Management in the Department of Health and Welfare

Second Follow-up Report
March 2009

Office of Performance Evaluations
Idaho Legislature

Report 09-09F

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Joint Legislative Oversight Committee

Rakesh Mohan, Director
Office of Performance Evaluations

Acknowledgments

We appreciate the cooperation and assistance of Department of Health and Welfare staff. Office of Performance Evaluations staff Maureen Shea and Jared Tatro conducted the follow-up review, and Carrie Parrish did the quality control.

Management in the Department of Health and Welfare

Second Follow-up Report

In 2006, we released a report identifying management concerns in the Department of Health and Welfare. Our follow-up report in 2007 found the department had made significant progress to address those concerns but still needed improvement in some areas. This report focuses on the department's continued efforts to improve communication and new steps taken to improve its management of workload and staffing.

Background

In our February 2006 report *Management in the Department of Health and Welfare*, we surveyed all department employees and identified concerns with some management practices. We made five recommendations for the department on turnover, communication, and workload and staffing analysis. In our December 2007 follow-up review, we found the department had implemented a recommendation on turnover and a recommendation on communication and employee grievance processes. Three recommendations on workload and staffing remained outstanding.

This follow-up review provides an update on the continued departmental efforts to improve communication, and it assesses the significant progress made in implementing three recommendations pertaining to workload and staffing. The Department of Health and Welfare's assessment of its current efforts to address our recommendations is provided in the appendix.

Department Continues to Improve Communication

Recommendation: *The Department of Health and Welfare should*

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

At the time of our 2007 follow-up review, we deemed this recommendation implemented assuming the department would continue to improve its communication methods and employee grievance process. This section provides an update on the department's most recent efforts.

In 2008, the department upgraded their electronic information network to more effectively organize and display information pertinent to staff. Easier access to department policies and important information may help facilitate two-way communication and keep staff informed.

Also in 2008, the department added a feature to its weekly online newsletter that allows staff to anonymously ask a question of or provide feedback to the department director. Since this feature's inception, the department reported that the director has responded to 50 questions.

Additionally, the department has continued to provide training for staff on communication related issues. In 2008, human resource specialists completed mediation training on conflict resolution.

We commend the department for continuing to improve interdepartmental communication.

Department Continues to Assess Workload and Staffing

The analysis of workload and staffing is an ongoing process and one that should adapt with changes in circumstance. Although the department faces challenges in data management and transferring workload models among programs, it continues to refine processes and assess workload and staffing needs.

Department Has Made Progress in Developing Workload and Staffing Models

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

This recommendation is directed to three divisions within the department: the Division of Medicaid, the Division of Family and Community Services (FACS), and the Division of Behavioral Health. We have separated the implementation status by division because each division has made varying levels of progress.

Division of Medicaid

The Division of Medicaid has established a process to evaluate workload and staff vacancies for each major program:

- Program managers are required to provide monthly reports on workload measures and performance metrics

- The division's central office management team reviews staff vacancies as a part of its weekly meetings

Since 2006, the division has transitioned and realigned the structure of program management. Instead of having program managers oversee a region, each program manager is now responsible for one statewide program or function. For example, three program managers within one Medicaid program oversee three different functions statewide. This central approach may help to establish a more consistent model of service delivery.

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

Division of FACS

In 2006, the department contracted with the American Humane Association to perform a workload assessment study and staff allocation model for the Child Welfare program within FACS. Before conducting another workload study for the program, division administrators reported that they need to finish implementing new procedures. In 2008, the division completed process mapping for adoption and permanency plans for children in foster care. Process mapping evaluates the steps taken to complete a task and determines what steps can be streamlined to reduce workload. Division administrators said they plan to conduct process mapping for licensing foster care homes next, after which FACS can use the American Humane Association model to conduct another workload study.

FACS has put a workload study for its Infant and Toddler program on hold indefinitely. The division found that software from the American Humane Association workload study completed for Child Welfare was not usable for the Infant and Toddler program because it lacked an advanced automated data system. The division issued a request for proposal for an advanced system, but subsequently canceled it because of insufficient funds.

FACS has also worked to improve client services within the Infant and Toddler program by beginning training and technical assistance on a statewide model of service delivery. However, further implementation has been postponed in anticipation of a shortage of funds.

Status: FACS has taken steps to improve processes to reduce and assess workload and has plans to move forward as funding permits. The *intent* of this recommendation has been **implemented**.

Division of Behavioral Health

At the time of our 2007 follow-up review, the Division of Behavioral Health did not have a reliable way to measure staff workload, in part because the division needed to update and improve its automated data system. This year, division administrators reported that they have chosen a new system, selected a vendor to install it, and anticipate launching the system in June.

