTOR

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April 20, 2007

Rakesh Mohan, Director
Office of Performance Evaluations
P.O. Box 83720
Boise, Idaho 83720-0055

Dear Mr. Mohan:

In February of 2006, the Office of Performance Evaluation (OPE) published a report entitled, Management in the Department of Health and Welfare. The report was the result of a study and a survey of Department employees conducted by OPE in 2006.

Results of the survey indicate there are several employee relation issues that need to be addressed not only at a Department-wide level, but also at the division, institution, and program level.

Given our mission, *To promote and protect the health and safety of Idahoans*, these issues are important to all of us. We all believe strongly that staff are a key factor to the success of the Department's mission and we are taking steps to address these employee-relations issues now.

Attached is an outline of our efforts and the working drafts of action plans for how we are moving forward. By successfully addressing these issues we will improve the culture of the Department and will improve our ability to achieve the Department's strategic plan.

I appreciate the additional time you have provided for this response.

Sincerely,

RICHARD M. ARMSTRONG
Director

RMA/eb

enclosures

ATTACHMENT A

Response

I. OVERVIEW OF PROCESS TAKEN

Department Wide Approach

When Dick Armstrong assumed the responsibilities of Director of the Idaho Department of Health and Welfare, he took time to evaluate the data from the survey completed by the Office of Performance Evaluation. Twenty-one key issues were identified that needed to be addressed either at the department, division, institutional, or program level.

On December 8 the Director, Deputy Directors, and Division Administrators met to review the issues. This leadership team chose to address nine (9) of these issues on a department-wide basis. The nine were chosen (instead of all 21) as issues over which the Department has the most control, will have the most impact on staff, and can be addressed during the next year.

Department-wide responses were created before divisions and programs started working on specific plans in order to gain consensus from leadership on how to address some key issues. This way, when divisions and programs start working on their plans, there is alignment with the direction to which the Department has already agreed.

Divisions, Institutions, and Programs

In most of the situations, the Department-wide responses (Attachment D) did not completely address an issue. Therefore, divisions, institutions, and programs needed to develop additional responses.

Each division and institution received a report specific to that division or institution, and respective programs. Not all 21 issues apply to every division, institution, and program. Each division and institution had a responsibility to develop responses for its identified issues. The report contained two components.

- A matrix that lists all 21 issues and identifies which ones apply to the department, divisions, institutions, and programs (Attachment B).

- An expansion of those issues that apply to that specific division, institution, and respective programs.

There was an understanding that not all issues could be addressed during the first year. Thus, division, institutions, and programs were asked to select 4 to 6 issues to address.

Note: One of the key challenges we faced when evaluating the data was the issue of the divisions of Family and Community Services (FACS) and Behavioral Health. After the data was collected, Behavioral Health became a new division created from within FACS. There is no separate data on Behavioral Health. Behavioral Health used data collected in FACS.

Developing Action Plans

In developing the action plans, divisions, institutions, and programs were asked to do five things.

1. Examine the issues the survey indicated are present in the respective division, institution, and programs.

   As an example, when examining each issue, divisions, institutions, and programs asked:

   - What additional information is available about the issue?
   - What is the "root" issue?
   - What is already going well in the division/institution/program related to the issue that can be build on or replicated as a best practice?
   - What interventions are necessary in order to resolve or improve the situation?
   - What needs to be done to continue to monitor the situation?

2. Identify a small, manageable number of key issues to address.

3. In the sections entitled "**Steps Taken (Explain any new actions implemented since Fall 2005)"** document the steps that have already been taken to resolve the issue.

4. In the sections entitled "**Next Steps (Explain other actions we will take)** document the work planned to resolve the issue. *(At the program level, supervisors and staff were suggested to have involvement in the decision making process.)*

5. Since employees took the time to articulate their concerns, work with employees to come up with some viable solutions.

Responses to Developing the Plan

In developing the action plans, divisions, institutions, and programs commented that several of these topics were interrelated. For example, if they successfully address workload, morale will go up, and stress and turnover will probably go down. Therefore, in some situations they ended up listing similar actions for different issues.

II. IMPLEMENTING ACTION PLANS

The Actions Plans were submitted in early February and the Director reviewed the submissions. As can be seen from Attachments D through O, a lot of actions have already occurred and many more are planned. In addition, while these plans are being implemented, they are also working documents that are continuously being updated. For example, Idaho State School and Hospital is beginning work on a new strategic plan. Management Services is having focus groups discuss strategies before beginning implementation.