The Division of Behavioral Health has also begun to research a workload model based on client acuity and has established a team to develop a plan for implementation.

Client acuity classifies clients into categories based on the severity of their needs. Lower acuity clients do not require as much work as higher acuity clients.

The division is defining its core business practices for statewide standardization, including time intervals for performing certain tasks. Division administrators said that once completed, they intend to put together a *written*, working plan to implement the client acuity model by the end of June 2009. The division has identified several benefits of the client acuity model:

- Statewide consistency in managing workload and evaluating options to make adjustments if workload changes
- Assignment of a specific workload effort to each employee based on client acuity
- Ability to address workload imbalances across regions

Status: The Division of Behavioral Health has made progress toward launching a new automated data system and developing a workload model; therefore, we conclude that this recommendation is **in process**.

Division of Welfare Has Made Efforts to Evaluate Staff Perceptions and Balance Workload

Recommendation: *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 workload among offices.*

The first part of this recommendation calls for the Division of Welfare to identify why staff do not perceive that workload is adjusted appropriately. To address this perception, the division conducted training for staff in 2007 and 2008 on how and why workload decisions are made.

The second part of this recommendation asks for an evaluation of workload within the division. Department officials stated that they regularly assess

workload and staffing in an effort to improve outcomes and noted that Idaho's federal partners have recognized the division's Food Stamp Program as one of the most improved in the nation in terms of its eligibility error rate.[1] In June 2008, as part of its new service delivery system that calls for "same-day service," the Division of Welfare replaced its front lobby clerical staff with case workers. This change has reduced errors and increased the timeliness of services, as evidenced by the Food Stamp Program's federal recognition. The division said it plans to implement an automated system to manage client traffic in the lobby when its budget permits.

Furthermore, the Division of Welfare has made recent efforts to effectively distribute workload and allocate staff:

- The division anticipates its updated workload model, the Resource Utilization Model, will be implemented this spring for the Child Support Services program.[2]

- The division is in the process of replacing its former data system with the new Idaho Benefit Information System (IBIS) for the Benefits program.[3] The replacement should be completed in July 2009, and IBIS should be implemented statewide following a 90-day pilot of the system. Division administrators report that the new information system will provide better data for assessing workload and staffing issues. After implementing IBIS, the department plans to define what updates need to be made to its workload model for the Benefits program.

Status: The Division of Welfare continues to evaluate processes for balancing workload and allocating staff. Assuming the division finishes the replacement of its information system and continues to move forward with its new method of service delivery, this recommendation has been **implemented**.

State Hospitals Have Improved Methods Used to Schedule Staff

Recommendation: *The Department of Health and Welfare should evaluate alternatives, including the development of in-house analytical capacity, to assist*

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[1] The error rate is calculated by evaluating the number of potential recipients that are denied eligibility and the number of recipients that lose eligibility when they should not have.

[2] The Resource Utilization Model uses the technique of random moment sampling—random moment sampling is a method for measuring how much time staff spend on certain case activities. It relies on staff to report their activities at randomly occurring times.

[3] IBIS will replace the Eligibility Programs Integrated Computer System (EPICS). The new system should not be confused with the State Controllers' personnel and payroll system, which uses the same acronym.

state hospitals in identifying the most cost-effective staffing, allocation, and scheduling methodologies.

Idaho's three state hospitals serve different populations. Idaho State School and Hospital serves people with severe developmental disabilities. State Hospital South provides psychiatric treatment and skilled nursing to adults and adolescents with serious mental illnesses. State Hospital North serves acute court committed psychiatric adult patients.

This recommendation has two parts: (1) determine the best ways to schedule staff, and (2) determine the most cost-effective mix of staff resources. Since our last follow-up review, each state hospital has made progress to address both parts. All three hospitals report that they have taken similar approaches to cost-effectively schedule staff:

- Implemented some form of a client acuity model to schedule staff based on daily patient care situations
- Two of the three hospitals have reviewed and adjusted staff-to-patient ratios to cost-effectively schedule staff [4]
- Evaluated staff leave and staff absences to assist in planning for staff scheduling
- Replaced some higher-level staff with mid- to lower-level staff to perform appropriate tasks in an effort to use staff expertise cost-effectively

Status: All three of Idaho's state hospitals have taken steps to make cost-effective staffing decisions that reflect patient needs. We conclude that this recommendation has been **implemented**.

[4] State Hospital North has not yet adjusted its staff-to-patient ratios but plans to do so.

Appendix A

Update of Implementation Efforts

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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January 20, 2009

Rakesh Mohan, Director
Office of Performance Evaluations
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Dear Director Mohan:

We are pleased to share with you our progress on the Office of Performance Evaluation (OPE) four recommendations from the report, Management in the Department of Health and Welfare. We have implemented all four recommendations, and we continue to monitor and improve our management of the programs and services within our Department on an ongoing basis.

If you have questions or need additional information, please contact Tamara Prisock at 334-5719 or prisockt@dhw.idaho.gov .

Sincerely,

RICHARD M. ARMSTRONG
Director

RMA/eb

cc: Wayne Hammon, Administrator, Division of Financial Management
Dr. Richard Roberge, Chairman, Board of Health and Welfare
Amy Castro, Senior Analyst, Budget and Policy Analysis
Tammy Perkins, Special Assistant to the Governor

Recommendation #1
Communication and Problem Solving Process

1. OPE Information

OPE 2006 Recommendation

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

The Department of Health and Welfare should:

A. Examine the causes for employees' lack of confidence when communicating with management;

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.

OPE 2007 Status Report on Department's Progress

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

2. IDHW Response

The recommendations from the Office of Performance Evaluations have been implemented, and we continue to evaluate and improve our communication processes to ensure Department employees receive the information they need to successfully perform their job responsibilities and that they are able to provide valuable information and feedback to Department management.

A. Communication

The Department continues to put into practice the communication activities we committed to in the last report. These include, but are not limited to:

- The use of the communication process we implemented two years ago. The process facilitates two-way communication between divisions and local offices.
- The increase flow of information from Central Office to all staff.
- The assignment of Field Office Leads in each field office to ensure all communication from management is accurately conveyed.

- Specific communication responsibilities for Regional Directors, Regional Support Teams and Field Office Leads. The leads will act as conduits for field staff to easily receive, respond, and convey information to and from management.

- The development of written communication updates to pass through channels so employees will receive consistent and accurate information.

- Implementation of a feedback loop. Programs managers and Field Office Leads will be responsible for seeking and forwarding feedback from staff back up the pipeline.

- Divisions making use of team sites to share information.

- Divisions and Institutions taking steps to address concerns and build two-way communication between staff and management through emails, meetings, and suggestions.

- DAs and program managers making concerted effort to meet with staff on a regular basis.

- Strong efforts are being made to not only explain the decision, but explain why decisions are being made.

Since our last report, IDHW has instituted additional communication activities. First, the Department upgraded our InfoNet in November 2008 so that important staff Information is more effectively organized and displayed.

We also have a feature in *Headline News,* our weekly internal on-line newsletter. The new feature is titled "Ask the Big Boss." Any Department staff member can send an anonymous question or feedback directly to Director Armstrong by clicking the "Ask the Big Boss" icon on the Department's intranet home page. Questions and feedback are then reviewed and answers are provided to all staff.

Since launching on April 24, the response from staff has been overwhelming favorable of this new communication tool. Employees have submitted 385 questions and Director Armstrong has responded to 50 (note: many of the questions are similar). While there have been questions about specific programs within the Department, the majority of questions fall in two basic categories: maintenance/building conditions and benefit/employment/staffing questions.

In particular, employees have used the forum to ask questions about policy changes and other announcements. For example, early in the year, after the Governor asked state agencies to survey employees about alternative transportation and flexible work schedules, dozens of staff sent questions and messages about that topic. The same happened when the announcement about the elimination of MDA leave was made.

Question topics shifted as the economy soured this fall and budget holdbacks began to be discussed. Staff sent in both questions about the impacts budget holdbacks would have as well as money saving suggestions. The 24 hour furlough announcement also generated a number of comments, questions, and suggestions.

B. Problem Solving Process

In the last report, based on the recommendations, the Division of Human Resources took several steps to address and revise policies. Since then, the Department has revised other policies based on the continued feedback we solicit and receive from staff at all levels.

HR continues to respond to employee concerns that come through non-traditional channels such as complaints made directly to senior administrators. HR then follows up with the appropriate management staff and employee(s) to address the situation or issue.

The Department's Division of Human Resources continues to offer training to supervisors that includes information about the Department's problem solving process and what supervisors need to do to help employees access the process and to educate employees about more informal ways we can solve employee relations issues. In addition to our *Orientation to Supervision* course offered quarterly, HR Specialists deliver well attended supervisory workshops and forums in their local areas.

In addition to the continued practices, the department has taken additional steps. All HR specialists completed a 40 hour mediation training to provide them with skills to help supervisors and employees resolve conflicts in a variety ways before the formal process is started.

We have also worked to improve the accessibility and clarity of the policies. For example, with the new InfoNet, policies are easier to find.