While the Director was pleased with the progress, in some cases, plans were not complete. Divisions need to make sure they document what actions have occurred to address the issues identified in the '06 OPE review.

The reports did not appear to have information on how the future action items would be implemented or dates on when they would be implemented. Everyone is being asked to review their submissions and address or add the following items.

- Did you get staff buy-in for these items?
- If so, how did you do it?
- If not, how do you intend to do it?
- Please assign dates to implement your action items.
- If the action item will take an extended time to implement, please include an expected completion date as well. (Note: Divisions, institutions, and programs were told that all action items don't have to be done immediately, the goal is to have a plan that provides guidance in accomplishing the task.)

III. NEXT STEPS

To determine our success, we will work with the Office of Performance Evaluations to conduct a follow-up survey. It is our good intention to work closely with the refinement of some of the survey questions.

The Department will evaluate other surveys in an effort to identify one we will use in the future on a regular basis.

IV. DEPARTMENT INTERACTION WITH THE BOARD OF HEALTH AND WELFARE

The Board of Health and Welfare has created subcommittees that monitor and stay updated on issues dealing with specific areas of the Department. Subcommittees meet a minimum of once every two months and provide informational updates to the full Board at each meeting. Additionally, the Director continues to report at each meeting.

The Subcommittees are organized as follows:

1. Support Services Deputy Director, Dave Butler
   - *Janet Penfold, Chair*
   - *Dan Fuchs*

2. Community and Legislative Services Deputy Director, Bill Walker
   - *Darrell Kerby, Chair*
   - *Quane Kenyon*
   - *Sara Nye*

3. FACS and Welfare Services, Dick Armstrong (Acting Supervisor)
   - *Dr. Richard Roberge, Chair*
   - *Senator Dick Compton*
   - *Dick Armstrong*

4. Health Services Deputy Director, Dick Schultz
   - *Stephen Weeg, Chair*
   - *Representative Sharon Block*
   - *Commissioner Tom Stroschein*

V. PROGRAM AREAS NEEDING FURTHER REVIEW

As indicated above, each division, institution, and program developed an action plan to address key issues (attachments E – O).

For the specific programs OPE identified as potentially needing further review, please refer to both *Attachment D: Department Wide Employee Relations Action Plan* and the following attachments:

Benefits
Please refer to Attachment *L: Division of Welfare and Programs Action Plan.*

Child Welfare
Please refer to *Attachment I: Division of FACS and Programs Action Plan.*

Facility Standards
Please refer to *Attachment K: Division of Medicaid and Programs Action Plan.*

Idaho State School and Hospital
Please refer to Attachment *M: Idaho State School and Hospital (ISSH) Action Plan.*

Physical Health Services
Please refer to *Attachment J: Division of Public Health and Programs Action Plan.*

State Hospital North
Please refer to Attachment *O: State Hospital North (SHN) Action Plan.*

VI. ACTION STEPS TO ADDRESS CHAPTER 4 RECOMMENDATIONS

1. Lack of Confidence (4.1.a)

No formal assessment was conducted to examine the causes for employees' lack of confidence when communicating with management. However, when developing the plans, every division, institution, and program did discuss this issue. The divisions, institutions, and programs are implementing communication programs to address this issue (attachments E through O).

At the department level, this issue was also discussed at length. In addition to the changes at the division, institution, and program levels, there are some Department-wide efforts. One of these is the implementation of was a new communication loop for key issues (see Attachment C). This was most recently used in communicating the Department's strategic plan. The Department is conducting a survey of how well we communicated.

In addition, there is some key training in improving communication that will be offered for all supervisors and managers starting this April. This training, Crucial Conversations, teaches employees how to effectively talk with each other instead of keeping silent, arguing, and talking behind each other's back. This has been used in several Fortune 500 companies and has recently been used by State of Washington public employees.

2. Employee Grievance Resolution Process (4.1.b)

Health and Welfare's Division of Human Resources (HR) has taken steps to address this issue. First, the Department has revised Section 20 of its Personnel Policies and Procedures Manual, which was titled: *Problem Solving, Sexual Harassment, and Other Illegal Discrimination, and Appeals.*

The new policy Section 18 – *Problem Solving* – is a stand-alone policy. Feedback received from staff indicated that the old policy was difficult to find, read, and understand. In February 2006, the policy was revised to make it more user friendly, i.e., easy to read and understand. We are also using the software Robo-Info to support an electronic policy and procedure manual, which provides for a "search" function, making specific policies easier to find.