During the past year, the Department's Division of Human Resources has enhanced its consultative role by more closely monitoring issues and developing a system to follow with manager. Employees, managers, and supervisors are fully informed of all of the options available for resolving issues but the goal is to ensure problems are addressed and resolved at the lowest possible level. The vast majority of issues are resolved before the formal process begins.

Recommendation #2
Leverage In-House Expertise to Assist Programs

1. OPE Information

OPE 2006 Recommendation

To help improve its workload management, OPE made the following recommendation to the department:

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.

OPE 2007 Status Report on Department's Progress

This recommendation is in process.

2. IDHW Response

The recommendation from the Office of Performance Evaluation has been implemented. Using imperative data to manage programs and services is fundamental to our Department's management philosophy.

We have processes in place that allow us to leverage expertise for establishing standards and models for program and workload management, and we continue to apply and refine the processes and models. It's important to note that we make progress despite some significant challenges:

- Since many of our data systems were developed for federal reporting rather then management reporting, we have difficulty in collecting the data we need. We have made significant progress in identifying sources of management data, and we continue to make progress as we can.

- We are not able to directly transfer specific models and/or processes from one service area to another. For example, processes and models which work well in the Division of Welfare do not transfer directly to the delivery of social services.

- Many of our programs operate in larger social systems within which the Department can influence but not control factors affecting desired outcomes and our ability to project and manage workloads. Examples include family and children's services, services for substance use disorders, and mental health services.

An example of the progress we have made can be found in work completed by the Division of Welfare. The Division of Welfare continues to use the Resource Utilization Model as a staffing tool. The model has been updated to be a more effective tool in staffing and workload

distribution for Child Support Services. The model will be updated for benefit programs upon full implementation of New Service Delivery and the Idaho Benefit Information System (replacement for the EPICS system). With New Service Delivery, the division will also be implementing an automated system for managing lobby traffic.

In fact, the work the Division of Welfare has done to refine its process for forecasting as well as its model for staff adjustments has resulted in recognition from our federal partners for being one of the most improved Food Stamp Programs in the nation.

Another example is the work that continues in the Division of Medicaid. During the past year, the Division of Medicaid conducted a focused review of program responsibilities, roles, and expectations to establish workloads for each major program. With that information, the division took the following actions:

- The division established a process for regularly evaluating staffing levels and allocating vacant positions.
- Program management has been realigned. Rather than managing all Medicaid programs in one region, each manager is responsible for statewide operations for an assigned program. This realignment has resulted in more consistent standards and performance.
- Program managers are held accountable for providing regular reports of workloads and performance metrics. This data is used in managing staffing levels and program performance, and the data is widely shared with division staff.

We have provided additional information for the work that has been completed in the divisions of FACS and Behavioral Health.

FACS

In the 2007 review, OPE stated:

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. 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.

Since that time, the FACS division has utilized the same modeling technique used in the Division of Welfare to develop correlation and identify time lag factors that affect services for children and families. That work, along with the implementation of additional processes and models we describe in greater detail below, has allowed the division to recognize the staffing differentials needed within the division.

In addition, the division has completed process mapping to develop models for efficiency and productivity in its foster care permanency planning.

FACS has also had to make some key decisions. The workload study software from the American Humane Association available for use with the developmental disabilities programs requires certain types of information from an automated system associated with disabilities programs.

The Division has worked over the last year to secure a new automated system but due to costs, has had to severely limit the type of information provided by a new system. The system will be developed in-house instead of procured through an external contractor. At this time, the only way to complete a workload study is to secure a contract with a vendor who *will not have to rely on caseload and other information provided by an automated system.* The American Humane Association software utilized for the Child Welfare study, therefore, will not have any applicability to a study of the Infant and Toddler Program.

The Division had been working with a national consultant to standardize the statewide model for delivery of services in the Infant and Toddler Program. The 'coaching model' is an evidenced-based approach to serving Infants and Toddlers in natural environments with a multi-disciplinary team. Due to expectations for budget reductions resulting from the holdbacks, this project has been placed on hold indefinitely. The Division has no plan to seek a workload study because of the limitations described above.

Allocation of budget and staff will continue based on the current distribution methodology which gives weight to percentages for five statewide measures: 1) historical allocation to Infant and Toddler Program; 2) total population of a region; 3) caseload for the Infant and Toddler Program; 4) total caseload for all children's services; and finally 5) the adult caseload. Attachment C in the previous report provided the specific weights and percentages for the distribution formula and is provided here again for reference.

IDAHO DEPARTMENT OF HEALTH & WELFARE COMMUNITY DEVELOPMENTAL DISABILITIES (EXCLUDING INFANT TODDLER) SFY 2008 METHOD OF DISTRIBUTION							
Weight	0%	50%	17%	17%	17%		100%
Region	Historical Allocation w/o Inf Toddler	Total Population	Inf Tod Caseload	Child Caseload	Adult Caseload		Allocation Percent
1	13.90%	14.10%	9.88%	10.03%	9.91%		12.02%
2	8.53%	7.03%	5.20%	7.43%	12.24%		7.66%
3	17.99%	15.94%	16.48%	21.23%	20.11%		17.61%
4	22.22%	27.24%	26.37%	18.92%	16.16%		23.86%
5	12.74%	11.94%	13.83%	13.90%	10.33%		12.31%
6	10.68%	11.36%	11.06%	9.07%	9.61%		10.64%
7	13.93%	12.39%	17.17%	19.42%	21.64%		15.90%
Total	100.00%	100.00%	100.00%	100.00%	100.00%		100.00%

Behavioral Health

After the last review, the leadership in the Division of Behavioral Health (BH) met to discuss the workload issue as it pertained to core clinical services. It was determined that BH could develop and implement a clinical services model that would serve multiple goals:

1. Better services to clients;
2. An efficient and effective workload model; and
3. Addressing imbalances in workload.

BH has examined mental health caseload models. Although it is difficult to quantify workloads, an approach that has worked in other venues is to examine caseload sizes based on uniform definitions of client acuity. For example, assume clients are assigned into one of three levels; high, medium, and low based upon acuity. High acuity patients would likely be on an Assertive Community Treatment (ACT) team, where caseloads are limited to roughly 10 clients per team member. Medium and low intensity clients would make up the majority of a typical workload. Clinical staff who have exclusively or primarily low intensity clients would have larger caseloads than clinical staff that are responsible for a higher percentage of medium intensity clients. The frequency of certain business practices; for example, prescriber visits and face to face contacts will increase as acuity increases.

As it pertains to the OPE recommendation, the benefits include:

- The ability to implement and manage a consistent statewide workload model with internal expertise.

- Each employee will have a specific workload effort. For example, an employee could have 20 medium acuity clients and 40 low acuity clients.

- Individual workload imbalances can be addressed based on efforts.

- If workload across the state increases the division can then make decisions including: Assigning selected staff for a higher workload for a designated period of time; Determining that more staff are needed for clinical positions; Creating more positions by either reassigning vacant positions or requesting new positions; and/or Examine when clients may be transitioned to Medicaid providers or Primary Care Physicians.

To date, three conference calls including central office and regional staff have been held. BH has identified an existing model as a starting point, established a work team, creating a foundation to build upon. One of the biggest challenges will be establishing buy in from staff since they are the ones delivering the services. This represents a large organizational change. Progress has been made as several key leadership employees are seeing the potential benefits.

The next steps include:

- Setting definitions
- Bringing staff onboard
- Establishing new processes and procedures
- Establishing a data system that can track the required elements

BH is on target and is expected to have a working plan to circulate for feedback by the end of June 2009.

Recommendation #3
Balance Workload Issues in Welfare

1. OPE Information

OPE 2006 Recommendation

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.

OPE 2007 Status Report on Department's Progress

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

2. IDHW Response

The recommendation from the Office of Performance Evaluation has been implemented.

During the past year, the Division of Welfare conducted staff meetings in all areas of the state to explain the Resource Utilization Model and how it is used as a tool for workload management and position distribution in the division. After full implementation of New Service Delivery and the new Idaho Benefits Information System, the Resource Utilization Model will be updated. As a part of the implementation of the new model, a communication/education plan will developed that will again include visits to field offices to educate staff about how work is distributed and staffed, including other information considered in addition to the Resource Utilization Model. The Division Administrator has also continued to visit field offices regularly, talking with staff about how they are adapting to the changes in the business and making sure they understand how staffing decisions are made.

Recommendation #4
Evaluate Staffing at State Hospitals

1. OPE Information

OPE 2006 Recommendation

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.

OPE 2007 Status Report on Department's Progress

This recommendation has not been implemented.

2. IDHW Response

The recommendation from the Office of Performance Evaluation has been implemented. The work that has been completed and continues is outlined below for each hospital.

Idaho State School and Hospital (ISSH)

The Idaho State School and Hospital (ISSH) is classified as an ICF/MR institution. The director, Sue Broetje, has over 14 years working in ICF/MR institutions and approximately 5 years conducting licensure surveys for ICF/MR institutions. During the five years as a licensure surveyor, a primary role was to evaluate adequacy of staffing levels in ICF/MR facilities, including the state institution. With approximately 20 years of management in health care programs, 14 of which have been in ICF/MR facilities Sue has developed expertise in analysis of staffing needs, workload management, and employee relations.