In addition to the *Problem Solving* section, other policies were also modified. These changes were communicated through the Department's internal newsletter *Headline News*. Also, all Health and Welfare Human Resource Specialists recently convened for a comprehensive review of the policy changes. HR staff then returned to their respective geographic areas and met with supervisors and staff in a variety of settings to discuss and answer questions about the new policies, which included the *Problem Solving* section.

We will continue to solicit feedback to see what the impacts of the changes to all policies have been.

Further, we will be taking additional steps beginning this Spring.

- The Division will gather information on specifics of perceived problems with the problem-solving process. Some sources of information would include: employees, employee representative organizations, and possibly legislators.

- Review policies and procedures for possible changes to address problem areas identified.

- Communicate the problem solving process to ensure it and available options for resolving issues is understood by employees. HR staff statewide are available to assist in communicating information through Regional Support Teams and Institutional Management Teams.

VII. ACTION STEPS TO ADDRESS CHAPTER 5 RECOMMENDATIONS

1. Workload and Staffing Models (5.1)

Staff workload was the second most commonly cited factor negatively impacting employee morale. Workload was mentioned by 45 percent of employees as a main contributor to low morale. Survey respondents also identified workload as one of the key factors that contributes most to turnover within the agency

The Director, Deputy Directors, and Division Administrators all understand and have heard quite clearly that many staff have a high workload and are stressed. The first step is to get specific information and data on the workload issues. All institutions and divisions will submit a workload monitoring plan for key positions to the Director no later than October 1, 2007.

2. Workload Adjustment (5.2)

All institutions will submit a workload monitoring plan for key positions to the Director no later than October 1, 2007 (see item 1 of this section).

3. State Hospital Cost-Effect Staffing , Allocations, and Scheduling Methodologies (5.3)

All institutions will submit a workload monitoring plan for key positions to the Director no later than October 1, 2007 (see item 1 of this section).

VIII. ACTION STEPS TO ADDRESS CHAPTER 6 RECOMMENDATIONS

OPE reported that despite the impact that turnover can have on an organization, the Department's personnel data is not structured in a manner that readily allows detailed analysis and monitoring of trends. The Department's data structure hinders the opportunity for easy or accurate analysis about turnover in particular divisions, programs, and facilities.

The information about Department turnover has been focused on overall turnover rates, and rates within particular job types and Department facilities. Although this information provides a useful understanding of job types where retention difficulties may be present, it does not provide Department officials with insight into specific areas where management, morale, or other problems may be negatively impacting the staff, and subsequently, the performance and fiscal resources of the agency.

Based on these observations, the Department of Health and Welfare updated its human resources data to allow for regular monitoring of turnover rates in specific divisions, programs, and work locations, as well as by job classification.

The frequency of turnover and exit interview data reporting to administrators is being moved to semi-annual from annual reports. This should assist the agency in being responsive to identified issues.

We are going to continue to generate reports utilizing data including but not limited to exit interviews, turnover data, disciplinary actions, and appeals, benefits participation, and utilization of classifications. Additional management reports, such as the timeliness and quality of performance appraisals, have been developed and provided to administrators. This information is intended to assist in executive leadership of the Department in human resource issues.

The Department's ability to access data through both the State Controller's IBIS system and Department's data warehouse is being improved. This provides the capability of summarizing and analyzing a variety of important data and information related to retention and compensation of employees.

Office of Performance Evaluations Reports Completed 2006–Present

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Pub. #	Report Title	Date Released
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06-02	Idaho Student Information Management System (ISIMS)—Lessons for Future Technology Projects	August 2006
06-01F	Public Works Contractor Licensing Function	August 2006
06-02F	Idaho Child Care Program	August 2006
06-03F	Timeliness and Funding of Air Quality Permitting Programs	August 2006
06-04F	Fiscal Accountability of Pupil Transportation	August 2006
06-05F	School District Administration and Oversight	August 2006
06-06F	Public Education Technology Initiatives	August 2006
06-07F	Higher Education Residency Requirements	August 2006
06-08F	Child Welfare Caseload Management	August 2006
07-01	Use of Average Daily Attendance in Public Education Funding	February 2007
07-02	Virtual School Operations	March 2007
07-03F	Higher Education Residency Requirements	July 2007
07-04F	State Substance Abuse Treatment Efforts	July 2007
07-05F	Idaho School for the Deaf and the Blind	July 2007
07-06F	Public Education Technology Initiatives	July 2007
07-07	Health Insurance Coverage in Idaho: A Profile of the Uninsured and Those with Coverage	July 2007
07-08	Options for Expanding Access to Health Care for the Uninsured	July 2007
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07-13	Estimating Private Health Expenditures in Idaho	December 2007
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