After the last OPE evaluation, ISSH discussed implementing a data collection and analysis system that was referenced by OPE. After a lot of thought, ISSH concluded two things. First, the cost of implementing a tracking system was high whether we did it internally or contracted for the work. We do not have the funds to do this.

Second, ISSH uses a number of tools and data for caseload assignment and management to provide the most cost-effective staff, allocation, and scheduling.

The tools and data that ISSH uses include the following:

- National Comparisons - We looked at the most recent national data that was available. This data included all states that operate large state institutions (42 states). Idaho rated very high in the staff to client ratios of the most essential positions. Idaho was very conservative in the

percentage of administrative/management staff when compared to national averages. The data is listed below:

Discipline	*National Ratio/%*	*Idaho Ratio/%*	*Ranking*
Nurses	.22	.38	4th (top 10%)
Direct Support Staff	1.52	2.64	4th (top 10%)
All Staff	2.79	3.95	8th (top 20%)
Administrative Staff	4.8%	2%	43rd (bottom 20%)

The average national turnover rate during this time period was 27.3%. Idaho was slightly lower at 26.2%.

- Evaluation of Staff Absences - The facility previously used a formula to determine the total number of direct support professionals needed. The formula that had been used historically was that it would take 1.58 FTE to ensure coverage for 7 days per week for every FTE needed. A sample study was done and the facility determined that due to vacation time, sick leave, and staff injury a more accurate ratio was 1.8. The staff schedule was adjusted to this higher rate.

- Client Acuity - ISSH has a definition of workload based on the acuity of client need (number of assaults, number of significant events that must be managed). Based on this information, we assign a minimum ratio of staff based on each individual's need (1:2 on duty for day and swing for 3 units and 1:3 for 2 units).

  This is an area that we continue to address staffing needs. It changes with every admission, discharge and transfer since each individual has a different level of acuity.

- Evaluation of Duties - While the acuity definition is very valuable, ISSH has also established that, from a cost effective perspective, they can manage clients with different levels of staff.

  While the facility has maintained a high direct support staff ratio, major reductions have been made in the nursing department. The duties of the LPNs were changed dramatically over the past year. ISSH conducted a time study of LPN duties and determined approximately 50-60% of their work time was spent passing medications to client. This task is one which was better completed by including as one of the training tasks that direct support staff completes. This shift in responsibilities is also consistent with the process used in community ICF/MRs and supports a developmental rather than a medical model. The ICF/MR program is a development model of service delivery. This resulted in the ability to reduce nursing positions by about 50% and come closer in line to national averages.

  Also, due to the reduction in census over the past year, the facility has made corresponding reductions in staff levels. This has been accomplished almost exclusively through attrition.

- Client to Staff Ratio - For caseloads other than direct support staff, the facility has generally used a strict client ratio caseload and balanced workloads according to numbers. We have been reviewing some alternative methods (such as number of client programs, etc.). Again,

this is a somewhat subjective area because every admission, discharge and transfer impacts this number.

- Ongoing Reevaluation - Every time there is an admission, discharge or transfer, the facility evaluates the impact on the caseloads and makes adjustments as needed.

- Input from Reviewer - As an ICF/MR institution the facility has intensive and frequent surveys for the federal ICF/MR requirements. As mentioned above, we have a good staffing ratio compared to other state institutions (i.e. we have a lot of direct staff to clients).

  While some staff had expressed concerns about adequate number of staff, the federal surveys conducted over the past year did not find deficiencies in the staff ratios provided by the facility.

- Facility Practices - There has been significant work in addressing paperwork reduction. This includes both the generation and review processes associated with the paperwork. The facility has intensive and frequent surveys to meet the federal ICF/MR requirements. The results of these surveys drive both the processes of the facility and the staffing ratios to a large degree. Recently the facility reduced a paperwork system that required five different pieces of documentation to two. Currently the nursing staff is working on reducing and streamlining multiple paperwork documentation systems. Productivity improvement is an ongoing process as we continue to look at effectiveness and efficiencies of each of our systems.

State Hospital South (SHS)

In May 2008 IDHW had a change of leadership at State Hospital South (SHS) at the physician and director positions. The new clinical director has over 14 years of experience as a clinical director in the private sector in Idaho. The changes in hospital leadership provided an opportunity to reevaluate the staff workload models.

At SHS, the need to staff effectively and efficiently is comprised of two parts: Determining the best ways to schedule state hospital staff, and determining the most cost-effective mix of staff resources

- Determining the best ways to schedule state hospital staff -

Extensive time and resources have been utilized to ensure that staff are scheduled in a way that ensures our mission (i.e., State Hospital South is dedicated to the *effective* treatment and recovery of Idaho's most severe mentally ill citizens to enable their return to community living.) and vision (i.e., SHS strives to be a well respected leader in the provision of *cost-effective*, evidenced-based, and recovery-oriented mental healthcare as a primary hospital-based safety net provider for the State of Idaho.) are being met.

SHS is supported in our desire to maintain staffing effectiveness by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and Centers for Medicare & Medicaid Services (CMS) standards and regulations. Thus, not only do we monitor ourselves, we are continually audited to ensure we are scheduling our state hospital staff appropriately.

Several facts provide evidence that we are effective in our scheduling efforts. First, we have eliminated virtually all over-time costs during this fiscal year.

Second, we have recently reviewed the scheduling of staff at the hospital where flex-time was increasing our overall staff utilization and costing the state more to run our facility. After reviewing this practice, we have eliminated these inefficiencies. Employees have agreed to less flexibility in their schedules in exchange for the assurance that we are being cost effective stewards of taxpayer dollars and for reliability and dependability from their coworkers.

The level of staffing for nursing employees (e.g., psychiatric technicians, CNA's, LPN's, and RN's) is determined by our nursing acuity algorithm. Our nursing staff provide the 24/7 staffing of SHS, allowing other professions to work regular hours and minimizing the need for more costly medical professionals (e.g., physicians) to be on staff at all hours to provide for the medical needs of our patients. Essentially, this formula provides the basis for how many employees are necessary at any given time. For example:

Adult Unit Base Staffing (Each 5 Points add 1 Staff)
Add 5 points if census is 26-30 patients
Add 3 points if 2 hours or more in patient escorts or activities
Add 3 points per shift for first Close Monitor; add 5 points per shift for each additional Close Monitor
Add 3 points for each Close Observation per shift (Day and Afternoon Shifts ONLY)
Add 3 points for each 5 patients on Precautions (including Medical and Safety Checks)
Add 3 points for each Episode of Seclusion/Restraint
Add 1 point for each Medical/Psychiatric Problem Requiring Staff > 1 hour
Add 2 points for each Admission, Transfer, Discharge

Our practice at SHS follows best practice in determining our acuity formula. Additionally, our practice first pulls staff from other areas of the hospital, when possible, prior to calling in additional staff when the acuity in a particular area increases.

Our physician staffing also follows best practice standards for staff to patient ratio. We have minimum requirements for our physicians in terms of productivity (e.g., admissions per day) and monitor their adherence to these criteria daily. Administrative and indirect support employees are maintained at necessary levels and each time there is attrition, the refilling of that position is considered and justified by executive oversight.

There are times during short-term absences of staff (e.g., FMLA) that critical staffing shortages occur. Rather than double filling, SHS has the practice of shifting and sharing duties among available staff. For example, recently our laundry supervisor has had to go on FMLA for 6 weeks. Laundry is staffed by two individuals, including the supervisor, and cannot afford to be staffed at 50%. Our physical plant director in cooperation with our custodial and maintenance supervisors has set out a job duty sharing schedule that will cost the hospital nothing and will efficiently utilize staff from these other departments during the short-term need for additional assistance in the laundry.

- Determine the most cost-effective mix of staff resources -

Per JCAHO guidelines, all hospitals must look at staffing variables (e.g., number of staff on the unit) in correlation with patient outcome variables (e.g., seclusions) to determine whether the most effective staff mix is being utilized. These correlations assist the hospital in determining whether there are either negative or positive patient outcomes based on the type and number of staff being utilized on all shifts. The hospital records and analyzes this data on a continual basis and reports outcomes annually. Necessary changes are made based on results of the analyses.

Additionally, several medical staff vacancies have occurred over the past year. Considerable efforts were made to recruit psychiatrists who were local and to not utilize "head hunter" contractors who charge tens of thousands of dollars to find staff for hospitals. We were successful in recruiting psychiatrists without the use of these contractors.

We have also recruited less costly medical professionals (e.g., PA's) to assist our psychiatrists in patient care, thereby reducing our overall operating costs but still providing quality care to our patients. Finally, we regularly utilize less costly nursing staff (e.g. LPN's vs RN's) where regulations allow for this substitution.

State Hospital North

In July 2008, IDHW had a change of leadership at State Hospital North. With this change came an opportunity to reevaluate the staff workload models. The new director, Gary Moore, has over 30 years of healthcare experiences combining clinical, surgical, and administrative responsibilities. Particular areas of expertise include hospital turn-around, medical staff/trustee relations, and management team development.

For many years state hospitals across the country have researched to find comparisons to psychiatric inpatient staffing. To date, for our treatment setting, we are not aware of a specific staffing standard or system, benchmarks, or national, federal, state government or facility standards. Most standards refer to having qualified, adequate and safe staffing based on the needs of patients, because patient population, needs and setting will vary.

Historically state hospitals have tracked patient acuity. Acuity can be calculated and compiled periodically, to help us make decisions and monitor for trends. Acuity system alone is not effective for financial planning and staffing, since it measures acuity after the fact and is not necessarily an indicator of the future.

The most effective and common system for staffing has been combination of acuity and staff to patient ratios, with allowances for exceptions as documented by Nursing based on patient needs. Over the past six months we have reviewed acuity reports and concluded we can adjust staff to patient ratios from 1:7 to 1:6 and still provide a safe environment and quality patient care. SHN Nursing implemented 1:6 staff ratio November 2008 to sustain capacity at 60 beds, and afford the General Fund reductions. SHN will monitor both clinical and financial data to review the impacts.

Nursing direct care staff is defined as RN, LPN and Psychiatric Technicians. Supervisors and managers are authorized to supplement staffing with part-time temporary employees, i.e., when staff are absent for training and leave, and for special needs related to patient and staff safety, such as acute medical care, one-to-one, close observation, seclusion or restraint or any unusual occurrence requiring staff time and attention. SHN currently has plans to decrease the number of RNs, and increase the number of LPNs and Psychiatric Technicians. The change will result in more FTE on duty without increasing costs, due to difference in hourly rates.

Psychiatrists and Nurse Practitioners (Licensed Independent Practitioners or LIPs) will be staffed a minimum 1:15, or 4 FTE for 60 patients. In addition SHN will fill 1 FTE Nurse Practitioner for medical services and train to psychiatry, or contract for coverage, for LIP vacancies and scheduled absences.

Clinical Supervisors have recommended 1:10 Clinicians, or 6 Clinicians for 60 patients. Following the recommendation, SHN established additional Clinician and PSR positions. Currently SHN has 2 FTE Clinical Supervisors, 5 FTE Clinicians and 2 FTE PSR.

SHN and SHS compare staffing for their acute adult psychiatric inpatient units. SHN does not provide services comparable to SHS adolescent, skilled nursing, and 18-212 evaluation and treatment services.

Currently SHN is licensed by Idaho DHW and governed by APA 16.03.14, including statements regarding staffing--for example:

- If hospital offers psychiatric services it shall be directed and evaluated by psychiatrist and staffed by adequate numbers of qualified personnel to meet patient needs

- There shall be sufficient numbers of personnel in all categories to ensure quality of patient care and staffed by sufficient number of quality personnel in keeping with the size and scope of services offered by the Hospital

- Physician on call 24 hours

- RN on duty at all times

IDAHO DEPARTMENT OF
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March 12, 2009

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

Dear Director Mohan:

Thank you for providing the draft report, *Management in the Department of Health and Welfare*. We appreciate the opportunity to review the document prior to its release.

We are pleased with the progress made by the Department and appreciate its acknowledgement by your staff. This has certainly been a valuable process.

It has been a pleasure working with you and your staff on this activity.

Sincerely,

RICHARD M. ARMSTRONG
Director

RMA/eb

cc: Richard Roberge, M.D., Chairman, Board of Health and Welfare
Wayne Hammon, Administrator, Division of Financial Management
Tammy Perkins, Special Assistant to the Governor
Amy Castro, Senior Analyst, Budget and Policy Analysis

Office of Performance Evaluations Reports, 2007–Present

Publication numbers ending with "F" are follow-up reports of previous evaluations. Publication numbers ending with three letters are federal mandate reviews—the letters indicate the legislative committee that requested the report.

Pub. #	Report Title	Date Released
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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
07-09F	Child Welfare Caseload Management	December 2007
07-10F	Management in the Department of Health and Welfare	December 2007
07-11F	School District Administration and Oversight	December 2007
07-12	Cataloging Public Health Expenditures in Idaho	December 2007
07-13	Estimating Private Health Expenditures in Idaho	December 2007
07-14	Trends in and Drivers of Health Expenditures in Idaho	December 2007
08-01	Governance of Information Technology and Public Safety Communications	March 2008
08-02F	State Substance Abuse Treatment Efforts	March 2008
08-03F	Virtual School Operations	March 2008
09-01	Public Education Funding in Idaho	January 2009
09-02F	Higher Education Residency Requirements	January 2009
09-03	Idaho Transportation Department Performance Audit	January 2009
09-04	Feasibility of School District Services Consolidation	February 2009
09-05F	School District Administration and Oversight	February 2009
09-06F	Use of Average Daily Attendance in Public Education Funding	February 2009
09-07F	Child Welfare Caseload Management	February 2009
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Desktop publishing by Margaret Campbell and Brekke Wilkinson

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